

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Community Hospital of the Assumption
Centre ID:	OSV-0000662
Centre address:	Thurles, Tipperary.
Telephone number:	0504 27700
Email address:	mairead.greene@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Alice Clohessy-McGinley
Lead inspector:	Mairead Harrington
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	56
Number of vacancies on the date of inspection:	4

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times

From:	To:
14 February 2017 09:00	14 February 2017 19:00
15 February 2017 08:45	15 February 2017 17:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection. Registration for this centre is due to expire on 6 May 2017. The inspection took place over two days. The centre had previously been inspected on 4 February 2016. That report, including the provider's response and action plan, can be found on www.hiqa.ie.

Members of the management team were in attendance throughout the inspection and demonstrated an effective understanding of the statutory duties and the responsibilities associated with their respective roles. Inspectors spoke with staff members and observed practice and communication in the delivery of care. As part of the process, inspectors met with members of the management team and staff, as well as residents and relatives. Members of senior management, with responsibility

for ensuring effective resourcing of the service, were in regular attendance at the centre. The person in charge and management team were found to be actively involved in the day-to-day running of the centre and were readily available and accessible to both residents and staff. In advance of the inspection questionnaires had been completed by a number of residents and relatives. Feedback in these was consistently positive and complimentary of staff and the quality of service delivered.

The centre was well resourced, with access as required to a range of allied healthcare services such as physiotherapy, occupational therapy and podiatry. The services of a medical practitioner were also regularly provided and accessible at the centre. The report is set out under ten outcome statements. The statements describe what is expected in a designated centre and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People 2016.

A number of areas for improvement identified on previous inspection had been addressed, such as training and access to independent advocacy services, for example. However, limited action had been taken to improve premises related issues in relation to multi-occupancy rooms, these issues are further detailed in the body of the report.

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 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:

A statement of purpose was in place that contained all the required information as set out in Schedule 1 of the regulations. It declared the purpose and philosophy of care, and provided information on governance, staffing and services available. The person in charge confirmed that the statement of purpose was kept under regular review.

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:

Service at this designated centre is provided by the Health Service Executive (HSE). The HSE provides service across a number of centres nationally. The organisational structure includes tiered managerial oversight on a local, regional and national basis. The system of governance for the centre was in keeping with that of other centres in the

organisation. A nominated person with responsibility for representing the HSE was in place. Care was directed through the person in charge supported by two assistant directors of nursing and a team of administrative and nursing staff. The organisational structure as set out in the statement of purposed included the necessary deputising arrangements. Staff members responsible for deputising for the person in charge were appropriately experienced and qualified. Effective communication systems were in place to support service at the centre.

Management meetings took place regularly with regional meetings in place that provided a forum for senior management to share information and learning. Communication systems at a local level included regular staff and management meetings. Committees with designated responsibility for specific areas were in place, for example on infection control. Quality management systems to monitor the delivery of service included regular and relevant auditing procedures in areas such as falls, infection control and medication management. Staff meetings took place regularly to ensure that staff were kept appropriately informed of learning issues where identified. At the time of the inspection management confirmed that appropriate resources were available to ensure the effective delivery of care in keeping with the statement of purpose. On-site services were available in areas of allied healthcare, such as podiatry, physiotherapy and occupational therapy. Where facilities required improvement, around premises issues for example, action plans had been agreed and the business manager was available to confirm that these proposals were continually under review.

A quality improvement plan was in place and the person in charge had completed an annual quality review. Regular resident meetings took place and minutes of these were available for reference. However, the annual quality review required further development to fully reflect the requirements of the regulations in relation to resident and family consultation and communication.

Judgment:

Substantially Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was an established member of management and registered nurse with experience appropriate to the role. Care was directed through the person in charge. A clear and regular reporting system was in place. Residents and staff spoken with could identify the person in charge and understood that the role carried responsibility and

accountability for the service and that issues and concerns could be addressed to the person in charge for action, if necessary. In the course of the inspection, the person in charge demonstrated an understanding of the regulations and standards appropriate to the duties and responsibilities of the role. The person in charge also demonstrated a commitment to person-centred care and compliance with the statutory requirements.

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 centre maintained a suite of relevant policies in keeping with Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The person in charge confirmed that these were kept under regular review and were revised and amended to reflect any changes in related policies and legislation as required. Copies of the relevant standards and regulations were maintained on site. Staff spoken with were able to demonstrate an appropriate understanding of the policies discussed and their application in practice. For example, managing safeguarding reporting mechanisms and responding to emergencies, including fire and evacuation procedures. Documentation in relation to the timely servicing and maintenance of equipment was in place. Records and documentation were securely controlled, maintained in good order and easily retrievable for monitoring purposes.

Records checked against Schedule 2, in respect of documents to be held in relation to members of staff, were in keeping with requirements.

Other records required to be maintained by a centre as per Schedule 4 of the regulations, such as a complaints' log, records of notifications, fire checks and a directory of visitors, were also maintained and accessible for reference. Resident records checked were complete and contained information as detailed in Schedule 3, including care plans, assessments, medical notes and nursing records.

A current insurance policy was available verifying that the centre was adequately insured against accidents or injury to residents, staff and visitors.

The directory of residents was viewed by the inspector and found to contain comprehensive details in relation to each resident such as name, contact details for relatives and contact details for their general practitioner (GP).

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):

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

Findings:

Action had been taken to address areas for improvement identified on previous inspection. All members of staff had received up-to-date training on recognising and responding to abuse. Practice at the centre, in relation to the management of allegations of abuse, reflected the protocols and approach set out in the relevant national policy on safeguarding vulnerable persons at risk of abuse. Staff spoken with understood what constituted abuse and, in the event of such an allegation or incident, were clear on the procedure for reporting the information. A nominated member of staff held responsibility for the role of designated officer. The inspector reviewed processes for recording allegations that were in keeping with relevant protocols. Residents spoken with stated they felt safe in the centre and were clear on who was in charge and who they could go to should they have any concerns they wished to raise.

There was a comprehensive safety statement, dated February 2017. Policies and protocols in relation to the management of residents' finances and belongings were in place. Members of staff with responsibility for managing these systems were able to demonstrate transparent processes around the recording of transactions. Systems of oversight included both an internal audit process and an annual external audit of the client property accounts. Where possible residents managed their own finances, either independently or with the support of family. Systems in place to safeguard residents' finances included the recording of individual transactions, which were double signed in keeping with policy. A balance check on the cash amounts held in envelopes for residents reconciled with the records maintained.

There was a relevant policy on the management of behaviours dated November 2015. An assistant director of nursing was qualified to deliver related training and a regular training programme was in place. Staff were seen to reassure residents and divert attention appropriately to reduce anxieties that were related to the behavioural and psychological symptoms of dementia. A restraint policy was in place dated September 2016 that provided direction around the definition and use of different types of restraint. Where restraints such as bedrails were in use, assessments had been undertaken and nursing notes reflected regular monitoring and review as appropriate. In cases where pro re nata (PRN) medication was prescribed to manage the behavioural and psychological symptoms of dementia, the administration of this medication was in keeping with the prescription and was also subject to regular monitoring, review and audit.

Judgment:

Compliant

***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:

Policies and procedures relating to health and safety were in place dated February 2017. An emergency plan clearly set out relevant procedures in the event of an emergency and also identified alternative accommodation in the event of an emergency evacuation. The centre operated an operational risk register that was kept under regular review. A health and safety committee was in place that convened on a quarterly basis to review related issues. A risk management policy was in place that required review to reference those areas required under the regulations in relation to unauthorised absence, assault, accidental injury, aggression, violence and self-harm. The person in charge addressed this issue and revised the policy during the inspection.

A fire safety register was in place and a member of staff was able to demonstrate that routine checks took place as required on alarm panels, exits and fire equipment to ensure effective fire safety precautions. Fire drills were conducted regularly and records of these were available for reference. Regular fire safety training was provided and records indicated fire training for all staff was up-to-date. Suitable fire equipment was available throughout the centre which was regularly maintained and serviced; documentation was available to confirm this. Regular checks of fire prevention and response equipment were in place including emergency lighting and fire extinguishers. There was a smoking room on each unit that was equipped with accessible fire safety equipment such as an extinguisher and fire blanket. Call bells were fitted in all rooms

where required. Emergency exits were clearly marked and unobstructed. General equipment servicing and maintenance was undertaken and related documentation was available for reference in this regard.

Responsibility for infection prevention and control was clearly defined and meetings took place regularly at local and regional level to consider related issues. The centre partook in a regular programme of assessment and review in relation to the occurrence and management of healthcare related infections. Notifications of any infectious outbreaks were submitted in keeping with requirements and related reports were available that demonstrated any learning as appropriate. There was evidence of an effective and regular cleaning routine throughout the centre. Staff members were able to describe practices that protected against cross contamination, including the use of a colour-coded cleaning system. Staff were observed using personal protective equipment appropriately. Staff also demonstrated effective hand-hygiene practice in the course of their routine duties. Staff had received health and safety and infection control training relevant to their role. An external service provided a laundering facility for bed linen. Sluice rooms and bathrooms were appropriately equipped and hazardous substances were securely stored.

Judgment:
Compliant

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:
Written operational policies were in place that governed the ordering, prescribing, storing and administration of medicines to residents. This included guidance on the handling and disposal of out-of-date medicine. All policies had been reviewed in November 2016. Pharmacy facilities were available on site. The person in charge reported that the pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland. A regime of regular audit and review was implemented. Competency assessments were undertaken and a supervised training schedule was in place. A sample of prescription records was reviewed and found to contain all the information required by the regulations, including biographical information and a photograph of the resident. Where medicines were prescribed on a pro re nata (PRN) basis, the maximum dose recommended in a 24 hour period was recorded. Prescription records allowed for the accurate recording of whether or not medicines should be crushed. Protocols were in place to refer residents for review by the prescriber in circumstances where a medicine

might be consistently refused.

A member of nursing staff demonstrated practice in relation to the administration of medicines. This included appropriate reference to the prescribing directions to ensure that each resident received the correct amount of the right medicine at the prescribed time. A signature bank all administering nurses was in place. Compliance aids to assist with the correct identification of medicines were readily available. Where medicines were refrigerated, temperatures were being recorded and monitored. Dates of opening were recorded on medicines. Opened medicines were regularly reviewed; those beyond or approaching their recommended usage date were segregated for disposal as appropriate. Protocols around the secure storage of medicines were in place. However, on one unit, the door to an office where the controlled drug locker was located was unsecured. This controlled drug locker was also being used for the safekeeping of petty cash for some residents. The person in charge confirmed that this practice was not in keeping with policy.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

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

Findings:

An incident log was in place that clearly recorded all the relevant information around the circumstances and impact of incidents. Incidents requiring formal notification were submitted in keeping with statutory timeframes. Action identified on the previous inspection had been taken and quarterly returns now included information on the use of bedrails and other forms of restraint. However, in cases where pro re nata (PRN) medicine was prescribed to manage the behavioural and psychological symptoms of dementia, the administration of this medication was not being notified in the quarterly returns as required by the regulations.

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:

The centre operated a care planning format that reflected a standardised template across the organisation. Care plans confirmed that there were suitable arrangements in place to meet the health and nursing needs of residents. The centre provided a broad range of care, including respite and convalescence, as well as continuing long-term care. The admission policy set out the procedure for assessing all residents. Pre-admission and admission procedures included comprehensive assessments by an appropriately qualified person. Care plans were developed in line with admission assessments and residents' changing needs. Admission assessments identified relevant information on the background of residents and their personal preferences, as well as a full profile of their medical and healthcare needs. The previous inspection had established that effective care planning was in place with appropriate systems around assessment and care in relation to the needs of daily living. The care plans reviewed in this instance were consistent with those previously inspected and information around care in this sample was also found to be person-centred and relevant. Validated assessment tools were used to determine residents' needs in relation to nutrition, mobility and cognition for example. The care plans provided relevant directions and advice to staff on appropriate interventions to be considered when delivering care. Care plans were reviewed regularly in keeping with regulatory requirements, or as the needs of the resident changed. Residents' health was monitored and routine observations were recorded at least monthly. The inspector spoke with members of staff and management in relation to their understanding of the care required in a sample of cases. Both staff and management were familiar with the profile of these residents and were able to demonstrate an effective understanding of the care plans in place and any related underlying issues.

Records reviewed indicated that residents had regular access, or as required, to allied healthcare professional services, such as speech and language therapy, dietetics, dental and optical services. Nutrition needs were assessed and care plans detailed both the preferences of residents and how their meals should be prepared. Food was freshly prepared and residents were routinely offered choice around meals. Where residents required a specialised diet the necessary information was clearly set out and staff were trained and understood how to support care as required. Care services within the centre were well resourced. A resident medical director was in place. Physiotherapy services were available and readily accessible. The centre had access to an on-site pharmacy facility. Additional resources included the on-site availability of a podiatrist and occupational therapist. The availability of these resources supported multidisciplinary input, where required, in the review of specific care plans. Consultancy services in

relation to both gerontology and psychiatry were accessible. The services of a psychologist were available and related input on case reviews was evident. Correspondence relating to advice and assessments, following referrals or transfers, were filed for individual residents. Care plans reflected consultation with residents and communication notes confirmed ongoing interaction and consultation with relatives of residents as appropriate.

Judgment:

Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

At the time of inspection the centre was registered for occupancy by 72 residents. The centre was a purpose built facility that had re-opened on its existing site in 2006. The centre provided residential accommodation divided into three units. The premises were laid out as described in the centre's statement of purpose. Unit A comprised 11 single rooms and 2 four-bedded wards, and provided care focused on rehabilitation. Unit B comprised 7 single rooms and 6 four-bedded wards, with a focus on continuing care. Unit C comprised 12 single rooms and 2 four-bedded wards, and provided care with a focus on dementia. The size and layout of bedrooms, other than the multi-occupancy wards, were appropriate to the needs of residents. All single bedrooms were clean, bright and had adequate personal storage space, including a lockable unit for each resident. All rooms had en-suite facilities. The rooms were comfortable and adequately decorated. Call-bells were visible and accessible in all rooms. All areas of the designated centre, including the sensory garden and outside seating area, were seen to be well maintained and in good condition during the inspection. Overall the centre was bright, nicely decorated and maintained, with suitable furnishings in communal areas. There was a central communal dining area with seating for approximately 25 people. There was a chapel for residents where mass was said daily. A family room was available and could be used by relatives of residents as required. Residents had access to adequate bathroom and showering facilities, including an assisted bath facility.

Some improvements in layout had been made. For example a bathroom area had been converted into storage space for wheelchair equipment. Furniture in the dining area of

Unit C had also been removed and arranged to better facilitate mobility in that space during mealtimes.

The centre provided communal space for residents with separate sitting rooms available on each unit where residents could meet visitors in private, if they so wished. However, the design and layout of this space did not always fully support the assessed needs of residents. For example, couches provided as seating in some of these rooms were not appropriate for use by residents who required assistance to sit or stand. Additionally, the size of these couches impacted on the usable space in the room and restricted access for residents using specialised seating or mobility equipment. The centre provided three separate smoking rooms. However, space to accommodate residents at mealtimes was limited and there was no dining area on one unit.

The centre had catering facilities that were well equipped and appropriate to provide an effective service in keeping with the layout and occupancy of the centre. The inspector spoke with staff members responsible for transport and maintenance who were able to demonstrate that equipment and facilities were well maintained and readily accessible for residents.

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):

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

Findings:

There was a policy on providing information to residents and a relevant residents' guide was available and up-to-date. The centre provided access to independent advocacy services and contact information was on display on notice boards in the centre. Staff spoken with understood their duty of advocacy for residents in the first instance. Regular resident committee meetings took place and family members could also attend to advocate for their relative. Minutes of these meetings were available for reference and issues discussed included advocacy access and upcoming plans for St Patrick's day and Easter. There were no restrictive visiting arrangements and on the days of inspection visitors were in regular attendance at the centre. Relatives and visitors

spoken with remarked positively on their experience and observation of care at the centre. There was a mass service daily that was well attended by both residents and visitors. The centre provided facilities for residents to meet with visitors in private and no restrictions on visiting hours were imposed.

The centre had dedicated resources and staff with responsibility for delivering an activity programme. These staff had received training relevant to their role to support them in providing meaningful activities appropriate to the assessed abilities of individual residents. Records of the activities provided were maintained that included a record of the residents that attended. Activities provided for residents with a cognitive impairment included sensory stimulation and diversional therapy. Animal therapy was also provided. Regular scheduled activities included music, arts and crafts and baking. There was music on both days of inspection and mass took place daily in the chapel. The inspector saw that effort was made to mark relevant cultural occasions and, during the inspection for example, there were brightly designed displays and decorations in resident rooms and other areas of the centre themed around Valentine's Day. The centre also had access to a transport facility for outings and to access events in the local area. Residents were facilitated to visit the local town when they wished.

As referenced at Outcome 12, the layout of the premises did not fully meet the needs of residents. Many residents in continuing care were accommodated in multi-occupancy rooms for up to four people with limited private space. Management and staff acknowledged the impact of these circumstances on the privacy of residents. Actions to address areas for improvement, that had been identified on the previous inspection, had been partly implemented. Efforts had been made to personalise individual rooms and two twin rooms had been reduced to single occupancy. However, the continued use of multi-occupancy wards for up to four residents did not support communication and the receipt of personal care in a manner that promoted and protected privacy and dignity. Residents in these wards were seen to receive visitors at their bed-side. While privacy screens were in use in these wards they were inadequate in ensuring privacy of communication for residents. There was a TV in each multi-occupancy ward; however, residents could not always exercise personal choice around what to watch. Additionally, not all residents in these wards could see the screen effectively. One unit had no communal dining area. Staff explained that residents could go to the central dining area for meals. However, this option was not always practical as the central dining area could not accommodate all residents. Residents were therefore sometimes restricted to taking their meals either in their rooms or, in the four-bedded wards, at their bedside. During the inspection one resident was being fully assisted with their meal in a multi-occupancy ward. While the care provided was appropriate, the circumstances did not afford privacy to the resident. Work practices reflected a person-centred approach and effort was taken to ensure specific plans of care for residents were positioned discreetly. However, in some instances name labels were in use and visible over residents' beds, which was not in keeping with the protection of their privacy. Management made arrangements to facilitate residents' preferences for accommodation where possible. In these cases it was evident, from both care plans and discussion, that effort was taken to review circumstances on an individual basis. However, the practical availability of accommodation in less than a three-bedded space for residents on continuing care could not always be provided. Management and staff confirmed that a number of residents in multi-occupancy wards were on a waiting list for availability of a room of their own, or

to share with no more than one other person.

Judgment:

Non Compliant - Moderate

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:

Action had been taken to address shortcomings identified on the previous inspection and all volunteers now had their duties set out in writing. Recruitment and vetting procedures were in place that verified the qualifications, training and security backgrounds of all staff. A sample of staff files was reviewed and documentation was appropriately maintained as per Schedule 2 of the regulations. Management confirmed that Garda vetting was in place for staff in keeping with regulatory requirements. A record of current professional registration details was in place for nursing staff. The centre engaged a number of volunteers who had been vetted and appropriate supervision arrangements were in place.

The system of supervision was directed through the person in charge with administrative and clinical support. Assistant directors of nursing were responsible for designated areas of operational duty, such as staff planning for example. These responsibilities further included the management of staff resources and competency reviews to identify and address training needs. Systems of line management accountability were in place. Supervision was also implemented through monitoring and control procedures such as audit and review. An appropriately qualified, registered nurse was on duty at all times. Copies of the Standards and Regulations were readily available and accessible by staff. At the time of the inspection staffing levels were in keeping with the planned roster, however, there was significant reliance on agency staff to support these levels. Members of management and staff spoken with confirmed that the planned staff roster did not always reflect the actual staffing arrangements and that contingency measures to meet staffing requirements included the redeployment of existing staff. Staffing was included for continual review on the operational risk register of the centre. Also, meaningful access to communal areas for residents in the evenings was limited. The inspector noted

that many of the communal sitting areas were not in use as there were insufficient staff to support residents access and enjoy these areas at these times. Feedback to the inspector confirmed that residents routinely remained in their rooms or wards from early evening onwards, though some were also seen to visit with relatives and family members in the corridor area.

Staff spoken with were familiar with the standards and regulations and were aware of their statutory duties in relation to the general welfare and protection of residents. A regular programme of training was in place that captured all mandatory training. Additional training was provided appropriate to the role and function of staff. A senior staff member was also qualified to deliver training on the management of behaviours that might challenge. Staff spoken with confirmed that they were supported to attend training as required.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mairead Harrington
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Community Hospital of the Assumption
Centre ID:	OSV-0000662
Date of inspection:	14/02/2017 and 15/02/2017
Date of response:	03/04/2017

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:

The annual quality review required further development to fully reflect the requirements of the regulations in relation to resident and family consultation and communication.

1. 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.

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 annual quality review will be fully reviewed and developed in consultation with the residents and families and staff within the Community Hospital of the Assumption. An appropriate questionnaire tool is now finalised to enable management to capture the valuable contributions from residents/relatives and staff. A staff meeting will be held week commencing 20th March, 2017 to discuss the annual review and the key components for development in 2017.

Proposed Timescale: 30/04/2017

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:

On one unit the door to an office where the controlled drug locker was located was unsecured. This controlled drug locker was also being used for the safekeeping of petty cash for some residents; this practice was not in keeping with policy.

2. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

The door to the office in Unit A where the controlled drug locker was situated was secured immediately. All doors to offices where controlled are stored in the hospital are secure. Key pads are to be fitted as an additional security measure.

Lockable Cash boxes have been purchased for each of the three units to store petty cash for Residents if and when required. There is a locked press available in residents wardrobes to store any valuables or money.

Proposed Timescale: Completed.

Proposed Timescale: 03/04/2017

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:

In cases where pro re nata (PRN) medication was prescribed to manage the behavioural and psychological symptoms of dementia, the administration of this medication was not being notified as a restraint in the quarterly returns.

3. 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:

All pro re nata medication will be recorded in the next quarterly returns to HIQA and as per regulation thereafter.

Proposed Timescale: April 2017 submission

Proposed Timescale: 30/04/2017

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 communal sitting areas in some units did not fully support the assessed needs of residents; couches provided as seating in some of these rooms were not appropriate for use by residents who required assistance to sit or stand.

Additionally, the size of these couches impacted on the usable space in the room and restricted access for residents using specialised seating or mobility equipment.

4. 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 sitting room in Unit C will be refurbished with suitable couches and chairs appropriate for use by all suitable residents. This reorganisation will allow additional space to be made available to accommodate additional residents using specialised seating or mobility equipment in the confines of the sitting room. This sitting room will also accommodate the introduction of sensory equipment as under design phase currently by the CNM II in consultation with Occupational Therapist.

Proposed Timescale: 31/07/2017

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 premises did not fully support the assessed needs of residents. The centre provided three separate smoking rooms. However, space to accommodate residents at mealtimes was limited and there was no dining area on one

unit.

5. 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 Tobacco Free campus plan for CHOA will be launched on the 29th March, 2017 at the Health and WellBeing pop up event in Thurles. We aim to have the Community Hospital of the Assumption, a Tobacco free campus by 31st July; 2017.

This will allow all current in house smoking rooms to be converted to communal sitting rooms in some units and as a defined dining area for Unit A. Unit B and Unit C have a dining area which meets the needs of the Residents who are unable to attend the Central Dining Servery due to their dependency levels. Presently, the majority of Residents in Unit A (Rehab) attend the Central dining area on a daily basis.

Proposed Timescale: 31/07/2017

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 use of multi-occupancy wards for up to four residents restricted residents in exercising their personal choice around:

privacy for personal activities including communication,
entertainment such as viewing and listening to preferred TV programmes,
not sharing a room with more than one other person.

6. 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:

Since the announced HIQA Registration Inspection, the original 10 Multi Occupancy rooms have been converted from 10 x 4 bedded rooms to 9 x 3 bedded rooms and 1 x 4 bedded room remains, in Rehab Unit only. This is outlined in the revised Statement of Purpose, February, 2017. The planned configuration of these beds are two long term care residents and one short stay resident.

This re-configuration of the multi-occupancy rooms will increase and enhance the opportunities for residents to express personal choice.

All residents have the option of exercising their personal choice regarding entertaining / communicating with family members/ visitors in their bedroom or in the sitting rooms within their unit. Staff would always exercise discretion when communicating with the

residents and maintain the residents dignity at all times. Since Jan. 2017 we are currently trialling alternative TV options in the Multi-occupancy rooms in Unit B by replacing the current smaller TV with a widescreen larger TV and TV's are also available in the Communal sitting rooms in every Unit. The residents in the multi Occupancy rooms are given the choice of availing of single room where possible but some residents prefer to remain in the company of residents in the multi occupancy rooms.

Proposed Timescale: In progress

Proposed Timescale: 03/04/2017

Theme:

Person-centred care and support

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

In some instances name labels were in use and visible over residents' beds which was not in keeping with the protection of their privacy.

7. 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 name plates will be removed. It is necessary therefore to engage with clinical staff to discuss all alternative options and systems to support staff, as the Community Hospital of the Assumption currently has 29 Short Stay clients and a high level of activity in the clinical areas. Consideration will be given to alternative discreet positioning of name plates so to ensure protection of privacy for all residents.

Proposed Timescale: 30/04/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The planned staff roster did not always reflect the actual staffing arrangements.

8. Action Required:

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

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

The planned staff rosters are completed by the Assistant Director of Nursing and signed off with the Clinical Nurse Manager on a weekly basis for the coming week. However,

ongoing daily changes are necessary to replace sick leave or any unexpected leave. Agency staff are available to accommodate roster deficits but it is not always possible to cover every shift due to unavailability of staff or no available staff. Therefore staff roster changes within the units is necessary to ensure appropriate skill mix. The planned roster ensures the number and skill mix of staff is appropriate to the needs of the residents.

A meeting was held on 16th March 2017 in the Community Hospital of the Assumption, feedback from a HSE internal audit, review of the current rostering and pay systems. An action plan to review the current manual rostering system is now in draft form with a view to reducing the number of source documents for recording of attendances/absences.

Proposed Timescale: 31/05/2017

Theme:

Workforce

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

Staffing levels did not support residents in having meaningful access to communal sitting areas in the evenings.

9. Action Required:

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

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

The current staff rosters do ensure appropriate staffing levels in the evenings, but with minimal access to meaningful activities. In Unit C meaningful activities, such as music sessions, storytelling are specifically tailored to meet the needs of the residents. Diversional therapy support hours will be reviewed from the current WTE allocation, with view to increasing the resource and tailoring same to support staff with meaningful activities in the evenings.

Residents do have meaningful access to communal sitting areas within their units, in the evenings and some also avail of the communal areas in the main concourse of the hospital. The proposed re-design of the existing Smoking rooms in Unit C and Unit B will give welcome additional recreational space for the residents.

Proposed Timescale: 31/10/2017