

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	St Ita's Community Hospital
<b>Centre ID:</b>	OSV-0000664
<b>Centre address:</b>	Newcastlewest, Limerick.
<b>Telephone number:</b>	069 62311
<b>Email address:</b>	ann.mcmorrow@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Maria Bridgeman
<b>Lead inspector:</b>	Mary Moore
<b>Support inspector(s):</b>	Breeda Desmond;
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	72
<b>Number of vacancies on the date of inspection:</b>	6

## **About monitoring of compliance**

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
26 May 2015 10:15	26 May 2015 19:30
27 May 2015 08:30	27 May 2015 18:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

This inspection was the seventh inspection of the centre by the Authority. The last inspection undertaken in August 2014 was thematic in its approach but also followed up on some of the actions that had emanated from the previous inspection of the 15 and 16 October 2013.

Prior to this inspection residents and relatives were requested to complete questionnaires to provide feedback to the Authority on their experience of the centre and the care and services provided. The feedback received from both residents and relatives was positive and this would concur with the feedback given to inspectors during the course of inspection. Nine relatives completed questionnaires and the majority of them took the time to provide substantial narrative; the feedback relayed

consultation and participation between them, their family member and staff as to the care and services provided. Where issues of dissatisfaction had arisen inspectors were reassured from the feedback provided that these had been satisfactorily addressed by staff.

Inspectors spoke with staff and reviewed records including policies and procedures, nursing and medical records, complaints records, health and safety and fire safety related records. Inspectors observed the delivery of care and practice and staff/resident interactions. Inspectors met and spoke with residents throughout the inspection and found residents to be engaged, informed and interested in the inspection process and eager to reassure inspectors as to the kindness and competence of staff.

There were 72 residents living in the centre and 16 vacant beds based on the number of beds originally registered; the person in charge confirmed that the centre currently has operational capacity for 73 residents. Staff had assessed the needs of 50% of the residents as high to maximum dependency. Inspectors were satisfied that suitable arrangements were in place to meet residents' healthcare and social needs. Staff spoken with were familiar with residents' needs and preferences.

Of the eighteen outcomes inspected the provided was judged to be in compliance with seven and in substantial compliance with five; in moderate non compliance with four and in major non compliance with two, the premises and health and safety and risk management.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Statement of Purpose***

***The there is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The statement of purpose contained much but not all of the information required by Schedule 1 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The organisational structure did not reference all grades of staff employed.

A description of the rooms in the designated centre including their size and primary function was not included.

This was addressed before the draft report issued to the provider and a revised and amended statement was submitted to the Authority.

**Judgment:**

Compliant

***Outcome 02: Governance and Management***

***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There was a clearly defined management structure in place; roles, responsibilities and reporting relationships were clear. The person in charge was supported in the day to day operational management of the centre by two assistant directors of nursing (ADON), the hospital administrator and relevant heads of department such as catering; each clinical area had a clinical nurse manager (CNM). Inspectors were satisfied that staff were clear as to their responsibilities and articulated responsibility for their respective areas; staff meetings and the operation of respective committees such as health and safety, nutrition and end of life care facilitated effective communication between staff.

The person in charge had implemented a quarterly schedule of audits of areas pertinent to the safety and welfare of residents such as falls, meals and mealtimes, medication management and restraint practice. Each audit had a quality improvement plan with identified responsible persons and timeframes. The person in charge intended to use these audit findings and quality improvement plans to inform and support the annual review of quality and safety of care as required by Article 23 (d). There was evidence of improvements made as a result of this process such as the restructuring of resident mealtimes, the provision of meaningful activity and alterations to medication management systems.

Staff had sought to enhance the systems for consulting with residents and their relatives; extra suggestion boxes had been provided and were prominently displayed, staff said that relatives had been formally invited to attend the residents' forum.

Feedback from relatives indicated that management and staff were readily available to them. Staff agreed with inspectors that the existing systems for consultation did not successfully meet the desired objective and this is discussed again in Outcome 16; Residents' rights, dignity and consultation.

There were sufficient resources to ensure the effective delivery of care but the reliance on agency staff is discussed in Outcome 18; Suitable staffing.

**Judgment:**

Compliant

***Outcome 03: Information for residents***

***A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors saw that the residents guide was readily available throughout the centre. Inspectors reviewed the guide and saw that it contained all of the information required by Article 20.

There were systems in place for ensuring that each resident had a contract agreed on admission to the centre. A random sample of resident records seen by inspectors included a contract for provision of services. The contract outlined the care and services to be provided to the resident and the inspector saw from the contract that these were all predominately provided within the basic fee levied by the provider; staff spoken with confirmed this. However, the contract required minor amendment as the sample seen by inspectors did not reference national financial support schemes and the arrangements for the receipt of such monies where appropriate.

**Judgment:**

Substantially Compliant

**Outcome 04: Suitable Person in Charge**

***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The person in charge was appointed to her post in early February 2015. She was a registered general and psychiatric nurse and evidence of current registration with her regulatory body was in place. The person in charge had the required experience and senior management experience having held the post of ADON in a similar facility since 2010. The person in charge worked full-time and was present in the centre Monday to Friday. The person in charge articulated knowledge of and commitment to her regulatory responsibilities, commitment to the residents, staff and provider and to ongoing improvement. The person in charge demonstrated commitment to ongoing professional development and has successfully completed further postgraduate education in nursing older people, management, infection prevention and control and psychosocial interventions in mental health.

**Judgment:**

Compliant

**Outcome 05: Documentation to be kept at a designated centre**

**The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.**

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Overall inspectors were satisfied that the records required by Schedules 2,3 and 4 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were generally well maintained and inspectors readily retrieved the required information from them.

There was documentary evidence that the provider was insured as part of its national schedule of insurance.

Systems were in place for the management and storage of records pertaining to residents no longer living in the centre.

Policies and procedures were current and the subject of review.

However, inspectors saw that a record of each medication administered signed and dated by the nurse administering the medication was not at all times maintained.

There were unexplained gaps in one staff employment history presented to inspectors for the purpose of establishing regulatory compliance.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Absence of the Person in charge**

**The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.**

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There were suitable arrangements in place for the management of the centre in the absence of the person in charge on both a routine and unexpected basis. There were two ADON in post both of whom worked full time and alternate weekends. A designated CNM was allocated responsibility for the centre on a daily basis from 17:00hrs to 20:00hrs. There was a dedicated night time supervisor. There was no reported absence of the person in charge that required notification to the Chief Inspector.

**Judgment:**

Compliant

***Outcome 07: Safeguarding and Safety***

***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors were satisfied that there were measures in place to safeguard residents and protect them from abuse. Training records seen indicated that staff attendance at safeguarding training was monitored, staff identified as requiring training or refresher training were identified and prioritised; 54 staff had attended training to date in 2015. Staff spoken with confirmed their attendance at training, understood what constituted abuse and their reporting responsibilities. There was documentary evidence that staff and management responded appropriately to any alleged abuse, that residents were supported to ensure that they felt safe and reassured that there were no barriers to reporting concerns. Residents told inspectors that they felt safe in the centre and inspectors noted that residents were relaxed in the company of staff.

The new overarching policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse" was available to staff. However, there was a lack of clarity as to whether this policy was the policy to be implemented in practice and no record that staff had received training in its implementation. Post inspection the provider submitted documentary evidence that 42 staff had received induction on its implementation.

The inspector reviewed the systems for managing residents' finances and was satisfied

that they were operated in line with the providers national guidelines on these matters. Residents were facilitated to access their monies as requested.

Inspectors saw the use of bedrails that was evidence based but also practice that was not in line with evidence based policy. For example on one unit bedrails were not in use and practice was informed by completion of a risk balancing assessment tool. Where the tool indicated that alternatives were the most appropriate and safest intervention the inspectors saw these interventions including movement/pressure sensors and low-low beds in place. However, inspectors also saw that some bedrails in the centre were in use without the completion of the risk balancing tool. For example where one record indicated that bedrails were used at the request of residents however, further records indicated that their use was initiated following subjective staff concerns for resident safety. These findings would concur with the providers own findings from an audit completed in March 2015 which found only 69% compliance and deviations from the required restraint processes.

Fifty staff had attended training in April/May 2015 on responding to and managing behaviours that challenged. There was a recently reviewed policy on the management of such behaviours that referenced the use of ABC (antecedent, behaviour and consequence) records to inform the development of a therapeutic management plan. However, while staff were seen to respond appropriately, some care plans seen did not reflect a therapeutic, person centred approach with concerning terminology advising "a firm approach" to be used and an emphasis on pharmacological intervention. One completed ABC chart was seen but it had no apparent impact on the plan of care. Staff spoken with said they did not routinely use the ABC chart to record exhibited behaviours.

**Judgment:**

Non Compliant - Moderate

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Inspectors saw that there was both an organisational and centre specific health and safety statement in place dated 2015.

A centre specific plan dated April 2015 was available setting out the contingencies for responding to emergencies; this included the arrangements for the alternative

placement of residents if necessary. There was a generator on site that was inspected and serviced on an annual basis.

The risk management policy set out the arrangements for identifying and assessing risks, the measures and controls in place to manage the identified risks. The policy also set out the arrangements for the identification, recording, investigation and learning from accidents, incidents and adverse events; this was supported by the providers wider risk management structures.

Records seen supported fire safety systems and precautions that were monitored, reviewed and inspected. Inspectors saw records of the daily and weekly inspection of the fire detection system, fire escape routes and fire fighting equipment. Certificates seen indicated that the fire detection system was tested and serviced on a quarterly basis most recently in May 2015. Staff spoken with confirmed their attendance at both fire safety training, practical simulated fire evacuation drills and specific training on the actions to be taken should the clothes of a resident catch fire. Training records indicated that 92% of staff employed had attended training to date for 2015. Staff articulated adequate knowledge of the actions to be taken in the event of fire including the procedure for progressive horizontal evacuation.

Diagrammatic fire evacuation notices were prominently displayed throughout the centre. However inspectors noted in the Orchid unit that one fire escape route as displayed was not actually physically identified as an escape route and did not have the appropriate signage in place. Two main escape routes were on manual key final fastenings.

Inspectors as on previous inspections of this centre were not satisfied that infection prevention and control procedures were consistent with the National Standards for the Prevention and Control of Healthcare Associated Infections as published by the Authority.

Inspectors were advised that the provider implemented its own "Communication and Inter-Facility Infection Control Transfer, Admission and Discharge Policy"; a local policy that applied to nine of the providers designated centres. Inspectors saw that all nine bedrooms on the Camellia unit had signage in place advising that infection prevention and control standard precautions were in place; four bedrooms in the Bluebell unit had standard precautions in place; approximately 61% of residents. Staff spoken with told inspectors that it was local policy to screen all residents on admission for healthcare associated infections (HCAI); however the timeframe within which to complete screening was unclear with up to 72 hours reported by some staff.

Inspectors did observe good practice in relation to staff completing hand hygiene on both entering and leaving bedrooms. Personal protective equipment (PPE) and alcohol hand hygiene dispensers were prominently and readily available. However with particular reference to the National Standards for the Prevention and Control of Healthcare Associated Infections as published by the Authority inspectors noted that;

- the premises was not designed and laid out to minimise the risks associated with infection and cross-infection
- there were insufficient measures in place to report and management any incident that may have or could have compromised resident safety and the prevention and control of

infection. Staff had in the first quarter of 2015 recorded as two separate clinical incidents the admission of residents with ESBL (Extended Spectrum Beta-Lactamase) into shared accommodation as no single room accommodation was available

- while policy stated that residents were to be screened within 48 hours of admission staff said that it was within 72 hours
- while the inter facility pre-admission assessment was designed to establish a residents confirmed or suspected infection status staff said that this did not always happen and residents were admitted without the required completed assessment. For example one record seen by inspectors stated one resident was screened and confirmed as VRE positive ( Vancomycin Resistant Enterococcus) following admission
- no data was available to inspectors to establish and differentiate residents who were admitted with an established infection and those who acquired an infection in the centre or indeed the number of residents who had never been screened
- staff while using PPE did not change the PPE when handling items belonging to different residents in shared rooms
- catering staff were seen to perform hand hygiene on entering and leaving each room but not each time they removed and cleared off utensils used by different residents in the room including trays, plates and cutlery
- no relative was observed to use PPE while delivering "hands-on" care as stipulated in local policy
- staff were observed to simultaneously remove clinical and non clinical waste on a trolley through the residents communal room
- unrestricted access to cleaning stores was observed
- staff spoken with with responsibility for environmental hygiene told inspectors that they did not have any training on cleaning procedures
- only one unit operated a system of clear segregation of duties where staff did not multi-task between caring, cleaning and catering. Staff said that there was no requirement for standard precautions on this unit. Staff who multi-tasked told inspectors that insufficient time was allocated to environmental hygiene.

Inspectors observed and saw documentary evidence of unsafe manual handling practice. The person in charge told inspectors that there was an identified deficit in staff training on manual handling and that ten training sessions were planned for July 2015.

Inspectors saw that staff had both floor based and ceiling mounted hoists available to them and there was documentary evidence that these were serviced in line with mandatory requirements most recently in March 2015; staff also had access to flat sheet sliding systems. However, inspectors observed unsafe practice when staff assisted residents to stand and staff confirmed that they did not utilise transfer/handling belts. A manual handling plan alerted inspectors to the practice of manually lifting a non weight bearing resident; staff spoken with confirmed this practice. Inspectors saw that two manual handling incidents and staff injuries were reported in the first quarter of 2015. Given that the practice continued at the time of inspection it was reasonable for inspectors to conclude that the accident had not been sufficiently investigated so as to eliminate the practice and the risk of further injury to both staff and residents.

**Judgment:**

Non Compliant - Major

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There were policies and procedures and systems in place to monitor the safety of medication management practices, however deficits were identified by inspectors.

There was a multi-disciplinary medication management committee that had met twice in 2014 and again most recently in March 2015. Medication management practice was the subject of regular audit. Medication including controlled medications was seen to be securely stored. A controlled drugs register was maintained and stock balance checks at the change of each shift were undertaken.

Procedures were in place for the reporting and investigation of medication management errors and there was evidence of learning and altered practice in response to error. Records seen indicated that nursing staff had completed medication management training in April and May 2015.

However, there was no nursing rationale provided for the administration of medications prescribed on a PRN basis (medication that were not scheduled or required on a regular basis), such as for example in the management of behaviour that challenged.

The inspectors observed good medication administration practice. However, a review of retrospective medication administration records demonstrated regular omissions in the recording of medication administration.

A code was utilised to indicate the purposeful non-administration of medication but the entry was not always initialled/ signed by the nurse making the entry.

**Judgment:**

Non Compliant - Moderate

***Outcome 10: Notification of Incidents***

***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Arrangements were in place to ensure that notifications as required by Article 31 were submitted to the Chief Inspector. Having reviewed the accident and incident records inspectors were satisfied that the required notifications had been submitted by the person in charge.

**Judgment:**

Compliant

***Outcome 11: Health and Social Care Needs***

***Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors were satisfied that arrangements were in place to meet residents' healthcare requirements. Residents had access to twice daily medical review and treatment Monday to Friday. As required by their assessed needs staff said and records seen supported that residents had timely access to other healthcare services including speech and language therapy, occupational therapy, physiotherapy, dietetics, psychiatry of older age and chiropody; many of these services were based on site. Well-being was monitored by regular blood profiling and the monthly monitoring of vital signs and body weight. Records of reviews, referrals and recommended treatments were in place.

Each resident had a nursing plan of care and inspectors reviewed a sample of care plans across the units. Each care plan was based on a comprehensive assessment of each residents needs and was supported by a suite of evidence based tools to identify and quantify risk such as risk of falls, wound development or compromised nutrition. The care plans seen reflected the assessed needs and were updated in line with the residents changing needs and at a minimum three monthly. A separate record was maintained to evidence the participation of the resident or their relative; however some of these while signed were undated.

Some care plans were very person centred and contained good narrative personal details; some however were not and reflected an impersonal medical model of care with

repeated use of the term "the patient". As discussed in Outcome 7, plans of care for behaviours that challenged did not accord with contemporary evidence based practice or local policy. There was some duplication of care plans; for example one resident with an identified nutritional need had three nutritional care plans in place two of which had recent updates. This was of concern to inspectors but staff on duty clearly described the care to be delivered based on the most recent instructions of a dietetic referral.

**Judgment:**

Substantially Compliant

**Outcome 12: Safe and Suitable Premises**

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The design and layout of the premises does not conform to the matters listed in Schedule 6 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The provider had made incremental improvements to the centre. One unit previously deemed not fit for purpose by the Authority was closed in 2014 and residents were relocated to the purpose built dementia specific Orchid Unit. At the time of this inspection inspectors saw that the newly constructed rehabilitation unit was near completion and once fittings were in place the existing rehabilitation unit was to relocate. The person in charge said that discussions were at a very preliminary stage as to what purpose the vacated rehabilitation unit would serve.

Inspectors saw that the dementia unit was finished to a high standard; residents were accommodated in two twin and eight single en-suite bedrooms that met resident's needs and provided adequate space and privacy. Adequate dining and communal space was provided, internal walkways were safe, facilitated independence and orientation with areas of interest and diversion; residents had ready access to a safe and secure garden. Further facilities provided to residents included a hairdressing salon and a pleasant room for prayer and quiet reflection.

Bluebell unit accommodated 24 residents and retained three multi-occupancy rooms,

one four bedded room and two three bedded rooms. Camellia unit accommodated 37 residents and 35 of these residents were accommodated in seven five bedded rooms. The rooms had en-suite sanitary facilities and overhead hoists were in place. The provider had reduced the number of residents accommodated in the multi-occupancy bedrooms and in some rooms the vacated space had been used to provide pleasant areas of seating however, the amount of personal bed-space available to each resident had not been enhanced.

Overall 61.5% of residents are accommodated in multi-occupancy rooms of three residents and greater; 94.5% of residents on Camellia unit were accommodated in five bedded multi-occupancy rooms. On a day to day basis the multi-occupancy rooms presented challenges to staff and risks to residents in relation to infection prevention and control; this is discussed in detail in Outcome 8.

There were four recently refurbished twin bedded rooms on Bluebell Unit. The inspectors noted and staff confirmed that the available clearance into two of the rooms appeared narrow given the needs of their occupants. Based on the measurements provided to inspectors the clearance in one bedroom (the Arra room) was not sufficient for wheelchair users.

There was a dual purpose communal/dining area in Camellia Unit, access to a dining area shared with the rehabilitation unit was available however, this was located off the unit. This arrangement did not suit the needs and dependency levels of all residents and would require of staff that they supervise and provide assistance in two areas at mealtimes, one of which was removed from what was seen to be a busy clinical area; the reported arrangement was not seen by inspectors to be utilised. Inspectors observed that one dining table that seated six was available to 37 residents; 24 residents took their meals in their bedrooms.

Some areas particularly in Bluebell Unit had significantly scuffed and damaged paintwork.

The floor covering in room 3 of the Camellia Unit was in poor condition with an uneven surface and evident repairs.

**Judgment:**

Non Compliant - Major

***Outcome 13: Complaints procedures***

***The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The complaints policy and procedure did not comply with regulatory requirements however, inspectors were satisfied that complaints were satisfactorily responded to and managed.

Inspectors reviewed the complaints received to date in 2015, six in total, five from relatives and one from a resident. Records seen indicated that complaints were listened to, investigated, action was taken as necessary and complainant satisfaction was established.

However, inspectors saw two differing complaints policies one of which named the complaints officer as the person in charge and one which did not identify the complaints officer. One policy advised complainants to contact the Authority who would then respond and investigate the matters complained of; this is incorrect, outside of the legal remit of the Chief Inspector and misleading to complainants.

These failings were partially addressed prior to the draft report issuing to the provider ; however the revised and amended policy did still not identify the person nominated in the centre to monitor complaints and ensure that they were appropriately responded to and that the required records were maintained.

**Judgment:**

Substantially Compliant

***Outcome 14: End of Life Care***

***Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

End of life care and practice was guided by a suite of policies including procedures for the nursing verification of death, notification requirements facilitating differing religious and cultural practices. The inspectors were satisfied having spoken with staff and relatives and having reviewed documentation that staff supported residents to achieve a comfortable and dignified death. There was an end of life committee in place; the inspectors saw that the committee completed audits to ensure compliance with the action plan that emanated from the last inspection. The most recent audit findings of May 2015 found that 80% of residents had an end of life care assessment completed to ascertain their preferences and choices. An audit of the records of six deceased resident

found that five of the six residents had an end of life care plan. The sample of care plans seen by inspectors all had a complete end of life care assessment; the recorded information was personal and meaningful.

Since the thematic inspection in August 2014 a further twenty eight staff had received end of life care education and training.

Where indicated care was supported by the specialist palliative care team. Family members were communicated with and facilitated to be with the resident as end of life approached. A designated room was available to families with seating including a bed-settee and facilities for making light refreshments. Adequate provision was in place for meeting residents' spiritual and religious needs. There was a spacious chapel on site that was frequently used for the repose of the remains and records seen confirmed that spiritual care and comfort was provided at end of life.

There were procedures in place for the management of unanticipated deaths and clinical records to support do not attempt resuscitation decisions. The latter were clearly recorded and reviewed on a quarterly basis.

**Judgment:**

Compliant

***Outcome 15: Food and Nutrition***

***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

With the exception of the social dimension of the dining experience on Camellia Unit due to inadequate dining space, inspectors were satisfied that residents nutritional requirements and preferences were met.

All meals were freshly prepared on a daily basis on site by the catering department. Inspection reports were available to confirm that the facility was monitored by the relevant Environmental Health Officer (EHO).

A menu was in place that operated on a three weekly cyclic basis and offered choice at each mealtime; the menu offered a variety of appealing choices. There were clear explicit procedures in place for ascertaining and communicating to catering staff each resident's meal preferences on a daily basis including any specific dietary requirements

and diet required in a modified consistency. While catering staff said that they were dependent on frontline staff to communicate each resident's needs and preferences to them, there were no reported barriers to facilitating choice. Inspectors saw that meals were appealingly presented including meals of a modified consistency, portion sizes were adequate and residents expressed enjoyment of their meals. Residents were seen to be provided with the required supervision and assistance by staff in a relaxed and respectful manner. A variety of fluids and light snacks were seen to be provided to residents at structured and reasonable timeframes. While there was a protected meal time policy in place family members were seen to be facilitated to provide assistance to their relative at meal times if this was their expressed preference.

Inspectors saw that the deficit noted in the modified diet option at evening meal at the time of the last inspection had been addressed and a variety of hot savoury options were now included on the menu.

Inspectors were satisfied that there were effective procedures in place to ensure that residents did not experience poor nutrition. Nursing staff assessed and monitored nutritional wellbeing through professional judgment, completion of a validated assessment tool and monitoring body weight. There was documentary evidence that the appropriate intervention was sought from the medical officer, the dietitian, or the speech and language therapist (SALT). Some duplication of care plans was noted but inspectors were satisfied that the required care was delivered. The duplication is addressed in Outcome 11.

Some residents did choose to take their meals at their bedside but the impact on the overall quality of the dining experience due to the lack of an adequate dining facility on the Camellia unit is discussed in Outcome 12.

**Judgment:**

Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***

***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

It was acknowledged that improvement was required in the systems for consulting with

and obtaining feedback from residents. Overall however, inspectors were satisfied that residents were treated with respect and that staff were committed to enhancing the quality of life for residents in the centre.

A spacious chapel was available on site and staff were seen to facilitate resident requests to attend mass which was said on a regular basis during the week. The residents guide stated that other denominations were welcomed; staff confirmed this but none were attending the centre at the time of inspection.

Traditionally a polling booth had been facilitated in the centre but had ceased this year due to the low uptake. Staff confirmed however that residents were either facilitated to exercise a postal vote or transport was made available for them to attend the local polling station.

There were no reported restrictions on visiting; this was confirmed by residents and relatives and inspectors observations; suitable private areas were generally available if required.

The person in charge said that links had been formed with the national advocacy service and there was documentary evidence that the service had been offered to residents as a support on particular matters. The centre going forward was to have a dedicated advocate from the advocacy service.

Prior to the inspection both residents and relatives had provided positive feedback on the variety of activities provided to residents. Inspectors saw that a room that had previously served as a staff meeting room had been converted into a social hub for residents. Residents were seen to gather here each morning for tea and chat; there was a very natural and relaxed dimension to what inspectors observed. Staff spoken with had a solid knowledge of resident's histories and interests and this would concur with the biographical records seen in residents care plans. On a one to one basis staff from the adjacent day care service offered therapies such as reflexology and reiki to residents.

However, this was a large service and it was difficult to see how one allocated staffing resource could attend to all residents if they so wished on a regular and consistent basis. Both the nominated provider and person in charge confirmed that this had been identified and it was planned to allocate a further resource to the provision of meaningful engagement.

There was a formal forum for consulting with and seeking feedback from residents, however the minutes did not demonstrate how it was representative of the majority of residents as resident participation was very low. Meaningful actions had however evolved from this forum such as the planned information day for residents and relatives on abuse and safeguarding.

**Judgment:**

Substantially Compliant

**Outcome 17: Residents' clothing and personal property and possessions**  
**Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.**

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There was a laundry on site but staff confirmed that minimal laundry services were provided on site to residents. Staff reported that the majority of residents had their laundry requirements attended to by family members and this would concur with the feedback received from relatives. All linen and the personal clothing of residents who did choose to avail of the laundry service was collected and returned twice weekly from the main laundry in Limerick. A system was in place to label and safeguard resident's personal clothing. There was no evidence to indicate that these arrangements were not sufficient.

Inspectors noted and staff agreed that the majority of residents had minimal personal storage space with narrow mobile single wardrobes provided.

**Judgment:**

Substantially Compliant

**Outcome 18: Suitable Staffing**

**There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.**

**Theme:**

Workforce

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

A planned and actual staff rota was maintained and staffing levels and skill-mix were

monitored by nursing management on a daily basis. However, staffing levels were maintained predominately through the employment of agency staff. This was managed through an agreed centralised contract and the provider endeavoured to ensure that the same agency staff were provided for the purpose of continuity. However, agency staff were used not just for unforeseen contingencies but on a regular and consistent basis. Nursing management confirmed that on a weekly basis since January 2015 the total staffing complement included an average of 19% agency staff.

Inspectors were not satisfied that the staffing levels in the dementia unit between 17:00hrs and 20:00hrs were sufficient to meet the needs of the residents particularly due to the exacerbation of behaviours that challenged at this time. Staff had evidence to support this including an incident where the sole nursing presence had to leave the unit in response to one such behaviour for approximately ten minutes leaving one multi-task attendant on the unit.

The recruitment of staff was managed centrally and based on a random sample of staff files seen by inspectors the provider was substantially compliant with the information requirements of Schedule 2. However, there were unexplained regular gaps in one staff employment history.

There was documentary evidence of current registration with their regulatory body for each nurse employed.

There was documentary evidence that volunteers were adequately vetted and had their role and responsibilities explicitly set out.

Staff training records demonstrated commitment to the provision and facilitation of staff training. Recently completed education and training included medication management, end of life care, the management of behaviours that challenged, safeguarding, fire safety and precautions, nutrition, basic life support, wound prevention and management and the provision of dementia care. However, a deficit was identified and acknowledged in manual handling training and the negative consequences of this have been discussed in Outcome 8. Given the requirement for infection prevention and control measures in the centre, and while training records indicated that training was provided to staff on an ongoing basis with 52 staff having attended training to date in 2015, the records also indicated that 20% of staff had not attended training since 2012. Staff with responsibility for environmental hygiene told inspectors that they had not received relevant training.

**Judgment:**

Non Compliant - Moderate

## **Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

Mary Moore  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

# **Health Information and Quality Authority Regulation Directorate**

## **Action Plan**



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Phaisnéis  
agus Cáilocht Sláinte

### **Provider's response to inspection report<sup>1</sup>**

<b>Centre name:</b>	St Ita's Community Hospital
<b>Centre ID:</b>	OSV-0000664
<b>Date of inspection:</b>	26/05/2015
<b>Date of response:</b>	13/08/2015

### **Requirements**

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### **Outcome 03: Information for residents**

#### **Theme:**

Governance, Leadership and Management

#### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The contract of care did not reference national financial support schemes and the arrangements for the receipt of such monies where appropriate.

#### **Action Required:**

Under Regulation 24(2)(c) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme, including the

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

arrangements for the payment or refund of monies.

**Please state the actions you have taken or are planning to take:**

The contract of care will be amended to reference national financial support schemes and the arrangements for the receipt of such monies where appropriate.

**Proposed Timescale:** 01/09/2015

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A record of each medication administered signed and dated by the nurse administering the medication was not at all times maintained.

There were unexplained gaps in one staff employment history.

**Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**

The importance of signing and dating medication administered by nursing staff was discussed at the CNM meeting on 25th of June 2015 as well as at individual ward meetings by DON and it was stated that this must be adhered to at all times.

Audit scheduled for August will evaluate and address compliance with recording of each medication administered being signed and dated by the nurse administering the medication.

The files requested by inspectors were of most recent employee' files and one of these was a local file while awaiting complete file from HR dept. Complete file is now on site

**Proposed Timescale:** 01/09/2015

**Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Behavioural care plans did not reflect a therapeutic, person centred approach with

concerning terminology advising “a firm approach” to be used and an emphasis on pharmacological intervention.

Staff spoken with said they did not routinely use the ABC chart to record exhibited behaviours.

**Action Required:**

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

**Please state the actions you have taken or are planning to take:**

MAPA training will continue and care plans will be reviewed to reflect a therapeutic, person centred approach in conjunction with the resident or care representative.

At the CNM meeting of 25/06/15 CNM's were advised to ensure all staff are aware of the policy on managing Behaviours that Challenge. Staff are to use the ABC chart (as per policy)to record and inform the management of behaviours that challenge or pose a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

**Proposed Timescale:** 01/09/2015

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Some practice in relation to the use of bedrails was not in line with nationally agreed evidence based policy.

**Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**

Staff training sessions will take place during August and September regarding the use of bedrails in line with national policy.

Audits in relation to the use of bedrails are taking place and will continue to ensure practice is in line with national policy.

**Proposed Timescale:** 01/11/2015

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The new nationally agreed overarching policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse" was available to staff. However, there was a lack of clarity as to whether this policy was the policy to be implemented in practice and no staff had received training in its implementation.

**Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**

The "Safeguarding Vulnerable Persons at Risk of Abuse" is the policy to be used by staff.

On the day of the inspection there was documentary evidence that the "Safeguarding Vulnerable Persons at Risk of Abuse" was available to staff and that 42 staff had received training in its implementation.

This training will continue until all staff are trained.

**Proposed Timescale:** 19/12/2015

**Outcome 08: Health and Safety and Risk Management**

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Inspectors observed and saw documentary evidence of unsafe manual handling practice.

Inspectors saw that two manual handling incidents and staff injuries were reported in the first quarter of 2015 but the poor practice continued.

**Action Required:**

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

**Please state the actions you have taken or are planning to take:**

Manual handling training sessions are taking place now. Refresher training 3rd July x 2, 10th July x 2, full training 14th,16th, 17th,21st,22nd,28th,30th,31st July 2015, with additional dates arranged for the Autumn. There is ongoing input from Occupational Therapy and Physiotherapy departments upon referral for any assessments or equipment required for use for residents.

CNM's instructed to review Manual Handling care plans at CNM Meeting of 25/06/2015.

A working group in Area 3 CHO are currently reviewing and standardising the Client Manual Handling Form and the Client Manual Handling Care Plan to be in line with the HSE Manual Handling and People Handling Policy 2012.

As residents condition may change on a weekly/ daily/hourly basis, the care plan must reflect an up to date appropriate risk assessment based on the residents condition at any given time. Staff are advised to carry out a risk assessment each time they plan to move a person and if the resident's ability fluctuates from day to day or dependent on the time of the day it should be reflected in the care plan.

A lead person will be identified for training as an In-house Manual Handling instructor for the transfer of theory into practice of techniques learned in training into the workplace as well as the need for appropriate measures for providing optimum care for specific resident groups – for example, bariatric residents and residents at risk of falling

**Proposed Timescale:** 01/10/2015

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Inspectors as on previous inspections of this centre were not satisfied as detailed in the body of the report that infection prevention and control procedures were consistent with the National Standards for the Prevention and Control of Healthcare Associated Infections as published by the Authority.

**Action Required:**

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

**Please state the actions you have taken or are planning to take:**

The Infection Prevention and Control Committee (An MDT group including IPC Manager) meet every 2 months where policies, audit, surveillance, antibiotics and training will continue to be discussed to improve compliance and action plans are evaluated.

Schedules of monthly IP&C audits are conducted in addition to unannounced audits by IP&C team. The aim of the audit process is to formulate quality improvement plans to improve and maintain high standards in line with best practice.

The Communication & Inter-facility Infection Control Transfer/Admission/ Discharge Policy has been re circulated to CNM's for implementation with all staff and signing sheet to be sent to DON by 6th of July 2015.

An audit by IP&C management team commenced on the Inter-facility Infection Control status at time of admission of each person/resident to St. Ita's from the Acute services for first quarter of 2015 and to ascertain compliance with The Communication & Inter-facility Infection Control Transfer/ Admission/ Discharge Policy.

Infection Prevention and Control Surveillance is ongoing and displayed on each ward computer and on ward notice boards. CNM's continue to complete and use this information at handover to ensure all staff are knowledgeable on infection control status of residents in their care.

Training on environmental hygiene to be conducted with staff involved in this work on 6th & 7 th of August and the 10th & 11th of September.

Infection prevention and control training continues with dates arranged for 4th August, 3rd September and 8th of October 2015. Staff who have not attended infection prevention and control training since 2012 will be initially prioritised to attend this training.

Six staff have completed the University Of Limerick Level eight Module on Infection Prevention and Control. They are accredited lead hand hygiene auditors. A project Hand Hygiene "Your Health our Hands" is being piloted in Camellia Unit to increase compliance with World Health Organization 5 Moments of Hand Hygiene by creating hand hygiene champions who continue to conduct ward based training sessions and audit compliance with hand hygiene.

#### **Proposed Timescale:** 10/10/2015

#### **Theme:**

Safe care and support

#### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

In the Orchid unit one fire escape route as displayed was not actually physically identified as an escape route and did not have the appropriate signage in place.

Two main escape routes were on manual key final fastenings.

#### **Action Required:**

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

#### **Please state the actions you have taken or are planning to take:**

Appropriate fire escape route signage is now in place.

One of the doors with final key fastenings has the key to unlock it contained in the

break glass red box located alongside it  
The other door on final key fastening has the key to unlock it contained in the break glass red box located alongside it, because it also has a code it has an emergency green door release system.(see attached photographs)

**Proposed Timescale:** 15/07/2015

## **Outcome 09: Medication Management**

### **Theme:**

Safe care and support

### **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

No nursing rationale was provided for the administration of medications prescribed on a PRN basis (medication that is not scheduled or required on a regular basis), such as for example in the management of behaviour that challenged.

A review of retrospective medication administration records demonstrated regular omissions in the recording of medication administration.

A code was utilised to indicate the purposeful non-administration of medication but the entry was not always initialled/ signed by the nurse making the entry.

### **Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

### **Please state the actions you have taken or are planning to take:**

The importance of signing and dating medication administered by nursing staff was discussed at the CNM meeting on 25th of June 2015 as well as at individual ward meetings by DON and instructions were given that this must be adhered to.

Audit scheduled for July will evaluate and address compliance with recording of each medication administered being signed and dated by the nurse administering the medication.

Nursing rationale for the use of PRN medication is documented in the residents care plan.

**Proposed Timescale:** 01/08/2015

## **Outcome 11: Health and Social Care Needs**

### **Theme:**

Effective care and support

### **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Some care plans reflected an impersonal medical model of care with repeated use of the term "the patient".

Plans of care for behaviours that challenged did not accord with contemporary evidence based practice or local policy.

There was some duplication of care plans

### **Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

### **Please state the actions you have taken or are planning to take:**

ADONS are conducting an audit of care plans.

MAPA training will continue and care plans will be reviewed to reflect a therapeutic, person centred approach in conjunction with the resident on a four monthly basis or more frequently if required.

It was agreed at the CNM Meeting of 25/06/2015 that the term "resident" or the persons preferred name will be used in care plan in future and has been communicated to all staff by CNM's.

**Proposed Timescale:** 01/08/2015

## **Outcome 12: Safe and Suitable Premises**

### **Theme:**

Effective care and support

### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The design and layout of the premises does not conform to the matters listed in Schedule 6 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

### **Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

### **Please state the actions you have taken or are planning to take:**

Under regulations 17(2) whereby the premises must conform to the matters set out in schedule 6, a time bound costed plan is awaiting sign off by Estates and the Chief Officer.

It is envisaged that the project will be in excess of €5 million and currently the project is unfunded.

A new Rehabilitation Unit has been built and is currently at fit out stage. It is envisaged that this will open in September or October 2015.

The vacated space will allow for further reconfiguration of current services working towards making the hospital compliant with HIQA standards.

Proposed Timescale: Opening of New Rehab Unit – October 2015  
Reconfiguration of current service 21st December 2015

**Proposed Timescale:** 31/12/2015

### **Outcome 13: Complaints procedures**

#### **Theme:**

Person-centred care and support

#### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The complaints policy was not fully compliant with regulatory requirements.

#### **Action Required:**

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under Regulation 34 (1)(f).

#### **Please state the actions you have taken or are planning to take:**

Complaints training will be scheduled to include the additional person in the Centre.

The complaints policy has been further amended and sent to the inspectorate.

**Proposed Timescale:** 01/09/2015

### **Outcome 16: Residents' Rights, Dignity and Consultation**

#### **Theme:**

Person-centred care and support

#### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was a formal forum for consulting with and seeking feedback from residents, however the minutes did not demonstrate how it was representative of the majority of residents as resident participation was very low.

**Action Required:**

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

**Please state the actions you have taken or are planning to take:**

The structure of the resident's forum is changed to have more residents as well as relatives in attendance, so they are consulted about and participate in the organisation of the designated centre.

**Proposed Timescale:** 01/08/2015

**Outcome 17: Residents' clothing and personal property and possessions**

**Theme:**

Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The majority of residents had minimal personal storage space with narrow mobile single wardrobes provided to them.

**Action Required:**

Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

**Please state the actions you have taken or are planning to take:**

The small narrow wardrobes will be replaced with larger wardrobes commencing in Bluebell Unit.

**Proposed Timescale:** 15/12/2015

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Agency staff were used not just for unforeseen contingencies but on a regular and consistent basis. Nursing management confirmed that on a weekly basis since January 2015 the total staffing complement included an average of 19% agency staff.

Inspectors were not satisfied that the staffing levels in the dementia unit between

17:00hrs and 20:00hrs were sufficient to meet the needs of the residents particularly due to the exacerbation of behaviours that challenged at this time.

**Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**

A review of rosters in the Dementia Unit will take place with due process to ensure sufficient staffing to meet the needs of the residents particularly due to the exacerbation of behaviours that challenge between 17:00hrs and 20:00hrs.

PIC is in discussion with Registered Provider with regard to staff recruitment.

**Proposed Timescale:** 01/12/2015

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

A deficit was identified in manual handling training.

Training records indicated that 20% of staff had not attended infection prevention and control training since 2012.

Staff with responsibility for environmental hygiene told inspectors that they had not received relevant training.

**Action Required:**

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

**Please state the actions you have taken or are planning to take:**

Manual handling training sessions are taking place. Refresher training 3rd July x 2, 10th July x 2, Full training 14th,16th, 17th,21st,22nd,28th,30th,31st July 2015. There is ongoing input from Occupational Therapy and Physiotherapy departments upon referral for any assessments or equipment required for use with residents.

Training on environmental hygiene to be conducted for staff who require training on the 7th & 8th August and 10th & 11th of September 2015.

As per Outcome 8, ongoing infection prevention and control training is planned for the 4th August, 3rd September and 8th of October 2015. Staff who have not attended infection prevention and control training since 2012 will be initially prioritised to attend this training.

Six staff have completed the University Of Limerick Level eight Module on Infection Prevention and Control. They are accredited lead hand hygiene auditors. A project Hand Hygiene "Your Health our Hands" is being piloted in Camellia Unit to increase compliance with World Health Organization 5 Moments of Hand Hygiene by creating hand hygiene champions who continue to conduct ward based training sessions and audit compliance with hand hygiene.

**Proposed Timescale:** 30/09/2015