<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Joseph’s Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000613</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Lifford Road, Ennis, Clare.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>065 686 3835</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:meave.oconnor@hse.ie">meave.oconnor@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Mark Sparling</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Moore</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Aoife Fleming; Maria Scally; Noelle Neville</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>98</td>
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<td>Number of vacancies on the date of inspection:</td>
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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.
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

<table>
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<tr>
<th>From:</th>
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<tr>
<td>17 June 2015 09:15</td>
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</tr>
<tr>
<td>18 June 2015 09:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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

This inspection was the seventh inspection of the centre by the Authority. The previous inspection was undertaken in August 2014 and based on the significant findings of that inspection the provider was issued with an immediate action plan to rectify failings in fire safety procedures and precautions; the provider responded positively and within the agreed timeframes.

Prior to this inspection residents and relatives were invited to complete a questionnaire on a voluntary basis to elicit their experience of the care and services provided by the provider. Overall respondents were complimentary of staff but three consistent areas of concern/dissatisfaction were identified; the physical environment, meaningful engagement and staffing levels. Respondents articulated a clear desire
for more privacy, more space, more sanitary facilities and somewhere to meet up and chat. Residents wanted more meaningful engagement and reported that they “had nothing to do”; this was also reflected in some of the relatives’ questionnaires. Concerns were raised as to the impact of staffing on residents choices and routines such as their personal hygiene, access to snacks and fluids, and having to wait for “long periods” for staff assistance. The findings of this inspection would support and reflect the majority of these experiences.

There were 120 registered beds in the centre, on the days of inspection 98 of these beds were occupied, 80 on a long-term basis and the remainder occupied by residents in receipt of short-term and respite care. Staff had assessed the needs of the majority of the residents (81) as of maximum dependency. Inspectors reviewed the premises, met with management and staff; spoke with residents and relatives throughout the inspection. Inspectors observed care and practice and reviewed records including nursing and medical, fire safety and health and safety, accident and incidents, complaints and staff related records.

Overall inspectors were satisfied that the centre was well governed and systems were in place for the ongoing review and monitoring of care and services. The maintenance of adequate staffing and skill-mix was described as “challenging” but inspectors were satisfied that this was managed proactively by the person in charge and the provider. Arrangements were in place to meet the health care needs of the residents and improvement was noted though more was required, in the provision of meaningful activities.

The premises is significantly non-compliant with regulatory requirements and does not meet the individual and collective needs of the residents in terms of their privacy, personal space, access to dining and communal space and adequate and accessible sanitary facilities.

There was evidence to support on some units entrenched staff routines that impacted negatively on the timing and quality of residents’ meals and mealtimes and the provision of fluids and snacks at regular and reasonable times. This latter failing had not been addressed as committed to in the provider’s response to the last action plan. Overall improvement was required to enhance consultation with and the meaningful participation of residents in the planning and organisation of the centre.

Based on the full eighteen outcomes inspected against the provider was found to be in compliance with four and in substantial compliance with six, in moderate non-compliance with seven and in major non-compliance with one, the premises.
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

*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:**
There was a statement of purpose available in the centre. This consisted of the aims, objectives and ethos of the centre including the facilities and services to be provided to residents. It included most items as listed in Schedule 1 of the Regulations however, it did not contain the following:

- The centre’s policy and procedures (if any) for emergency admissions
- Arrangements for the management of a designated centre where the person in charge is absent from the centre.

The statement was revised and amended prior to the conclusion of the inspection.

**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:**
This is a large and complex service but inspectors were satisfied that the service was adequately governed and resourced.
There was a clearly defined management structure with a dedicated clinical post of responsibility in place each day including weekends and at night. The nominated registered provider and other relevant business managers were also based on site and the person in charge reported that this facilitated ready access and support routinely and as required. The person in charge was supported on a daily basis by two Assistant Directors of Nursing (ADON); each unit had a Clinical Nurse Manager (CNM). Each member of the management team spoken with was clear on their respective role and responsibilities and each readily answered any queries in relation to residents or the administration of the service.

The person in charge confirmed that on a day to day basis the service and any requirements to meet residents’ needs were adequately resourced.

Inspectors saw that there were systems in place for the ongoing monitoring and review of the quality and safety of care and services provided to residents. These included internal audits and reviews such as falls and accident audits, nursing documentation audits, hygiene and infection prevention and control audits, risk register audits and consultation with residents on areas such as meaningful activity and the meals provided. Audit findings and any corrective actions required were fed back directly to each CNM. There was evidence that the system was effective such as the improvement noted in medication management, staff attendance at training, and the overall consistency of nursing care plans.

A provisional plan for the formal review of the quality and safety of care and services provided to residents and as required by Article 23 (d) was presented to inspectors. However, no one overarching review from which a report had issued and was made available to residents and relatives had taken place.

Judgment:
Substantially 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:**
The resident's guide was available in the centre. This contained most of the requirements of the Regulations such as a summary of the complaints procedure and arrangements for visitors. However, this guide had last been reviewed in May 2013 and did not contain the most up to date and accurate information regarding the services and facilities in the centre.
Inspectors reviewed a sample of resident's contracts of care and found that not all contracts set out the services to be provided, whether under the Nursing Home Support Scheme or otherwise to the resident concerned, the fees, if any to be charged for such services, and any other additional fees for services that the resident may chose to avail of but which was not included in the basic fee. There was no contract in place for a small number of long-stay residents and there was no contract in place that satisfied regulatory requirements for short-stay residents.

Judgment:
Non Compliant - Moderate

**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 worked full-time and was present in the centre Monday to Friday. The person in charge was suitably qualified and was currently registered in two divisions, general and psychiatric, of the nurse register. The person in charge was in post since 2012 but prior to this she had been an Assistant Director of Nursing (ADON) and had also shared the post of person in charge from 2009 to 2011. The person in charge maintained her knowledge and skills through ongoing professional development and had recently completed education on safeguarding and protection, infection prevention and control, nutrition and hand hygiene auditing. The person in charge had also completed post graduate education in Health Services Management. The person in charge was seen to be visible and accessible and was fully informed as to the needs of the residents, the operation and administration of the centre and her legislative responsibilities.

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
Themes: Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found the records listed in Schedules 2, 3 and 4 to be substantially complete, accurate and easy to retrieve.

The Directory of Residents was reviewed and was found to contain all of the matters listed in Schedule 3.

The designated centre has all of the written operational policies as required by Schedule 5. Inspectors found that policies and procedures were regularly reviewed and updated at intervals not exceeding three years.

Inspectors reviewed the centre's insurance policy and found that the centre was adequately insured against accidents or injury to residents, staff and visitors.

The inspectors reviewed a sample of staff files and found that they contained most of the requirements of Schedule 2. However, a small number did not contain a full employment history including a satisfactory explanation of any gaps in employment.

Judgment:
Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Themes: Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Suitable arrangements were in place for the management of the service during the routine or any unexpected absence of the person in charge. There were two experienced ADON’s one of whom had also previously shared the post of person in charge of the centre, who between them worked a rota that ensured a senior clinical management presence on site each day including weekends.

There had been no absence of the person in charge from the designated centre for a period 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:**
Arrangements were in place to ensure that residents were protected from harm and abuse.

There were systems in place to monitor staff attendance at safeguarding education; training records indicated that all staff had attended same and this was confirmed by the ADON who co-ordinated the staff training programme. Arrangements were also in place for the phased implementation of the more recent Safeguarding Vulnerable Persons at Risk policy with 39 staff to date having attended a familiarisation session. Staff had good access to the local elder abuse officer. Staff spoken with confirmed their attendance at training, articulated a good understanding as to what may constitute abuse, their reporting responsibilities and relationships; staff had ready access to the relevant policies and procedures. No resident spoken with including those with an understanding of the role of the inspector raised any concerns or worries and told inspectors that they felt safe in the centre.

Residents finances were seen to be managed in line with the providers agreed national guidelines. There was documentary evidence including receipts, staff and resident signatures to verify that residents were facilitated to access and manage their own finances and systems were in place to verify charges and transactions.

Inspectors saw therapeutic plans of care to guide the management of behaviours that had the potential to challenge. The plans outlined the behaviour, possible triggers and therapeutic strategies to be employed by staff when behaviours were exhibited. The plans were individualised to each resident and staff spoken with were familiar with the plans and the strategies to be employed by staff. A programme of staff training on responding to and managing behaviours that challenged had very recently commenced and two staff were trained to facilitate further training. However, inspectors noted that some residents also had current prescriptions for chemical intervention (antipsychotic medication) and where these had been administered (in one instance almost on a daily basis) in response to behaviours that challenged, administration was not supported by a nursing narrative record outlining the rationale for administration/chemical intervention.
including the behaviour exhibited and the trial and failure of agreed non-chemical interventions.

A restraint register was maintained and there was evidence of practice that was in line with national evidence based policy and the standards as issued by the Authority, but also practice that was not. Inspectors saw a risk balancing assessment tool for the use of bedrails, records of monitoring and release, evidence of the use of alternatives including low-low beds, impact reducing floor mats and movement alarms/sensors. There was documentary evidence that the continued requirement for the use of bedrails was the subject of review and the use of bedrails with four residents was recently discontinued. However, inspectors also saw that a relatives request for bedrails was allowed to supersede the findings of the clinical risk assessment which had concluded that the use of bedrails was not recommended. The risk of the continued use of bedrails with a resident who had fallen from bed with the bedrails in situ had not been reassessed. Some monitoring records were not consistently completed.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Measures had been taken to address the serious and concerning findings of the previous inspection.

There were up to date organisational, centre and unit specific health and safety statements in place.

There was a comprehensive risk management policy that set out the matters listed in Article 26 including the risks specifically identified in 26 (1) (c). Risk management was dynamic and risk identification and assessment evolved in line with events and service developments. The person in charge held a master risk register that had 27 open risks at the time of inspection many of which pertained to the physical environment such as limited work/bed-space for staff, the risk for cross-infection, lack of storage, lack of privacy and dignity for residents.

Arrangements were in place for the investigation and learning from serious incidents/adverse events involving residents. Inspectors reviewed a comprehensive analysis of falls completed by the clinical risk advisor in February 2015; the report highlighted the increased use of falls prevention strategies including low-low beds, impact reducing floor mats and sensor/motion alarms and an approximate 10%
Staff spoken with confirmed feedback and focussed action taken in response to the audit findings; inspectors were satisfied that appropriate risk reducing individualised interventions were in place including frequently reviewed falls risk assessments and care plans.

Significant improvement was noted in fire safety precautions and procedures. The fire register was well maintained and from it inspectors saw that the fire detection system was serviced and inspected on a quarterly basis and most recent in May 2015. The emergency lighting was also inspected and tested each quarter again most recently in May 2015. Fire fighting equipment was inspected and serviced in November 2014. Records indicated that where deficits were identified they were rectified. Fire call points were regularly and prominently available; final exits were seen to be unobstructed and on automatic release in the event of fire.

As indicated in the provider’s response to the last action plan permanent directional signage was prominently displayed throughout the centre; inspectors found these clear and effective; there was one agreed identifier for each unit.

A comprehensive programme of staff training of fire safety and management was in place that included the procedure and actions to be taken should the clothes of a resident catch fire. Records seen indicated and the ADON confirmed that all staff had attended fire safety training within the past twelve months, approximately 118 of them in 2015.

Fifty five staff had attended a recent practical simulated evacuation exercise; however staff confirmed that this was the first exercise of this nature undertaken.

There were local procedures in place for the routine inspection of fire safety precautions on a daily, weekly and monthly basis; however gaps were identified in the records of testing of the fire detection system.

Tobacco consumption by residents was accommodated externally. Practice was improved and inspectors saw individual and generic risk assessments and identified controls. Fire fighting equipment was available in close proximity to the smoking area. However, there was evidence from both staff and residents that there was possibly insufficient oversight and consistent implementation of all identified controls, specifically the removal of smoking materials at night times.

Records were in place that attested to the inspection and servicing of equipment including hoists used in manual handling; these were serviced in line with mandatory requirements. Each resident had a risk assessment and manual handling plan that specified the equipment and number of staff required for each transfer/manoeuvre.

There was an adequate site specific emergency response plan dated April 2015 that included provision for the alternative accommodation for residents in the event of evacuation. A generator was in place that activating automatically in the event of loss of power.

Staff spoken with had a good understanding of infection prevention and control.
procedures and fifty staff had attended education updates in January 2015. Staff understood the risk of cross infection presented by the multi-occupancy accommodation and stated that residents with known hospital acquired infections were not admitted to these rooms. Single room accommodation was very limited but it was seen to be used for the purpose of infection control on the day of inspection. There was a cleaning rota in place for routine but also the “deep cleaning” of the physical environment and equipment. However, all areas of the premises were not visibly clean particularly bed frames and the top of furniture. Some seating and cushions were not suited to effective cleaning; the finish on some bed tables was worn and defective. Each unit had a sluice room; however one of these was extremely untidy with no clear segregation of clean and dirty items and equipment.

There was unsecured, unrestricted access noted by inspectors to toiletries, latex gloves and a razor in one high risk area; these were highlighted to staff on duty.

Judgment:
Non Compliant - Moderate

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

Findings:
Inspectors were satisfied that medication management policies, procedures and practices facilitated safe practice; that deficits identified at the time of the last inspection were substantially addressed.

Medication management practice was guided by recently reviewed policy and procedures and supported and monitored by the senior pharmacist on site. Prescriptions were generated by the medical officer; there was no transcribing of medication. There were nurse prescribers onsite and inspectors were satisfied that systems were in place to ensure that their practice was within the scope of their collaborative practice agreement.

There was documentary evidence of the review of residents’ medication regimes by the medical officer and/or the consultant psychiatrist as appropriate.

Based on a random sample of medication prescription records across units the records were current and clearly legible.

Based on a random sample of medication administration records across units no omissions were noted and administration recording practice was the subject of regular
internal audit.

Medications were seen to be securely stored and the management of medications requiring stricter controls was in line with legislative requirements.

Two minor deficits were identified;
  • the maximum daily dosage of medications required on a PRN basis (medication that is not scheduled or required on a regular basis) was not always stated
  • a small quantity of eye drops with no recorded opening date or resident specific details were noted by inspectors.

**Judgment:**
Substantially Compliant

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**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:**
The person in charge has a solid established history of submitting and discussing as necessary required notifications to the Chief Inspector as prescribed in Article 31. Local arrangements were in place to ensure that details of all incidents were communicated from each unit to the person in charge; the person in charge also had direct access to and monitored the computerised nursing records.

There was a lack of clarity however in relation to the quarterly notification of restrictive interventions both physical and chemical. Guidance and clarity has recently issued from the Authority on these matters and should inform all future notifications.

**Judgment:**
Substantially Compliant

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**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:**
Based on the review of a random and purposeful sample of medical and nursing records across all units inspectors were satisfied that the necessary arrangements were in place to meet residents healthcare needs. Residents had as appropriate to their needs daily access to medical review and treatment; there was a structured out-of-hours medical rota. Records seen supported regular and timely medical review. Again and as appropriate to their needs, residents had good access to other healthcare professionals some of whom were based on site and included physiotherapy, dietetics, occupational therapy, psychiatry and podiatry. Records of referrals, reviews, admission and discharge correspondence were all in place. There was evidence of regular blood-profiling as required by therapeutic regimes or existing morbidities.

This was a large service but overall inspectors found a consistent standard of nursing assessment and care planning across all units; there was ongoing monitoring of these processes by nurse management to ensure that each resident had the required nursing supports in place.

Each residents care plan was informed by an assessment of their needs and a suite of evidence based tools for specific risks such as falls, wound development or compromised nutrition. Inspectors overall were satisfied that the plans of care reflected assessed needs and identified risks and were updated to reflect changing needs and at a minimum three monthly.

**Judgment:**
Compliant

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**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:**
As identified on all previous inspections the design and layout of parts of the premises
do 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 design and layout does not meet the individual and collective needs of the residents in a comfortable and homely manner, it does not promote the privacy, independence and quality of life of residents. It was confirmed to the inspector that while the provider had explored different options and was committed to the long term future of the centre, there was no definitive, agreed, time bound, funded, explicit plan to address the identified non compliance.

Hazel unit and Alder unit both accommodate 42 residents and are of similar design and layout. Neither unit offered adequate sitting, dining or recreational space; there was no dining space and communal space consisted of a small alcove off the main corridor with seating for approximately six residents. There were two single bedrooms on each unit that were not of a suitable size and layout for the needs of all residents and did not allow for the safe and effective use of assistive equipment by staff or access to both sides of the bed; the inspector observed this and staff spoken with confirmed it. The remaining private accommodation was provided for in multi-occupancy rooms for five and six residents. The inspector saw that the majority of residents spent their day in bed or at their bedsides, they had limited space for the storage of personal possessions with some seen to be stored on windowsills or on top of their single wardrobe. Ceiling mounted hoists were not in place and inspectors saw that staff had very limited room available to them to provide assistance and care or utilise assistive equipment within each identified bed-space; 81% of the residents were of maximum dependency.

There were insufficient numbers of showers (no baths were in place) and this was compounded by the lack of adequate and suitable storage facilities. There were only two assisted showers but evidence of the ongoing storage of wheelchairs, specialised seating and other items in this area on both the Hazel and Ash Units. There was one shower available to 24 residents on the Ash unit.

The impact of the design and layout of the environment on the quality of the dining experience is discussed in Outcome 15. The inspector also saw that residents had no means of securing privacy other than closing their bed screen, of enjoying quiet time or having private conversations with staff or visitors unless assisted to leave the unit and access the communal space available on the main “long corridor” of the overall service. Other than for the provision of activities these rooms were not seen to be utilised during the inspection process with visitors remaining with residents in what was already limited and crowded communal space on the units. The facilities for exercising choice to access television was limited due to lack of communal space and the multi occupancy accommodation as visibility was dependent on the location of the residents bed.

The Holly unit is a 12 bedded dementia specific unit. Resident private accommodation was provided in two single bedrooms and five twin bedded rooms; all had en-suite toilet facilities; the two single bedrooms and one twin bedded room also had an en-suite assisted shower. Residents were provided with adequate communal and dining space. However, all inspectors concurred that other than the pleasing communal and dining area that this was a bland, homogenous, bleak and uninviting environment that offered little by way of a therapeutic dementia specific environment. There were visible areas of damaged and scuffed paintwork. Staff spoken with confirmed that while a separate
bathroom with assisted bath and shower was available it was not used and the hygiene needs of residents without en-suite shower facilities were attended to in other resident’s bathrooms. Residents were not generally seen to be assisted to access the secure garden. One room occupied by two gentlemen contained instructions for staff on the hygiene requirements of a female resident. None of the above was in keeping with the stated purpose and function of facilitating “a person centred approach to care”.

Management told inspectors that investment in the dementia unit may have been limited as there was a longstanding ambiguity over “ownership” of the Holly Unit as it was originally built for the provision of mental health services; there was some informal suggestion of resident’s relocation to a recently vacated Rowan Unit. Inspectors reviewed this vacated unit and informed the provider that its design and layout did 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 and that any such move would not meet the individual and collective needs of the residents.

**Judgment:**
Non Compliant - Major

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<thead>
<tr>
<th>Outcome 13: Complaints procedures</th>
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<tr>
<td>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.</td>
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</table>

**Theme:**
Person-centred care and support

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
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</table>

**Findings:**
The complaints record for 2015 indicated that complaints were made, predominately by relatives of residents, in relation to the care and services provided. There was evidence of actions taken such as an acknowledgement of the matters raised, an offer of meetings and some investigation of some of the matters complained of. However, what was not clear from the records seen was how complaints provided an opportunity for learning and contributed to the system for the ongoing review and improvement of the care and services provided to residents. For example where the matters complained of pertained to an alleged lack of empathy and lack of confidentiality on behalf of staff, or a lack of stimulation and meaningful engagement for residents it was not clear as to whether allegations were upheld or what measures were taken to provide reassurance, establish if improvement was necessary and possible (for example enhanced access to activities) and prevent a reoccurrence. Some complaints had not been resolved within defined timeframes and were still open at the time of inspection three months after their receipt.

**Judgment:**
Non Compliant - Moderate
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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There were policies in place to guide end of life care and there was evidence that all grades of staff had attended further relevant education and training since the last inspection in August 2014.

Based on clinical records reviewed inspectors were satisfied that staff supported residents to achieve a dignified and comfortable death. There was evidence that staff continuously monitored each resident’s condition, was attuned to changes and sought timely and appropriate review and intervention from the medical officer; where appropriate care was supported by the palliative care team. All changes, reviews and interventions were clearly and regularly recorded. Staff kept family members informed, families were facilitated to be with the resident and facilities for their comfort were made available.

There was a deficit of single room accommodation available but staff said that the option of a single room was always made available if possible. Following death there was a mortuary and chapel available if requested.

Procedures were in place for the management of both anticipated and unanticipated deaths; records seen indicated that in the absence of explicit do not attempt resuscitation decisions staff implemented life saving interventions.

However, while it was evident that appropriate care was provided at end of life there was very little evidence to support improvement in staff efforts to ascertain and record residents end of life choices, preferences and wishes. Staff spoken with confirmed this and said the end of life care was addressed only by staff when “the time came”. This would concur with the records seen by inspectors which contained sparse or no details of resident’s wishes and plans for end of life care.

Judgment:
Non Compliant - Moderate

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

**Findings:**
While some improvement was noted since the last inspection the lack of dining space and entrenched staff practices had a significant negative impact on the quality of the dining experience for residents with little or no social dimension to meals evidenced on some units.

Improvement was noted on facilitating residents’ meal choices/preferences and this was now done on the previous day as opposed to a week in advance as had been the case at the time of the last inspection; meals were delivered to each unit on an individual basis based on residents’ expressed choice. Staff spoken with including the recently recruited catering officer confirmed this practice and also reassured inspectors that if residents changed their mind on the day this was facilitated once communicated to catering staff. Freshly baked products including brown bread and scones were also available to residents on a daily basis. There was a ready supply at unit level of a broad range of snacks including fruit, bread, cereals, cheese and yogurts.

Based on the findings of the last inspection improvement was noted in the arrangements in place for identifying risk, planning care, implementing, reviewing and updating as necessary to ensure that residents did not experience poor hydration or nutrition. A validated assessment tool was in use and where a risk was identified a nursing plan of care was in place; residents had timely access to medical, dietetic and speech and language review. Nutritional supplements as recommended were seen to be prescribed and administered as per the prescriber’s instructions. Staff spoken with were clear on resident’s specific nutritional requirements and care plans, including the provision of modified or fortified diet and no deviation in care was noted by inspectors.

However, only the Holly and Ash units had dedicated dining space; the remaining two larger units did not. On these units inspectors saw that the majority of residents had their meals served to them on trays while in bed or while seated at their bedside. Family members were seen to be facilitated to assist at mealtimes and they confirmed that this was their choice but again the multi-occupancy rooms and absence of dining space meant that this arrangement did not provide for due regard for the privacy and dignity of all residents. Adequate staff assistance and supervision was in place and there was evidence of good practice but throughout the course of the two day inspection the majority of staff were again seen to stand while assisting residents to eat and drink; at times but not always this was as a result of insufficient space between seated residents.

Inspectors were disappointed to see that some of the actions identified as necessary by the provider in response to the findings of the last inspection had not been implemented. Inspectors again observed that all three main meals were provided to residents within an eight hour timeframe with residents seen to receive their last
substantive meal at 16:00hrs. The delivery, serving and completion of meals were observed to be a rushed, task orientated experience. Inspectors again saw and staff spoken with confirmed that hot and cold drinks and snacks were not routinely offered to residents on all units between main meals. Staff again said that residents could request what they wished, however, given the dependency levels of the residents (82% maximum dependency) and/or cognitive ability inspectors did not believe this arrangement of requesting rather than offering to be suitable to the residents needs or in line with regulatory requirements.

**Judgment:**
Non Compliant - Moderate

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**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:**
Food and activity satisfaction surveys had been undertaken but overall there was little evidence as to how residents were consulted about how the day to day operation of the centre was planned and organised. There was a residents committee which met approximately every three months. However, resident participation was low and it was difficult to see in that context how it was representative and meaningful. Issues were raised by residents but inspectors found no evidence that issues raised during these meetings were dealt with effectively by staff and to the satisfaction of residents. There was evidence to support as discussed in Outcome 15 (Nutrition) that staff routines as opposed to resident’s choices and preferences dictated mealtimes and access to refreshments on some units.

Residents had access to independent advocacy services and information posters were displayed prominently on notice boards, however, the contact number for the advocacy service wasn’t clearly visible.

Residents were facilitated to exercise their political and religious rights. Residents informed inspectors that they could vote in the centre if they wished. The local community church was attached to the centre and residents could attend mass on a daily basis in the church. However, some residents informed inspectors that they would like to attend mass more frequently but were reliant on staff to take them to the church; residents felt that staff may be too busy to take them.
Residents had access to a television in bedrooms and in the limited communal space; however, as discussed in detail in Outcome 12, the ability to enjoy television viewing was dependent on the location of one's bed or indeed the wishes and requirements of other residents as the rooms were multi-occupancy. Daily newspapers were delivered to the centre for resident's use and residents had access to a portable telephone if required; some residents were also seen to have personal mobiles.

Staff were observed interacting with residents and speaking about residents in a courteous and respectful manner. However, due to the predominance of multi-occupancy bedrooms, there were insufficient facilities to provide residents with adequate, comfortable, personal or private space. In addition, insufficient dining and communal space was provided, meaning that residents had very little opportunity to meet, interact and engage with each other.

There was a part-time activities coordinator in place who initiated and supervised a range of activities in the centre, such as sonas, bingo, hand massage, arts and crafts, and exercises. On the second day of inspection, residents were seen to enjoy a lively music session. However, given the number of residents in the centre, there was evidence to support that resources were inadequate to ensure that all residents had sufficient opportunity to participate in meaningful and purposeful activities which suited their needs, interests, and capabilities. On both days of inspection, inspectors witnessed a high number of residents not participating in activities; it was a recurring theme in the questionnaires returned by relatives and residents; it was reflected in the complaints records; inspectors reviewed a further record where one resident recently reported that he was of low mood and bored, found the days very long and longed to participate in activities.

There was an open policy on visiting the centre and visitors spoken with said that they felt welcome to visit their relative in the centre. However, the multi-occupancy rooms and absence of dining and communal space meant that the presence of visitors at times, as seen by inspectors, did not provide for due regard for the privacy and dignity of all residents.

**Judgment:**
Non Compliant - Moderate

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**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 were no laundry facilities on site; the provider operated and accessed two external laundries, one for general linen and the other for residents’ personal clothing. The person in charge confirmed that some residents choose to have their laundry requirements attended to by family while approximately 33% utilised the service offered by the provider. There was no evidence available to inspectors including a review of the complaints log to suggest that these laundry arrangements were unsuitable.

Residents had limited personal storage space in the multi-occupancy rooms.

**Judgment:**
Substantially Compliant

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

**Findings:**
Inspectors saw that staff were busy and concerns had been raised by relatives surveyed in relation to inadequate staffing levels. Records seen indicated that based on full resident occupancy and the historical staffing rota there was a weekly 25% deficit in the agreed staff roster due to staff retirements or long-term sick leave; nursing management described the situation as “challenging” and confirmed that both residents and relatives had at times raised concerns. Staffing and skill-mix deficits were actively monitored; risk assessed and brought to the attention of the provider. Reported actions taken by the provider to mitigate the staffing deficit was the approval to appoint 13 staff (nursing and non-nursing), the operation of the service at less than full occupancy and the utilisation of agency staff (approximately 7% on a weekly basis). In the context of the resident occupancy level at the time of inspection (81%) there was no definitive evidence available to inspectors that staffing levels and skill mix were not adequate to meet the needs of the residents.

Policy and procedures were in place to ensure that each nurse employed provided evidence to their employer of their current registration with their regulatory body.

Recruitment was centralised and a sample of staff files reviewed were substantially
compliant with regulatory requirements; deficits identified in employment history are discussed and actioned in Outcome 5.

Persons providing services to residents on a regular basis had been vetted as appropriate to their role, they did not however have their role and responsibilities explicitly set out.

An improvement was noted in the maintenance of staff training records and inspectors were satisfied that mandatory training requirements for all staff were monitored and were within the required timeframes. Further training seen to be completed by staff reflected the assessed needs of the residents and included falls prevention and management, nutrition and dysphagia, medication management, wound prevention and management, end of life care, infection prevention and control, risk management, food hygiene, emergency first aid and basic life support. Staff with specific roles and responsibilities had completed relevant education such as caring for and delivering meaningful activities for residents with dementia.

Judgment:
Substantially Compliant

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
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Joseph’s Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000613</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>17/06/2015</td>
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<tr>
<td>Date of response:</td>
<td>15/07/2015</td>
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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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There had been no annual review as required by Article 23 (d) and (e).

Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The Hospital Management Team which meets monthly will undertake the Annual review of Quality and Patient Safety with the assistance of the Clinical Risk Advisor, Infection Control Manager, Pharmacist and Health and Safety Officer. Following on from this review any necessary improvements identified will be implemented. The overarching report referred to by the regulator will be prepared and will be made available to residents and their relatives. Reference will be made to this report in the Residents Guide which will inform where this report is located and also that the Clinical Nurse Manager will provide the report to the resident and relatives on request.

**Proposed Timescale:** 31/10/2015

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**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 resident’s guide had not been updated to reflect the most accurate information on the services provided at the centre.

**Action Required:**
Under Regulation 20(2)(a) you are required to: Prepare a guide in respect of the designated centre which includes a summary of the services and facilities in the centre.

Please state the actions you have taken or are planning to take:
The Residents Information booklet will be updated to reflect the most accurate information re the centre.

**Proposed Timescale:** 31/10/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all contracts set out the services to be provided, whether under the Nursing Home Support Scheme or otherwise to the resident concerned, the fees, if any to be charged for such services, and any other additional fees for services that the resident may chose to avail of but which was not included in the basic fee. There was no contract in place for a small number of long-stay residents and there was no contract in place that satisfied regulatory requirements for short-stay residents.

**Action Required:**
Under Regulation 24(2) (a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

Please state the actions you have taken or are planning to take:
Contracts of care will be amended to ensure that the services provided are set out and specified whether covered under the Nursing Home Support Scheme or otherwise. A review is being conducted to ensure there is a contract in place for all long stay residents. A contract for short stay residents will be put in place that satisfies the regulatory requirements.

Proposed Timescale: 16/10/2015

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 small number of staff files did not contain a full employment history together with a satisfactory history of any gaps in employment.

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:
Nursing and MTA staff files are regularly audited to ensure that the required documentation is present. Arising from this inspection further audit of staff files are being conducted and any gaps in employment identified will be addressed.

Proposed Timescale: 30/09/2015

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:
Where antipsychotic medication had been administered in response to behaviours that challenged, administration was not supported by a nursing narrative record outlining the rationale for administration/chemical intervention including the behaviour exhibited and the trial and failure of agreed non-chemical interventions.
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 (Managing actual and potential aggression) training has commenced and will continue.

A baseline audit had been done on the use of psychotropic medication. This will be monitored on an ongoing basis. A review of psychotropic medication use conducted with clinical nurse managers and pharmacist will include a review of nursing narrative in relation to their use and also the trial and failure of agreed chemical interventions.

The Senior Pharmacist also undertook an audit on the general issues concerning medication management at the centre.

The Senior Pharmacist will also undertake training with Nursing staff to enable reflective review of use of psychotropic medication.

Proposed Timescale: 31/10/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of bedrails was not at all times in line with national policy and standards.

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:
Review of Risk Balancing Assessment Tool will be undertaken and use of bedrails will be undertaken.
An audit is being undertaken to ensure that monitoring records are consistently completed and the use of bedrails are re-assessed appropriately.
We are currently liaising with the CNME to put in place further training on the national policy.

Proposed Timescale: 31/10/2015

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:
There was unsecured, unrestricted access noted by inspectors to toiletries, latex gloves and a razor in one high risk area; these were highlighted to staff on duty.

Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
A risk assessment has been completed identifying hazards and assessing the risks. It set out the actions put in place.
The CNM will ensure that all staff are familiar with the relevant risk assessment, hazards and actions.

Proposed Timescale: 14/07/2015
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All areas of the premises were not visibly clean particularly bed frames and the top of furniture. Some seating and cushions were not suited to effective cleaning; the finish on some bed tables was worn and defective. Each unit had a sluice room; however one of these was extremely untidy with no clear segregation of clean and dirty items and equipment.

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:
Monthly hygiene audits are undertaken. The Clinical Nurse Managers are ensuring that bed frames and the top of furniture are included in the cleaning schedule of the unit and this is included in the environment hygiene audits.

Some new over bed tables have been purchased and all over bed tables will be replaced by the end of September.

New storage has been ordered for the sluice room in one of the units and this will ensure clear segregation of clean and dirty items and equipment.
Drip trays have also been installed in 3 units.

Proposed Timescale: 31/10/2015
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Gaps were identified in the records of testing of the fire detection system.

**Action Required:**  
Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

**Please state the actions you have taken or are planning to take:**  
Audits will commence on the records of testing of the fire detection system to ensure there are no gaps in the records.

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

**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was a recent practical simulated evacuation exercise; however staff confirmed that this was the first exercise of this nature undertaken.

**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:**  
We will continue the schedule of fire safety training and this will include simulated evacuation exercises. The next scheduled dates for simulated fire training are 15/09/2015, 29/09/2015 and 14/10/2015

**Proposed Timescale:** 31/10/2015

**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was possibly insufficient oversight and consistent implementation of all identified controls, specifically the removal of smoking materials from residents at night time.

**Action Required:**  
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for
reviewing fire precautions.

Please state the actions you have taken or are planning to take:
The importance of uniformity and consistency of the implementation of identified controls including the removal of smoking materials at night time will be identified on updated risk assessments and care plans. This will strengthen staff awareness of same.

Proposed Timescale: 31/08/2015

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:
The maximum daily dosage of medications required on a PRN basis (medication that is not scheduled or required on a regular basis) was not always stated.

A small quantity of eye drops with no recorded opening date or resident specific details were noted by inspectors.

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:
Medication is dispensed with an attached label for individual items such as eye drops, gels etc to allow the nurse to insert the date of opening of same and also resident specific details.
A learning notice has been issued to Nursing and Medical staff to highlight the non compliance issues regarding PRN medications and the recording of opening dates and resident specific details on eye drops etc. Ongoing audit will be undertaken to ensure compliance.

Proposed Timescale: 15/07/2015

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a lack of clarity in relation to the quarterly notification of restrictive interventions both physical and chemical.
**Action Required:**
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

**Please state the actions you have taken or are planning to take:**
As clarified with the HIQA inspectors, the person in charge will report to the Chief Inspector on the quarterly notifications the use of restrictive interventions.

**Proposed Timescale:** 31/07/2015

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### 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 parts of the premises do 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 design and layout does not meet the individual and collective needs of the residents in a comfortable and homely manner, it does not promote the privacy, independence and quality of life of residents.

The dementia specific unit was a bland, homogenous, bleak and uninviting environment that offered little by way of a therapeutic dementia specific environment

**Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**
Refurbishment of unit in accordance with HIQA dementia guidelines has commenced to include painting, replacement of electrical fittings, replacement of seating, curtains, bed linen. A substantial amount of this work will be completed by 31st August, 2015 and the remainder of the work will be completed by the 30th September, 2015.

The provider has examined options regarding the design and layout of the designated centre and an option appraisal exercise has been undertaken. Arising from this a proposal has been prepared outlining the costs required to enable the centre to meet the HIQA environmental standards. The provider is committed to the long term future of the centre.

**Proposed Timescale:** 31st August, 2015 & 30th September, 2015

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

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### Outcome 13: Complaints procedures
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<th>Theme: Person-centred care and support</th>
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<tr>
<td>It was not clear from the records seen was how complaints provided an opportunity for learning and contributed to the system for the ongoing review and improvement of the care and services provided to residents.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
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<tr>
<td>Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>All complaints will be reviewed and opportunities for learning will be explored with the Clinical Nurse managers. This review will be included in the annual review of Quality and Safety of Care and Services provided to residents. This will be available to all Staff and residents.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 31/10/2015</td>
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<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Some complaints had not been resolved within defined timeframes.</td>
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<tr>
<td><strong>Action Required:</strong></td>
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<tr>
<td>Under Regulation 34(1)(d) you are required to: Investigate all complaints promptly.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>Complaints will be investigated in a timely manner and explanations documented when not possible.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 15/07/2015</td>
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<td><strong>Theme:</strong> Person-centred care and support</td>
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<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>There was very little evidence to support improvement in staff efforts to ascertain and record residents end of life choices, preferences and wishes.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
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Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
Training in end of life care is ongoing and Residents preferences will be recorded in their end of life care plan.
Proposed Timescale: Ongoing with next training dates scheduled for 15/09/2015 and 03/11/2015

Proposed Timescale: 03/11/2015

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The lack of dining space and entrenched staff practices had a significant negative impact on the quality of the dining experience for residents with little or no social dimension to meals evidenced on some units.

The majority of staff were seen to stand while assisting residents to eat and drink.

The delivery, serving and completion of meals were observed to be a rushed, task orientated experience. Inspectors again saw and staff spoken with confirmed that hot and cold drinks and snacks were not routinely offered to residents on all units between main meals.

Action Required:
Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

Please state the actions you have taken or are planning to take:
Engagement has recommenced with staff regarding the necessary roster changes to implement revised mealtimes. Also, arrangements to ensure that hot / cold drinks & snacks are routinely offered to residents on all units between main meals will be implemented by the 31st July, 2015.

In addition a group of health care professionals chaired by the Director of Nursing whose purpose is to review nutrition and menus will agree methods to improve the resident dining experience which will include introduction of protected meal times.

The provider has explored different options regarding the design and layout of the designated centre to include all dining areas for residents.

Proposed Timescale: 30/11/2015
**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 are insufficient opportunities for all residents to participate in activities in accordance with their interests and capacities.

**Action Required:**
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

**Please state the actions you have taken or are planning to take:**
An activities committee will explore options regarding activities for all residents including activities which will be held in the communal areas and also at resident bedside. The artist in residence takes part in the activities committee and advises on appropriate activities and options available.

We are making arrangements to enhance availability of activities for residents.

We undertook an activities survey in June with the residents and the feedback from this will be explored by the activities committee. A new expanded activities schedule will be put in place.

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

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There is insufficient space for residents to undertake personal activities in private.

**Action Required:**
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
The provider is continuing to explore options of improving the communal spaces available to residents to enable the resident to undertake their personal activities in privacy.

**Proposed Timescale:** Ongoing

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Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Many residents were not adequately consulted about and did not participate in the organisation of the designated centre concerned.

There was evidence to support that staff routines rather than resident choice and preference dictated how and when some services were provided.

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:
A second advocate is being introduced and will be invited to attend the relatives committee which is held every 2 months. The advocates will liaise with residents regarding their concerns and will bring them to the committee. Surveys will continue to gather information from relatives and residents regarding choices, preferences and their opinions on the day to day operation of how the centre is planned and organised.

Staff rosters and routines are being reviewed.

Proposed Timescale: 30/11/2015

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:
Residents had limited personal storage space in the multi-occupancy rooms.

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:
Within the current environment all efforts will be made to ensure adequate space will be provided for each resident to store and maintain his or her clothes and other personal possessions. Review of requirements to be undertaken by end September 2015.

Proposed Timescale: 30/09/2015
Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Persons providing services to residents on a regular basis had been vetted as appropriate to their role, they did not however have their role and responsibilities explicitly set out.

Action Required:
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
Roles and responsibilities will be included in the audit of staff files which will be undertaken.

Proposed Timescale: 30/10/2015