<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Finbarr’s Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000580</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Douglas Road, Cork.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>021 496 6555</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:Catherine.Ryan8@hse.ie">Catherine.Ryan8@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>
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<tr>
<td>Provider Nominee:</td>
<td>Patrick Ryan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Aoife Fleming; Maria Scally; Mary O'Mahony</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>89</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</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.
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: 20 May 2015 08:30  To: 20 May 2015 18:30
20 May 2015 08:20  21 May 2015 19:30

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

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

St. Finbarr’s Hospital, comprises five units with large institutional type buildings with accommodation for 89 residents and is situated in Cork city. The premises was built in the late 19th century on extensive grounds and is proximal to other services such as rehabilitation, dental, mental health, blood transfusion and Health Service Executive (HSE) administration offices which are located on the same campus. Three
of the units are on the ground floor and two are on the first floor, however, the units are not adjacent to each other but are situated at various locations throughout the grounds.

During this inspection, which was a renewal of registration inspection, the inspectors met with a number of residents, relatives and staff members. The inspectors observed practices and reviewed records such as nursing care plans, medical records, accident and incident logs, policies and procedures and a sample of personnel files.

The person in charge was knowledgeable of her obligations under the relevant standards and regulations, and demonstrated a commitment to providing a high standard of care to residents. Nursing and care staff were knowledgeable of residents' needs and provided a good standard of nursing care. There was good access to medical care comprising consultant geriatrician services in four units and general practitioner (GP) services in the fifth unit. Residents were referred for review by allied health/specialist services when indicated.

Seven completed questionnaires were received from residents and 11 from relatives and the overall feedback was complimentary of the care provided. Inspectors met with a number of relatives and while feedback was predominantly positive, a number of issues arose which are discussed in detail under Outcome 7.

Significant improvements were required, most notably in safeguarding practices and in the design and layout of the premises.

The record of one resident identified that the resident presented with bruising of unidentified origin, however, records were not available to indicate that this was appropriately investigated prior to a complaint from a relative.

Many residents were accommodated in multi-occupancy bedrooms, some of which had three, five and six beds. The beds in the dormitories were close together and did not support residents' privacy and dignity. In addition to unsuitable sleeping accommodation communal and dining space was also unsuitable. For example, there were no separate dining facilities in some of the units and communal space comprised a living/dining room combined that was not of sufficient size for the number of residents living in the centre. There was also inadequate storage space, including suitable storage for residents personal belongings and storage for equipment.

The action plan submitted by the provider in relation to unsuitable environment and specifically the response to the actions under Regulation 17(2), Regulation 09(3)(b), Regulation 11(2)(b), and Regulation 12(c), did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish the response to this action and is considering further regulatory action in relation to this issue.

Additional required improvements included:
- statement of purpose
• review of quality and safety
• policies and procedures
• training records
• risk management
• restraint assessment
• staff training
• risk management policy and practices
• notifications
• privacy and dignity

The Action Plan at the end of the report identifies what improvements are needed to meet the requirements of 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.
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 written statement of purpose describing the service that was provided in the centre. The statement of purpose consisted of the aims, objectives and ethos of the centre. The inspectors noted that the statement of purpose was made available for residents, visitors and staff to read. The statement of purpose had been reviewed in January 2015. Some improvements were required as it did not contain all the information required by the regulations, such as:
- criteria for admission, including emergency admissions
- a description of all rooms in the centre, including their size
- the total staffing complement in whole time equivalent
- arrangements for management of the service in the absence of the person in charge.

**Judgment:**
Non Compliant - Moderate

### 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 sufficient resources to support the effective delivery of care. There was a
clearly defined management structure identifying who was in charge. The person in charge was supported in her role by an assistant director of nursing and two clinical nurse manager 3 (CNM 3). Each unit was managed by a clinical nurse manager 2 (CNM 2) and a clinical nurse manager 1 (CNM 1). The person in charge reported to an acting general manager.

There was a programme of audits that included a Workplace Culture Critical Analysis Tool (WCCAT) which was an observational tool used to evaluate the culture within each unit and the environment. There was evidence of actions in response to required improvements identified through the audits. Additional audits included kitchen audits, care plan audits, infection prevention and control surveys and hand hygiene surveys. The review of quality and safety included consultation with residents through residents' forums, however, there was no action plan to identify what actions were taken in response to issues raised by residents or who was responsible for following through on the issues raised.

While there was evidence of audits, there was no record available of an annual review of the quality and safety of care as required by the regulations.

**Judgment:**
Non Compliant - Moderate

### 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:**
A residents’ guide was available for residents and relatives and this was available at the reception area of all of the units in the designated centre. This guide was compliant with the regulations as it contained a summary of services and facilities, the terms and conditions of admission, a summary of the complaints process and the arrangements for visits.

A number of contracts of care were viewed by the inspectors. The contracts of care were found to be comprehensive and were agreed and signed within a month of admission. The contracts stipulated the services to be provided and the fees included in the contract.

**Judgment:**
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 of the designated centre was a suitably qualified and experienced manager. The person in charge had the required experience in the area of nursing of the older adult and was engaged in the day-to-day governance and management of the centre.

Based on their interactions with the person in charge throughout the inspection, the inspectors were satisfied she had sufficient clinical knowledge and knowledge of the legislation and her statutory 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 People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
The inspectors reviewed a sample of staff files and found that they contained most of the information required under Schedule 2 of the Regulations. However, some of the staff files reviewed only contained one reference rather than two which is required by the Regulations. Also, not all of the files contained a full employment history, together with a satisfactory history of any gaps in employment.

The Directory of Residents was reviewed by inspectors. This did not contain all of the
items as required by Schedule 3 of the Regulations. 
Items missing included:
• the date on which the resident was first admitted to the designated centre 
• the name and address of any authority, organisation or other body, which arranged 
the resident's admission to the designated centre.

Residents’ records as required under Schedule 3 of the Regulations were maintained. However, some records were not complete. The restraint register was maintained but did not include all occasions where restraint was used.

Records listed in Schedule 4 to be kept in a designated centre were all made available to the inspector and were found to be complete.

The designated centre did not have a policy on admissions, recruitment, selection and vetting of staff, provision of information to residents and risk management. All other 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 were in place in the centre. However, not all policies had been reviewed and updated as necessary within three years as required by the regulations.

Inspectors viewed the insurance policy and saw that the centre was adequately insured against accidents or injury to residents, staff and visitors.

There was a policy on the use of restraint, however, it was dated 2010 and there was no evidence of a review at a minimum of every three years as required by the regulations.

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 designated 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 was no period when the person in charge was absent from the centre for 28 days or more. There were adequate arrangements in place for the management of the centre in the absence of the person in charge.

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:
There was an up-to-date policy on safeguarding vulnerable persons at risk from abuse. Training records were available indicating that a number of staff had attended up-to-date training in recognising and responding to allegations of abuse. However, training records incorporated records of training of other staff from areas of the hospital that were not part of the designated centre. It was therefore not possible for inspectors to determine if all staff in the designated centre had received up-to-date training.

A notification of an allegation of abuse had been submitted to the Authority as required by the regulations prior to this inspection. The allegation related to unexplained bruising on a resident. A subsequent investigation concluded that the bruising may have been as a result of staff members assisting the resident to the ground to protect the resident from injury due to a near fall event. Even though staff members spoken with by inspectors were knowledgeable of what to do in the event of suspicions or allegations of abuse, based on a review of the resident's records, inspectors were not satisfied that staff demonstrated adequate awareness or responded appropriately to possible signs of abuse by not investigating unexplained bruising prior to it being brought to their attention by a relative. Based on a review by inspectors of the report of the investigation into the allegation, inspectors were not satisfied that the investigation was sufficiently wide-ranging to incorporate all incidents of unexplained bruising.

A further allegation of abuse was made to inspectors during the inspection. The allegation related to the manner in which a staff member interacted with a resident. This was brought to the attention of the provider nominee and the person in charge who were advised by inspectors to submit a notification to the Chief Inspector and to conduct an investigation into the allegation. The provider a person in charge were also requested to put in place suitable safeguards to protect all residents from potential abuse.

Inspectors reviewed a sample of residents' financial records and were satisfied that adequate records were maintained and appropriate checks were in place to safeguard residents' finances.

There was a policy on the use of restraint, however, it was dated 2010 and there was no evidence of a review at a minimum of every three years as required by the regulations. The only form of restraint in use was in the form of bedrails. There were restraint
assessments in place, however, inspectors were not satisfied that the assessments adequately demonstrated an exploration of alternatives to the use of restraint and did not adequately address the risks posed by the use of restraint. There were safety checks in place, however, the safety checks were two-hourly and were not based on an individual assessment of each resident to determine to appropriate frequency of safety checks for each resident. A number of residents were prescribed and administered PRN (as required) medications for behaviour that is challenging, however, this was not included in the restraint register.

There was an up-to-date policy on the management of behaviour that is challenging. Based on interviews with staff and the observations of inspectors staff could identify and alleviate the underlying causes of behaviour that is challenging. Based on a sample of residents' records viewed by inspectors, there were behavioural care plans in place for some, but not all, residents that presented with behaviour that challenges.

**Judgment:**
Non Compliant - Major

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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):**
No actions were required from the previous inspection.

**Findings:**
There was an up-to-date safety statement. There was a folder named the risk management policy that contained policies on responding to abuse, the unexplained absence of a resident, accidental injury, aggression and violence, and self-harm. However, there was no overall risk management policy incorporating hazard identification and assessment of risks throughout the centre as required by the regulations. There was a risk register identifying hazards and control measures in place to mitigate the risks identified that was reviewed and updated at regular intervals. There was a health and safety committee that held meetings every three months and the membership comprised a range of staff from various backgrounds, such as nursing, administration, catering, public health, maintenance, dental and fire safety.

There were procedures in place for investigating and learning from accidents and incidents, Incidents forms were completed following an accident/incident and these were then reviewed by practice development on an individual basis and actions were taken to minimise reoccurrence. The system, however, could be enhanced through an overall review of accidents and incidents to identify trends as an opportunity for learning.

There was a plan in place for responding to emergencies, however, it required review in relation to the identification of safe placement of residents for a prolonged evacuation,
for example, in the event of a fire.

The environment was generally clean and well maintained. There were adequate systems in place for the segregation and disposal of waste, including clinical waste. There were adequate procedures in place for infection prevention and control, such as hand washing facilities and hand hygiene gel dispensers located at suitable intervals throughout the centre. There were adequate supplies of aprons and gloves and inspectors observed appropriate usage.

Due to the nature of training records, as already discussed in outcome 7, it was not possible for inspectors to ascertain if all members of staff had received up-to-date training in safe manual handling practice.

Inspectors reviewed fire safety records that demonstrated the appropriate maintenance of fire safety equipment, fire alarm system and emergency lighting. There were adequate measures in place for reviewing fire safety through fire safety checks and fire exits were seen to be unobstructed on the days of inspection. There were records available of fire drills and staff members to whom inspectors spoke were knowledgeable of what to do in the event of a fire.

**Judgment:**
Non Compliant - Major

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**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 was an up-to-date medication management policy that adequately addressed the ordering, prescribing, storing and administration of medicines. The policy did not address the handling and disposal of unused and out-of-date medicines. This action is addressed under Outcome 5.

Medication administration practices observed by inspectors were in compliance with relevant professional guidance. There were appropriate systems in place for the management of medications that required special control measures. These medications were stored appropriately and securely and counted following administration and at the end of each shift. There were no residents living in the centre that self-administered medications.

There was a comprehensive audit of medication management practices that incorporated an improvement plan, where improvements were required, and feedback to staff for the purpose of learning.
Medication requiring refrigeration were stored in the fridge and the temperature was monitored. However, records indicated that the recorded temperature was below the recommended range but this was rectified during the inspection. Medications were not individually labelled with residents' names and the provider and person in charge were requested to risk assess the storage and management of these medications for the risk of error when transferring these medications to the medication trolley.

**Judgment:**
Compliant

**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:**
Records of accidents and incidents were maintained in the centre and were notified to the Authority within the required timeframe as required by the regulations. While quarterly reports were submitted to the Authority, they did not include notification of the use of restraint as required.

**Judgment:**
Substantially 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:**
Medical cover in four of the units was provided by a consultant geriatrician and by a general practitioner (GP) in the fifth unit. Residents had good access to medical care, including out-of-hours, and there was evidence of regular review. There was evidence of good access to allied health/specialist services such as dietetics, speech and language
therapy and physiotherapy and there was evidence of referral and review.

Nursing notes indicated that nursing care was provided to a good standard. Residents were comprehensively assessed on admission and at regular intervals thereafter. Care plans were developed based on these assessments and were person-centred. However, improvements were required as there was a lack of clarity around the current care to be provided due the manner in which care plan reviews were recorded. For example, following an initial assessment, the planned care was recorded on the front page of the care plan template which provided clear guidance on the care to be provided. However, following reviews, planned changes to care were recorded in narrative form at the back of the template and this had the potential to provide conflicting information for staff that were not familiar with residents.

**Judgment:**
Substantially 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:**

The centre consisted of five units located within a larger HSE campus and comprised St Joseph’s 1, St. Joseph's 2, St. Stephen’s, St Enda’s and St Elizabeth’s units. The buildings were constructed in the late 19th century and were institutional in appearance consistent with the style of that era. The standard of décor was generally adequate and the centre was clean throughout. However, the paintwork was damaged in some areas such as in St. Joseph's 2.

St. Enda’s Unit, St Elizabeth’s St. Joseph’s 1 are all ground floor units while St. Joseph's 2 and St. Stephen’s units are both on first floors with access by stairs and lifts. Bedroom accommodation in St. Stephen’s Unit, St. Enda’s Unit, and St Elizabeth’s Unit was primarily in six-bedded multi-occupancy rooms with a small number of single and twin bedrooms. Bedroom accommodation in St Joseph’s 1 and St. Joseph's 2 was primarily single, twin and triple bedrooms, all of which were en suite with toilet and wash hand basin. Inspectors observed staff members respect the privacy of residents as much as possible within the limitations placed on them by the design and layout of the premises while they were providing assistance with personal care. Staff were observed closing curtains or screens between beds. However, apart from St Joseph’s units, the multi-
occupancy bedrooms in the other units were not suitable to meet residents’ needs. This was mainly due to the limited space provided in the areas surrounding the beds. Residents’ privacy and dignity was compromised due to the close proximity of many of the beds. There was inadequate private accommodation for residents to ensure that residents’ privacy and dignity was met on a daily basis. In these bedrooms, inspectors observed that residents were not able to undertake personal activities in private or meet with relatives in private. In addition, there were numerous challenges posed by the structure and layout of the physical environment. For example, some of the multi-occupancy bedrooms had large structural support poles at the entrance to the bedrooms, which did not allow for adequate manoeuvring space for the use of assistive equipment such as hoists. Inspectors were not satisfied that bedroom accommodation was suitable for residents living in the centre.

Communal space comprised combined living/dining rooms that were not adequate in size for the number of residents living in the centre. In some of the units there were inadequate private areas apart from bedrooms to receive visitors in private and insufficient space for residents to spend some time alone should they wish to do so. In addition to the inadequate communal space, residents in St. Stephen’s Unit, St. Enda’s Unit, and St Elizabeth’s Unit did not have access to secure outdoor space.

There was one large central kitchen on the campus which delivered residents’ meals to small pantries in each unit. A large communal space separate to the units had been converted into an activities centre where residents could convene and partake in group activities such as arts and crafts. This aspect of the service was managed by an activities coordinator.

There was inadequate storage space for residents personal property and possessions. Each resident had been provided with a lockable metal box for storing valuables. As found on previous inspections, all residents did not have access to wardrobes and bedside lockers and some residents' clothing was stored in cupboards at the side of the bedroom away from residents’ beds. Even though some residents had wardrobes they were not suitable in size to store an adequate amount of clothing.

There was inadequate storage space for equipment resulting in some equipment being stored inappropriately. For example, inspectors observed a hoist being stored in one toilet and linen skips were stored in another toilet causing an obstruction to the wash hand basin.

Apart from St. Joseph’s units there was an insufficient number of lavatories for the number of residents living in the centre as there were only two toilets provided in each unit.

Records were available demonstrating the preventive maintenance of equipment such as hoists, speciality chairs and beds.

**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):
No actions were required from the previous inspection.

Findings:
The centre operates under the HSE 'Your Service, Your Say' complaints procedure. There was no centre-specific document accessible for residents and relatives to inform them of the local process for managing complaints or to provide a step by step guide to make a complaint in the centre. The policy did not identify the complaints officer or the person nominated to ensure that all complaints were responded to and to ensure that records were maintained of all complaints as required by the Regulations.

The Regulations also require that a record is kept of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied. The individual complaints logs viewed on each of the units did not contain all of this information. It was also not clear from the inspectors review of the complaints in the centre what processes are in place to implement learning as a result of complaints being made.

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):
No actions were required from the previous inspection.

Findings:
There was a written policy to guide end of life care practices. There were care plans in place demonstrating that end of life issues were discussed with residents however, the care plans were generic and did not provide adequate detail of individual resident’s preferences and needs. The inspectors reviewed the records of a deceased resident that suggested care was provided to a good standard. There was evidence of regular review by the consultant geriatrician and GP and more frequently as end of life approached. There was evidence of referral and review by palliative care services.
A sample of records indicated that a medical decision had been taken for a small number of residents not to implement extraordinary measures in the even of sudden death, such as not to perform cardiopulmonary resuscitation (CPR). There was evidence in the medical records of the clinical rationale for these decisions for some of the residents for which this decision had been made, however, not for all. Additionally, it was not clear what process was in place for reviewing this decisions should residents' preferences or circumstances change. This action is addressed under Outcome 11. While there were guidelines available to guide decisions around resuscitation status, these were dated 2007 and therefore required review. This action is addressed under Outcome 5.

**Judgment:**
Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
There was a policy in place on monitoring and recording residents' nutritional status. Residents had their nutritional status assessed on admission and at regular intervals thereafter using a recognised assessment tool. Residents were weighed regularly.

Food was prepared in the main kitchen, which was located on the campus and was delivered in heated food trolleys to the kitchenettes on each of the five units. Food appeared to be nutritious, was available in sufficient quantities and residents had a choice of food. However, residents prescribed a modified diet, such as those with swallowing difficulty that were on liquidised diet did not always have a choice at mealtimes. Gravies/sauces and condiments were served separately if required. Liquidised/pureed food was served in separate portions. Staff were observed communicating and assisting residents, particularly those with a cognitive impairment, in a sensitive manner. On the day of the inspection, residents dined in the sitting/dining/activities rooms, in bed or at their bedside. Residents were very complimentary of the lunch. Evening tea was served from 16:30hrs onwards. Staff confirmed that a snack trolley was served to residents later in the evening and confirmed that residents could have a snack at any time.

A sample of medication administration charts demonstrated that nutritional supplements were prescribed by the attending medical officer. The absence of suitable dining facilities
is addressed under Outcome 12.

Judgment:
Non Compliant - Moderate

**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:**
Inspectors observed that staff addressed residents respectfully and that screening curtains were used in shared rooms when personal care was being delivered. However, due to the layout of the premises, residents did not have sufficient space and privacy. The size and layout of the multi occupancy rooms meant that there was very little space between some of the residents' beds. Residents were unable to undertake personal activities in private. The inspectors observed that some residents were trying to rest while another resident was talking beside them.

The centre was suitably resourced with daily entertainment and leisure facilities such TV, radio, newspapers and magazines. Two dedicated activities coordinators were available to the centre with a schedule of activities including sing-a-long, bingo and reminiscence therapy. The coordinators also initiated and supervised a range of outings from the centre and residents told inspectors how much they enjoyed these outings and how important and beneficial they were to them. There was also one on one activities available for residents and one resident spoke with inspectors about how she enjoys getting her nails done by one of the care assistants.

Residents have access to independent advocacy services and there are currently two independent advocates available for the residents in the centre. The person in charge informed inspectors that they hope to have more advocates available to the residents shortly. There is information on display in the centre to inform residents of how to contact an advocate should they wish to do so.

There was a good level of visitor activity throughout the days of inspection with visitors saying they felt welcome to visit. The inspectors met and spoke with a number of visitors who indicated that they had open access to visit their relative. Accommodation was available to receive visitors communally but there was no private space readily available for visiting.
A residents' forum meets in the centre every two months. This is chaired by one of the independent advocates. Items discussed included upcoming events such as the annual garden party, recent outings residents had gone on and issues that have arisen for residents. However, there was no clear agenda for the meetings and it was not clear from the minutes of these meetings how many residents had actually attended so it was not possible for inspectors to determine if this forum was a representative sample of the residents in the centre. Although the person in charge gave written responses to issues raised there was no clear action plan of what would be done to address specific issues raised by residents.

Residents were facilitated to exercise their political and religious rights. The person in charge confirmed that residents can vote in the centre if they wish to do so and a polling station would be brought to the centre for the residents for this purpose. Two Catholic Priests attend the centre weekly to say mass in the units and residents can also go to the chapel in the campus of the centre to attend mass on Sundays. Staff informed inspectors that residents of other denominations would also be supported to practice their faith should they wish to do so.

Residents have access to a portable telephone in the centre should they wish to make calls in private.

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 policy on residents’ personal property and possessions. Inspectors noted that a record of residents’ personal property was maintained and signed by residents when possible.

Linen and residents' clothing was laundered by an external organisation and there were adequate procedures in place to support the safe return of clothes to residents.

As already discussed under Outcome 12, there were inadequate storage for residents' personal property and possessions.

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.

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<tr>
<th>Theme:</th>
<th>Workforce</th>
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**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Based on observations of inspectors and a review of staff rosters there were adequate numbers of staff on duty.

There was evidence that staff regularly attended structured meetings and inspectors viewed minutes of these meetings. Inspectors viewed the staff training matrix, however, the matrix contained records of training for staff that worked in other parts of the campus and therefore it was not possible for inspectors to ascertain with accuracy the status of training for staff working in the centre. Staff members spoken with by inspectors confirmed that they were supported by management to attend training.

There were a number of volunteers that regularly attended the centre and the person in charge provided evidence that all received supervision and support while working in the centre and had their roles and responsibilities set out in a written agreement between the designated centre and the individual.

Inspectors reviewed a selection of staff files and noted from these files that most of the documents as required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were available. However, from the sample of staff files reviewed not all files contained three written references, including a reference from a person’s most recent employer, a full employment history together with a satisfactory explanation for gaps in employment and a vetting disclosure in accordance with the National Vetting Bureau was not available for one volunteer..

**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:

John Greaney
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 Finbarr's Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000580</td>
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<tr>
<td>Date of inspection:</td>
<td>20/05/2015</td>
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<tr>
<td>Date of response:</td>
<td>21/07/2015</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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not contain all the information required by the regulations, such as:
- criteria for admission, including emergency admissions
- a description of all rooms in the centre, including their size
- the total staffing complement in whole time equivalent
- arrangements for management of the service in the absence of the person in charge.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
The Statement of Purpose has been updated to reflect the above changes requested by HIQA, however all admissions to residential units are planned admissions.

**Proposed Timescale:** 08/07/2015

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<thead>
<tr>
<th>Outcome 02: Governance and Management</th>
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<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The review of quality and safety included consultation with residents through residents' forums, however, there was no action plan to identify what actions were taken in response to issues raised by residents or who was responsible for following through on the issues raised.

2. **Action Required:**
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

**Please state the actions you have taken or are planning to take:**
Following a Resident’s meeting the advocate chairing the meeting will in future submit a template logging issues which have arisen and require action. This will be followed up by the Director of Nursing and an action plan identified, as required.

**Proposed Timescale:** 30/06/2015

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| Theme: Governance, Leadership and Management |

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While there was evidence of audits, there was no record available of an annual review of the quality and safety of care as required by the regulations.

3. **Action Required:**
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

**Please state the actions you have taken or are planning to take:**
An annual review of quality and safety of care will be completed.
Proposed Timescale: 31/12/2015

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:
The there was a policy on the use of restraint, however, it was dated 2010 and there was no evidence of a review at a minimum of every three years as required by the regulations.

4. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
St. Finbarr’s Hospital uses the HSE National Policy, however to ensure compliance, this policy will be documented as being adopted by St. Finbarr’s Hospital and will be reviewed every 2 years to ensure compliance.

Proposed Timescale: 30/06/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The designated centre did not have a policy on admissions, recruitment, selection and vetting of staff, provision of information to residents and risk management as required by Schedule 5 of the Regulations.

5. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
Policy documents relating to admissions, recruitment, selection and vetting of staff, provision of information to residents and risk management are now in place.

Proposed Timescale: 30/06/2015

Theme:
Governance, Leadership and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all policies required under Schedule 5 of the Regulations had been reviewed and updated as necessary within three years.

6. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
St. Finbarr’s Hospital use HSE National Policies when available, however to ensure compliance, policies will be documented as being adopted by St. Finbarr’s Hospital and will be reviewed every 2 years to ensure compliance.

Proposed Timescale: 30/06/2015
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there were guidelines available to guide decisions around resuscitation status, these were dated 2007 and therefore required review.

7. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The current guidelines are presently out for review to the medical staff and will be documented as being reviewed when returned.

Proposed Timescale: 30/09/2015
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The medication management policy did not address the handling and disposal of unused and out-of-date medicines.

8. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement
policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
St. Finbarr’s Hospital Medication Management Policy addresses the handling and disposal of unused and out of date medicines.

**Proposed Timescale:** 23/06/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The Directory of Residents did not contain all of the items as required by Schedule 3 of the Regulations.

**9. Action Required:**
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

**Please state the actions you have taken or are planning to take:**
All the additional information required is now contained in the Directory of Resident’s.

**Proposed Timescale:** 30/06/2015

**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Improvements were required in the use of restraint, for example:

- restraint assessments did not adequately demonstrate an exploration of alternatives to the use of restraint
- restraint assessments did not adequately address the risks posed by the use of restraint
- the safety checks were two-hourly and were not based on an individual assessment of each resident to determine to appropriate frequency of safety checks for each resident
- when PRN (as required) medication was used for behaviours that challenge it was not included in the restraint register.

**10. 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:**
All residents with bedrails in use will be further risk assessed and if necessary placed on
the restraint register. Appropriate safety checks, as per individual risk assessment will be completed.
All PRN administration of medication for behaviours that challenge will going forward be included in the restraint register and notified to HIQA in accordance with guidelines.

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<td><strong>Theme:</strong> Safe care and support</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all staff had up-to-date training in responding to behaviour that challenges.

**11. Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Please state the actions you have taken or are planning to take:**
St. Finbarr’s Hospital continues to avail of HSE provided training in Behaviours that Challenge and this is ongoing depending on the availability.

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<td><strong>Theme:</strong> Safe care and support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Improvements were required in relation to staff training, for example:
- staff did not demonstrate adequate awareness or respond appropriately to possible signs of abuse by not investigating unexplained bruising
- it was not possible for inspectors to determine if all staff in the designated centre had received up-to-date training in recognising and responding to abuse.

**12. Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
All staff have received training in Elder abuse. This training is ongoing and will ensure adequate awareness and response to allegations of abuse.

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<td><strong>Theme:</strong> Safe care and support</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An allegation of abuse was made to inspectors during the inspection.

13. **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:**
Following on from this allegation the Director of Nursing met with the complainant. The Senior Social Worker for the Protection of Older People facilitated the process. The General Manager and the Director of Nursing met with all the staff members and all staff submitted written statements. All training records were reviewed and identified that all staff had up to date training in Elder Abuse and in Behaviours that Challenge. Following this investigation there was no evidence found to support the allegation, however to continue to support our residents we have secured the placement of an independent advocate.

**Proposed Timescale:** 30/06/2015

**Theme:** Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Based on a review by inspectors of the report of the investigation into an allegation of abuse, inspectors were not satisfied that the investigation was sufficiently wide-ranging to incorporate all incidents of unexplained bruising.

14. **Action Required:**
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

**Please state the actions you have taken or are planning to take:**
A review of the resident’s medical and nursing notes took place to identify the cause of bruising. A full medical review was completed and all staff members were interviewed. The review identified that the resident was a high risk of falls and it was determined that the bruising may have been as a result of staff members assisting the resident to the ground to protect the resident from injury due to a near fall event. All training records were reviewed and identified that all staff had up to date training in Elder Abuse and in Behaviours that Challenge. To continue to support our residents we have secured the placement of an independent advocate.

**Proposed Timescale:** 30/06/2015

**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 no overall risk management policy.

15. **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:**
HSE Risk Management Policy adopted by St. Finbarr’s Hospital and is in place.

**Proposed Timescale:** 30/06/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The emergency plan required review in relation to the safe placement of residents in the event of a prolonged evacuation, for example, in the event of a fire.

16. **Action Required:**
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

**Please state the actions you have taken or are planning to take:**
A review in relation to the identification of safe placement of residents for a prolonged evacuation has been completed in consultation with the Chief Emergency Management Officer HSE-South and the following places have been identified and documented in the Emergency Plan. 1. South Infirmary Victoria Hospital, 2. Mercy University Hospital, 3. Beaumont Residential Care, 4. St. Luke’s Home, 5. Marymount Curraheen

**Proposed Timescale:** 24/06/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system for reviewing accidents and incidents could be enhanced through an overall review of accidents and incidents to identify trends as an opportunity for learning.

17. **Action Required:**
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.
Please state the actions you have taken or are planning to take:
Incidents and accidents are collated monthly by NIMS - this information is discussed and disseminated at all Senior Nurse and Ward Manager’s Meetings. Trends identified are then discussed and followed up by Practice development and used as an opportunity for learning by all staff.

**Proposed Timescale:** 30/06/2015

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**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:**
Due to the non-labelling of medications with the residents name the PIC was requested to risk assess practices in relation to the handling of medications from delivery to administration.

18. **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:**
All medications continue to be administered under the direction of the prescriber and appropriate documentation completed. Nurses continue to adhere to Nursing and Midwifery Board of Ireland and the five rights of medication management.

**Proposed Timescale:** 24/06/2015

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**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:**
While quarterly reports were submitted to the Authority, they did not include notification of the use of restraint as required.

19. **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:**
These will be included in subsequent quarterly reports submitted to HIQA.

**Proposed Timescale:** 08/07/2015

### 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:**

Improvements were required in care plans, for example:

- there was a lack of clarity around the current care to be provided due the manner in which care plan reviews were recorded
- care plans for end of life care were generic

**20. 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:**
All resident’s undergo a comprehensive assessment on admission and a plan of care is developed with 10 weekly evaluations completed. Generic End of Life Care forms are used to capture individual end of life care planning for residents.

**Proposed Timescale:** 30/06/2015

**Theme:**
Effective care and support

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

There was evidence in the medical records of the clinical rationale for end of life decisions for some of the residents for which a decision of not for resuscitation had been made, however, this was not recorded for all residents for which the decision had been made. Additionally, it was not clear what process was in place for reviewing this decisions should residents' preferences or circumstances change.

**21. Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
A decision around resuscitation is made by a consultant in St. Finbarr’s Hospital. They have been requested to follow up on this.

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

### 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 premises were not suitable, due to:
- multi-occupancy bedrooms that did not support residents' privacy and dignity
- inadequate communal space
- inadequate sanitary facilities
- inadequate storage space for residents personal property and possessions
- inadequate storage space for equipment
- inadequate secure outdoor space
- the paintwork was damaged in some areas of the premises.

22. **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:**
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

### 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:**
There is no centre-specific document accessible for residents and relatives to inform them of the local process for managing complaints or to provide a step by step guide to make a complaint in the centre.

23. **Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
The current centre specific document accessible to resident’s and relatives has been updated to include specifics in how to make a complaint, who to complain to and the named person who is the complaints officer as well as the outside agencies contact details when disatissified.

**Proposed Timescale:** 30/06/2015

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The Regulations require that a record is kept of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied. The individual complaints logs viewed on each of the units did not contain all of this information.

24. **Action Required:**
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
The current log books have been reviewed and the template has been changed to reflect the details required.

**Proposed Timescale:** 30/06/2015

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
It was not clear from the inspectors review of the complaints in the centre what processes are in place to implement learning as a result of complaints being made.

25. **Action Required:**
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

**Please state the actions you have taken or are planning to take:**
All complaints are reviewed in line with the HSE policy Your Service your Say. Learning is disseminated through the meeting matrix.

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

**Theme:**
Person-centred care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no person nominated in the centre to ensure that all complaints are responded to and to ensure that records are maintained of all complaints.

26. **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 in Regulation 34 (1)(f).

**Please state the actions you have taken or are planning to take:**
The Complaints Officer’s name has now been added to the centre specific policy and ensures that all records are maintained on all complaints. Contact details of the outside agencies if a person is disatissified with the response received is also included.

**Proposed Timescale:** 30/06/2015

### 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:**
Residents prescribed a modified diet, such as those with swallowing difficulty that were on liquidised diet did not always have a choice at mealtimes.

27. **Action Required:**
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

**Please state the actions you have taken or are planning to take:**
The general kitchen facilitates all requests for food choices at meal times. This includes choices for residents who are prescribed textured diets. All residents will continue to be offered choice at all mealtimes.

**Proposed Timescale:** 08/07/2015

### 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:**
The size and layout of the multi occupancy rooms meant that there was very little space between some of the residents’ beds and residents were unable to undertake personal activities in private.
28. **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 response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Accommodation was available to receive visitors communally but there was no private space readily available for visiting.

29. **Action Required:**
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident’s room, if required.

**Please state the actions you have taken or are planning to take:**
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

**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:
There was inadequate storage space for residents' personal property and possessions.

30. **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 response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.
### Outcome 18: Suitable Staffing

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not possible to ascertain from the available records the status of training for all staff working in the centre.

31. **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:
Staff are employed in St. Finbarr’s Hospital with a remit to work in the older person’s services and the rehabilitation units. All training has been captured to date to reflect this. Work is in progress to separate the records to ascertain status of training in the older person services residential units.

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

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>It was not possible to ascertain if all staff had up-to-date training in manual handling.</td>
</tr>
<tr>
<td><strong>32. Action Required:</strong></td>
<td>Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
<td>Staff are employed in St. Finbarr’s Hospital with a remit to work in the older person’s services and the rehabilitation units. All training has been captured to date to reflect this. Work in progress to separate the records to ascertain status of training in the older person services residential units.</td>
</tr>
</tbody>
</table>

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