### Centre name:
Leopardstown Park Hospital

### Centre ID:
OSV-0000667

### Centre address:
Foxrock, Dublin 18.

### Telephone number:
01 295 5055

### Email address:
info@lph.ie

### Type of centre:
Health Act 2004 Section 38 Arrangement

### Registered provider:
Leopardstown Park Hospital

### Provider Nominee:
Ann Marie O’Grady

### Lead inspector:
Leone Ewings

### Support inspector(s):
Angela Ring; Shane Walsh

### Type of inspection:
Announced

### Number of residents on the date of inspection:
155

### Number of vacancies on the date of inspection:
14
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: 08 March 2017 10:00  
To: 08 March 2017 18:00  
From: 09 March 2017 08:00  
To: 09 March 2017 18:30

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

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

Summary of findings from this inspection

This report sets out the findings of a two-day inspection, the purpose of which was to inform a decision for the renewal of the centre's registration. Some improvements had taken place since the time of the last inspection, including the reduction of a multi-occupancy bedroom in one unit called Djouce, while residents are now all accommodated at a ground floor level. However, the provider had not yet fully
addressed the major non-compliances relating to the premises found on the last inspection on 25 August 2015. At this and previous inspections, it was reported there were significant deficiencies in the design and layout of the centre, that do not meet the requirements of the regulations and the Standards and significantly compromise residents' rights to privacy and dignity. These deficiencies include four large open-plan multi-occupancy units where up to 15 residents share a room (Tibradden, Enniskerry, Kilgobbin and Kilternan). In addition aspects of the design and layout of the four-bedded multi-occupancy units on Glencree and Glencullen are not person-centred and do not ensure privacy. Deficiencies in the use of Djouce and multi-occupancy rooms for respite were also noted. These deficiencies in the layout and design of the units were highlighted and discussed with the provider nominee and person in charge at a number of meetings. The provider submitted interim and long-term plans to the Authority to address the deficiencies and a condition of registration was put in place for the agreed time frame for completion by the end of October 2017. However, works to address all of the identified deficiencies in accommodation had not begun. HIQA has requested a written update in terms of implementation of the improvements, to be submitted in writing to the Chief Inspector for review and to include costed plans with time frames to support the required changes.

During the course of the inspection, the inspectors met with residents, relatives, staff, the person in charge and the provider. The views of residents, relatives and staff were listened to, practices were observed and documentation was reviewed. Surveys completed by residents and or their relatives were also reviewed. Inspectors analysed 12 questionnaires completed by residents and relatives. All feedback was reviewed and informs the content of this report both positive and negative.

Overall, the inspectors found that care was delivered to a good standard. Staff knew the residents well and discharged their duties in a respectful and dignified way. The management and staff of the centre were striving to improve residents’ outcomes. Residents appeared well cared for and mostly expressed satisfaction with the care they received in the centre. Some feedback received related to the laundry, food service, environment, end-of-life care and facilities. Residents spoke positively about the staff who cared for them. Positive feedback was included from people who had also experienced the other facilities on-site such as day care, respite admissions and therapy services prior to admission.

The provider and the person in charge are responsible for the governance, operational management and administration of services and resources. They demonstrated sufficient knowledge of the regulatory requirements. Overall, major improvements were required in two of the outcomes to meet the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland (2016). The centre is arranged into nine separate areas (described in Outcome 12 of this report) with 149 beds for long-term care and eight for short-term respite, and an additional 12 are short-term step-down rehabilitation beds. At the time of the inspection the number of residents living in the centre was confirmed as being 155 residents, with two residents in hospital. Occupancy had decreased by one bed owing to the requirements of the non-standard condition in place at the time of the last registration renewal. Some vacancies were noted in a
number of units. As part of this inspection, unsolicited information received by HIQA and statutory notifications made by the provider and person in charge were also followed up.

Compliance was found in 10 of the 18 outcomes monitored at the time of this inspection. However, improvements are required by the provider in eight of the 18 outcomes inspected. Two outcomes are major non-compliances, in relation to premises and residents' rights dignity and consultation; seven actions are the responsibility of the provider and four that of the person in charge. The action plans at the end of this report identify areas where improvements were required in order to fully comply with the regulations. These include premises, residents' rights dignity and consultation; governance and management; health and safety and risk management; medication management; health and social care needs; and residents' clothing, property and possessions.
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 written statement of purpose was submitted as part of the registration renewal process. The inspectors were then provided with an updated document at the time of the inspection which detailed the aims, objectives and ethos of the service and met Schedule 1 requirements.

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

**Findings:**  
A clearly defined organisational management structure was in place that outlined the lines of authority and accountability in the centre. The annual report for 2015 was made available to inspectors during the inspection. This report did not fully meet all the requirements of the regulations. The provider confirmed that progress was being made
to review the quality of care and safety at the centre for 2016 to include feedback and inputs from residents. At the time of the last inspection the person in charge had prepared a newsletter and this was made available to all residents, with a range of information for residents and the results of audits carried out in the centre. This newsletter, although very informative, and interesting, did not meet the legislative requirements in terms of ensuring the voice of the residents was central to the annual report of quality and safety in the centre. Feedback received from residents and relatives were that in general supports, including advocacy and social work to give residents a voice, were utilised and valued.

Overall, there were satisfactory governance arrangements in place. The provider is the representative of the entity in her role as chief executive officer and she is full-time in this role. She is based in the designated centre and worked closely with the new person in charge. She demonstrated leadership and accountability in her role throughout the inspection and reports to the Board of Management. Board meetings were held with the Board of the Hospital where all areas of clinical governance were minuted.

The findings of this inspection confirmed that day-to-day systems were in place to monitor the quality and safety of care. The provider and person in charge had the support of a staff member tasked with the role. The quality and safety manager managed the systems in place to review several areas of health and quality of care with key performance indicator data collected each month. This formed part of a regular review of quality of service and healthcare provided for residents. The indicators included incidence of falls, use of restraint, medicines errors, incidence of pressure ulcers, episodes of responsive behaviours and infection control matters. A detailed analysis and a comparison with the previous audits were carried out and there was evidence of action taken and improvement brought about. Nonetheless, major non-compliances in terms of the current premises and the impact on residents' privacy and dignity for residents had yet to be addressed.

**Judgment:**
Substantially Compliant

**Outcome 03: Information for residents**
*A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspectors were satisfied that residents had an agreed written contract with the provider. A sample of contracts of care reviewed were signed within one month of
entering the centre, and they also included the fee and any other additional fees for services to be provided. A revised contract of care was being drafted to include details of where each resident would be accommodated in the centre in line with legislative requirements.

A detailed residents' guide was in place and contained details of services in place at the centre. The admissions procedure included provision for residents and relatives to visit a unit with an empty bed to see facilities prior to making a decision to come into long-term residential care.

**Judgment:**
Compliant

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**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 had changed since the time of the last inspection. The person in charge is a registered nurse, with management qualifications and experience as required by legislation. The provider had submitted all the required information at the time HIQA was notified of this change. The person in charge was found to be suitably qualified and experienced nurse who has post-graduate management qualification. He was assessed as a fit person to undertake this role during a review of fitness that took place on 26 October 2016.

He was observed interacting with residents during the inspection, was well known in the centre, and he demonstrated adequate knowledge of the regulations and standards.

**Judgment:**
Compliant

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

Findings:
Improvements had taken place in the written policies reviewed including policies on safeguarding, restraint and end-of-life care.

The records as listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness and accuracy. Overall, a good standard of record-keeping could be seen throughout the inspection, and records requested were accessible.

A sample of staff files were reviewed and found to contain all the requirements of Schedule 2 of the regulations.

The centre was adequately insured against accidents or injury to residents, staff and visitors, as well as loss or damage to residents property.

A directory of residents was maintained which contained all of the matters as set out under Regulation 19.

The designated centre had all of the written operational policies which had been recently reviewed as required by Schedule 5 of the regulations. Policies were evidence-based and guided practice.

Judgment:
Compliant

Outcome 06: Absence of the Person in charge

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

Theme:
Governance, Leadership and Management

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

Findings:
There were suitable arrangements in place for the assistant director of nursing to
deputise for the person in charge in his absence.

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

**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:**
The inspectors were satisfied that safe systems were in place to protect residents from being harmed or suffering abuse. There was a detailed updated policy to guide staff, who also received appropriate training and refreshers.

Many aspects of care and communication were observed to be person-centred where staff and management promoted residents' rights. However, as outlined in Outcomes 12, 16 and 17 of this report, this was not always fully implemented due to environmental restrictions. The inspectors found that staff training in the protection of vulnerable adults was up-to-date. Staff spoken with were knowledgeable of the different types of abuse and the reporting arrangements in place. The inspectors spoke with a number of residents who said that they felt safe and secure in the centre.

The provider and person in charge were aware of the requirement to notify any allegation of abuse to HIQA. A number of reports had been received since the time of the last inspection. Further to a review of records and actions taken, the inspectors confirmed that all reports were actioned in line with policy, and measures to safeguard residents were taken without delay. Some of the reports received related to responsive behaviours between residents with cognitive difficulties. Measures to mitigate any risks were found to have been fully implemented by the provider, person in charge and wider multi-disciplinary team involved.

Residents who required support with finances could access this service at the centre. Records were maintained by a senior finance administrator at the centre. A review of the resident property policy and procedures and records held at the centre was satisfactory.
Access to advocacy and medical social work supports were also available to residents and relatives on-site.

A policy on the management of responsive behaviours that guided practice was in place. A sample of resident records of residents who presented with responsive behaviours was reviewed by inspectors. Supportive care plans were developed and in place to inform staff and guide practice. All care plans were updated following specialist input and review from the wider mental health team. Inspectors found evidenced-based tools were used to monitor behaviours where required. Staff were familiar with the residents and understood their behaviours, what triggered them, and implemented the least restrictive interventions as outlined in the written care plan. Staff documented the rationale for use of any psychotropic medication, and audited and reviewed its use. Some areas of good practice relating to dementia care were observed by inspectors, including low arousal environment, good communication techniques and person-centred practices which supported residents living with dementia.

The policy, practice and assessment forms reviewed reflected practices observed. Policies were now updated and in line with national policy. The inspectors confirmed use of alternatives prior to the use of any restraint as outlined in Towards a Restraint Free Environment in Nursing Homes (2011). The person in charge ensured that a detailed risk assessment took place and the least restrictive intervention was in use. The records of any alternatives which had been trialled (prior to the use of bedrails) could be clearly evidenced on a consistent basis. The nursing risk assessments completed were clear and reflective of practice observed by inspectors.

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

**Findings:**
The risk register and the risk management policy met the requirements of the regulations to inform and guide staff. An up-to-date health and safety statement was available, and reviewed by inspectors.

The safe systems in place outlined in the risk management policy to manage the specific and potential risks in the centre were implemented. Nonetheless, the provider had not
yet fully addressed some aspects of environmental risk review, including storage of oxygen and risks associated with poor storage arrangements at the centre. Further risks identified on this inspection were included in feedback given to the provider who agreed to action these risks:
- risks associated with the use of a passenger lift for storage of a mobile hydraulic hoist
- storage of clinical equipment such as fridges, shelving and portable weighing scales in residents’ bedrooms
- review of risks associated with absence of handrails in some areas to promote mobility and independence
- review risks associated with the storage of moving and handling equipment in communal spaces
- fire safety risk relating to the use of a two-bedded room within a larger multi-occupancy four-bedded room
- dirty utility facilities in the Djouce unit were not suitable or sufficient
- inappropriate storage of equipment in residents' shower and toilet areas

Overall, there were satisfactory arrangements in place for appropriate maintenance of fire safety systems such as the fire detection and alarm system. Improvements had taken place since the time of the last inspection. Fire safety equipment was serviced and fire exit signage was found to be in place, and all accommodation was now on the ground floor. This was a condition of the current registration which included a reduction in the bed number by one in the Djouce unit, and was implemented in full.

The procedures to follow in the event of discovering a fire, or on hearing the alarm, were displayed around the building. Staff were aware of each resident’s mobility, and any requirements for support in an emergency evacuation. The fire policy provided guidance to reflect the revised size and layout of the building and the evacuation procedures to include residents accommodated on each floor of the building. The updated layout and instructions were visible to residents staff and visitors to the centre.

Staff had completed annual refresher training in fire safety procedures. Records indicated fire drill practices were completed. Routine checks were undertaken to ensure fire exits were unobstructed, automatic door-closers were operational and firefighting equipment was in place and intact.

There were clear procedures in place for the prevention and control of infection, and all areas within the centre was visibly clean and hygienic. Hand testing indicated the temperatures of radiators and taps dispensing hot water did not pose a risk of burns or scalds. Hand gels for disinfecting were located along the corridor and at the front entrance. Staff were observed practicing hand hygiene, and adequate wash-hand basins were provided for use in the centre. Nonetheless there were some areas for improvement noted by inspectors during the inspection. For example, the layout of the location of drying racks, hand-washing facilities and a bed pan washer in separate areas in the Djouce unit, beside residents' toilet facilities was not optimal. Additionally, the proximity and spacing of beds in some clinical areas needs review to ensure that the risks associated with any infection outbreak could be managed to control and reduce the spread any healthcare-related infections.

Falls and incidents were documented and audited. In the sample of accident report
forms reviewed, vital signs for residents were checked and recorded and the resident’s next of kin and general practitioner (GP) were informed. Training records evidenced that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet each resident’s needs and safe practices were observed by inspectors. Staff were able to explain the steps they followed in the event of someone having a fall, and this was in line with the centre’s policies and procedures. Any fall or incident triggered staff to undertake a comprehensive clinical and nursing review. This review included elements of best practice around bone health, safety awareness, social and falls prevention strategies.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Overall, medicines were found to be managed well, and safe practice was observed. However, the non-compliance relating to the times of administration of medicines did not consistently reflect the prescribed times in all records reviewed. This is a recurrent non-compliance since the last inspection.

Medicines management audits were conducted within each area of the centre as part of the quality and clinical governance system in place. Staff confirmed that a pharmacist who supplied medicines to the centre was available for support and advice. Nursing staff were familiar with the procedure for storage and disposing of unused or out-of-date medicines. The medicines prescription sheet contained full details for all medicines prescribed.

Residents were protected by the centre's policies and procedures for medication management. Medicines were stored securely in the centre in a trolley or within locked storage cupboards. Secure fridges were available to store all medicines, and prescribed nutritional supplements that required refrigeration. Fridge temperatures were checked and recorded on a daily basis.

Controlled drugs were stored securely within locked cabinets in each area, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of the shifts.
The inspectors observed nursing staff safely administering medicines to residents. The nurses on duty knew all the residents well, and were familiar with the residents’ individual medication requirements. Medication administration practices were found to adhere to current professional guidelines. The rights of the resident relating to taking their medicines were respected, including the right to refuse.

The inspectors reviewed a number of the prescription and administration sheets and identified that practices conformed to appropriate medication management practice. The inspector reviewed records which confirmed that all nursing staff had completed training in relation to medicines management.

Independence relating to medicines in terms of self-medication was not found to be fully considered or promoted as an option. A discussion was held with the provider and person in charge to consider this as an option where appropriate.

Judgment:
Substantially 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:
A record of all incidents occurring in the designated centre was maintained and notified where required to the Chief Inspector.

The person in charge and his deputy was familiar with the incidents that required notification in three working days, along with a report of specified incidents to be made every three months.

There was a system to record, report and review all incidents in terms of clinical governance.

Judgment:
Compliant

### Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care.
The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

**Theme:**
Effective care and support

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

**Findings:**
Overall, inspectors found residents' health and social care needs were well met. Feedback received from residents and relatives confirmed that staff supported residents to achieve their goals and promoted independence. Improvements were required with the documentation of care including care plans; this had been highlighted on the last inspection for improvement also, but had not yet been fully addressed.

All prospective residents had an assessment completed on admission. Care was planned for a range of health care needs where a risk was identified. The documentation of care plans and consultation with residents had required improvement at the time of the last inspection, this was still in progress. A sample of residents' care plans were reviewed during this inspection. The care plans were in an electronic record-keeping system that staff could access. Care plans were developed where a need was identified. However, the documentation of plans required improvement as the plans did not consistently guide staff practice or reflect the good practices carried out by staff. Some written care plans contained generic statements obtained from the electronic system plan, for example behaviours that challenge and falls care plans. Care plans were not central to the daily care provision and were not consistently informing and guiding staff in relation to residents changing health-care needs. There was some evidence that care plans were updated by staff. Nonetheless, the actual care delivery was not fully recorded or reflective of care seen by inspectors in all of the sample reviewed. Some feedback received from residents indicated consultation had commenced, but the record-keeping system did not always allow for residents or relatives to see their care plans on a consistent basis to be involved with care reviews. For example, inspectors saw electronic nursing notes provided information on the treatment and condition of the residents. However, a further summary handover document was being used by some staff and had superseded the care planning process in some cases.

There were good practices in the management of residents' nutritional needs, the management of falls and the arrangements in place for wound care. There were regular review of residents' healthcare needs using evidence-based assessments tools. These were completed every three months. Where an identified need arose, care plans were developed. The staff were knowledgeable of residents' care needs and had also received training to enhance their practices and keep them up-to-date with best practice. There was evidence of referral to the relevant health professionals. Mobility assessments and physiotherapy reviews informed the care plans of residents. A full-time medical officer
was based in the centre, and there was evidence of regular review of residents' medical needs. A second medical officer provided additional support. The residents also had a choice of retaining their own general practitioner. Appropriate arrangements were in place for out-of-hours and on call and at weekends.

There was a range of allied health professional services available in house for example, physiotherapy, occupational therapy, dietician, speech and language therapy, social work and pharmacy services were provided. Where recommendations were made by these professionals, they were recorded and residents' care plans were updated. For example, residents and relatives spoke about goals being met including mobility, attending social activities such as art, learning new skills and attending music sessions at the centre.

Judgment:
Non Compliant - Moderate

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:
Overall the findings were that the physical environment in Leopardstown Park Hospital does not meet all of the residents' needs and the requirements of the regulations. There are significant improvements required in order to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland 2016. As stated in the summary, the provider was fully aware of the deficiencies in the centre and had submitted a proposal that outlined an interim and a long-term plan to address the deficiencies in the premises. However, to date these plans have not been fully implemented.

The centre is located in an urban area, on a site which has the benefit of some green space, mature trees with landscaped well maintained areas, pathways and seating. There is parking on-site and also space for the centre's transport vehicles. A large chapel and communal day space areas are also in place, in addition a day care service operates from this site.
The main reception area is staffed and visitors access into the building is controlled. The original building dates from 1917, with additions, including the major new-build of Glencree and Glencullen in 2008. The original nurses' accommodation is now used by residents from the Clevis unit.

This was the overall centre configuration reviewed by inspectors, as stated in the most up-to-date statement of purpose. The provider is applying for 169 spaces to be registered - down from the current registration of 171 places. One bed on the Djouce unit has been removed to comply with a registration condition, and now all accommodation is located on the ground floor only.

There are 149 beds for long-term care and eight are short-term respite, and an additional 12 short-stay rehabilitation beds as follows:

Djouce unit - 10 beds
Accommodates female residents, two residents for long-term care and up to eight short-term respite admissions. In the Djouce unit there is one single room, one four-bedded room which also has a two-bedded room within this area, and a three bed multi-occupancy room. There is adequate communal space in Djouce with access to a small courtyard garden area which contains a smoking section. Djouce although safely accommodating residents was identified to the inspectors as not being suitable for residents who may exhibit exit-seeking behaviours and who may require higher supervision needs.

Clevis unit - 29 long-term care beds
This house may accommodate 29 people in single bedrooms with hand wash basins. This is a two-storey converted building separate from the main building and laid out over four corridors. There is a passenger lift and stairs in place and most residents are independent or low dependency. There is a step to access the front door, and an alternative level accessible entrance through the sun room. Suitable kitchen, storage, communal sitting and dining room, shower and toilet facilities were in place and residents had decorated their rooms to their individual tastes. A separate admissions policy governed the assessment of suitability for Clevis.

Woodview - eight beds (step-down short-term beds)
This consultant-led unit can accommodate people on short-term rehabilitation stays of up to eight weeks in the centre. Additional supports - including physiotherapy, occupational therapy and speech and language therapy - are made available. One single room, and a multi-occupancy space - one accommodating four and three in the middle of the unit. A large day room overlooking the grounds was in place and a shower room with two toilets. The overall aim is to discharge people home to their own homes. (Four additional short-term 'step-down' beds are located on-site also; two on Glencree unit and two on Glencullen unit).

Glencree / Glencullen - 27 beds each (54 in total, 25 long-term care and two step-down)
Both units were built in 2008. In order to get to Glencullen, staff residents and visitors must also walk through Glencree. The accommodation is mainly four-bed multi-occupancy, with single and twin rooms available on both units. There is suitable and
sufficient shower and toilets provided in both units, with day dining space also in place. A visitors room is located nearby with the coffee-dock area also used between the units.

Tibradden, Kilgobbin, Kiltiernan and Enniskerry. There are 15 residents living together in one room in each of these units, which are divided into open bays. There are two to three single bedrooms also located in each of the units.

The structural deficiencies in relation to these units are as follows:

- The units were institutional in nature, with between 4 and up to 15 residents sharing a room
- Suitable storage for residents' personal possessions and clinical storage was not in place
- There was insufficient space around the beds to ensure privacy and dignity. For example, personal and intimate care is carried out by residents' bedsides, with only a screen dividing the bed, and in most cases the main corridor of the room went by their bed, or they were located adjacent to a doorway
- There was insufficient room to receive visitors or for residents to sit out by their beds at the same time
- There was an infection control risk as beds were in close proximity to other. For example, there were gaps of just three feet (1 metre) between some of the beds. This increased the risk of cross contamination
- Beds were very close together and as a result there was no means of maintaining a private space for each resident to block out noise and malodours
- There was limited storage space for residents to store clothes, for example, wardrobes were not large enough to store all residents clothes or were only accessible only in another residents space. For example, on Glencree
- There was limited space for residents to personalise the small space around their beds, and most residents had one small locker to store personal belongings and display personal items
- There was inadequate quiet/private space for residents to meet visitors although a visitor's room and coffee-dock is in place on-site, it may not be adequate for the numbers of overall residents to use
- There was inadequate storage space for equipment which was stored along corridors and in communal bathrooms which posed a potential hazard
- There was one open-plan shower and toilet with no door provided in the Tibradden unit

Despite these deficiencies the centre was in a clean condition and was maintained to a good standard internally and externally. Overall it was well decorated. There was direct access to a number of secure gardens from the centre, including an enclosed sensory garden. Appropriate assistive equipment was provided to meet residents’ needs such as hoists, seating, specialised beds and mattresses. Inspectors found that kitchen and laundry facilities were satisfactory and met the requirements of the regulations.

Minimum standards relating to provision of suitable showers and toilets could not be met for the number of residents the centre wishes to accommodate.

**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 inspectors confirmed that any complaints that occurred in the centre were listened to and acted upon. Feedback was welcomed including comments, compliments and complaints and seen as a useful tool to improve service provision. The centre had written policies and procedures in place for managing complaints in the centre. The procedure for making complaints was found to be user-friendly and implemented fully. There was a guide explaining how to make a complaint available to residents and their representatives displayed near the front reception area. The inspectors recommended that further information be made available on each of the nine units for those who wished to give feedback.

The policy named a nominated person to manage complaints and a nominated person to oversee the management of complaints. An appeals person was also named in the event of dissatisfaction with the complaint. The complaints process was broadly in line with the Health Service Executive's (HSE's) policy on complaints.

The inspectors reviewed the record of complaints and found that all formal complaints had been appropriately addressed (or were in process). The outcome of the complaint as well as the satisfaction of the complainant was also recorded.

Inspectors spoke to a number of residents and relatives and asked if they knew what the procedure was if they wished to make a complaint. All were aware of who they could speak to if they wished to make a complaint and all made complimentary comments about the staff and the person in charge stating that they felt staff and management would act upon any complaints or concerns they raised immediately. Some residents outlined verbal complaints they had made and stated that they were happy with the response they had received after making the complaint.

Judgment:
Compliant

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity
Theme:
Person-centred care and support

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

Findings:
Inspectors found the provider ensured residents received care at their end of life care from an emotional, social and spiritual perspective. The person in charge has made improvements in the written policy, which had been updated since the time of the last inspection. Further improvements were found to be required in terms of providing privacy and dignity to those residents whose identified preference is for a single room at the time of death. Particular needs were noted where the resident is accommodated in eight of the nine areas where multi-occupancy rooms are used. Feedback received prior to and during the inspection confirmed that staff had spoken to relatives and residents and this need had been identified, but that it had not always been possible to meet this need. The inspectors formed the view further to detailed feedback from relatives and residents that residents' preferences for private accommodation could not be met on every occasion. However, an acknowledgement that staff put in place best practice in many other aspects of end-of-life care provision.

A policy on end of life provided guidance to staff, although many of the good practices carried out and services found in the centre were not always fully reflected. Staff had received training in end-of-life care, and practices relating to care of deceased residents were seen to be respectful. An action from the previous inspection was complete and care plans were developed for residents who required them. However, some care plans did not fully evidence the care delivery, and details of each resident's wishes were not consistently incorporated into their care plans.

The were strong links with the local palliative care team. In addition, two nurses were trained to provided care and support in palliative care. Inspectors spoke to staff who said they provided guidance and direction when residents were approaching this stage in their lives. The staff in the centre were also provided with training in palliative care and end-of-life.

A chapel and private room was available to residents at any time and religious services took place on a regular basis. Inspectors were informed that family members could stay overnight, in a designated family room in the event that their loved one was unwell or dying. Refreshments were also provided.

Judgment:
Non Compliant - Moderate

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities
adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

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

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

**Findings:**
Overall, feedback received about meals and food service was positive. Residents confirmed that the food service was good, choice was offered and individual likes and dislikes were respected. Mealtimes were found to be social occasions and were well supervised with staff from the catering team present to monitor service provision.

Residents were provided wholesome and varied food and drink adequate to their needs, and assistance was offered in a discreet and sensitive manner. Inspectors saw residents being offered a variety of snacks including fruit and hot drinks during the day. Inspectors spent time with residents in a number of dining rooms at lunch time. The residents who required support during their meal were discreetly and respectfully assisted by staff, who sat beside them and chatted quietly. A menu was displayed on each table, which outlined with the choice of meal for the day. There was also choice at mealtimes for residents on a modified consistency diet. The meals served at came out in hot trolleys from the main catering kitchen, and were served to residents. One area for improvement centred on the practice of pre-plating of food in some units, and this was not custom and practice in all areas.

Staff were present during the meals in most units supervising to ensure each resident enjoyed their chosen meal. The meal served at lunchtime looked and smelled wholesome, and residents confirmed they enjoyed the food service.

The person in charge ensured processes were in place to ensure residents nutritional and hydration needs were fully met. Nutritional assessments and monitoring systems were in place and completed for all residents. Referrals could be made to the speech and language therapist and dietician who were based in the centre. Inspectors read care plans for residents who had difficulty maintaining weight or had specific nutritional needs. Where a risk was identified for example, a reduction in weight or poor nutritional intake, additional measures were taken such as using dietary monitoring records and fluid balance charts.

Each day, a menu plan was completed by each unit in the centre for the kitchen staff. It reflected residents' individual dietary requirements and choice of food. The catering manager regularly met the residents and monitored feedback on their likes and dislikes. There was a four-week rolling menu which was reviewed by the catering manager with input from the dietician. A nutrition committee also met. This committee included the catering team, dietician and person in charge.
Judgment:
Compliant

**Outcome 16: Residents’ Rights, Dignity and Consultation**
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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

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

**Findings:**
Systems of receiving feedback and surveying residents were in place, a residents committee had been established representing the views of residents to management. Historically the ethos of the centre was geared towards the providing care to residents who were ex-servicemen, but now the service was open to those from any gender and background. Residents meetings took place and feedback was given to the chief executive officer and person in charge where indicated. Comment cards and details of advocacy services and social work provision were visible and accessible in the centre.

Opportunities to engage in meaningful activity were available, and external outings were planned for using the centre’s transport. For example, shopping trips and trips to the sea in Bray took place. Activities such as art therapy, music concerts and gardening were examples of activities residents confirmed they enjoyed. Some residents told inspectors that access to a Luas station near the entrance of the centre was also an advantage with good transport links. Staff were aware of the many activities that each resident liked to undertake, both in private and in groups. Residents had access to television, radio, reading materials and newspapers at the centre. However, some residents told inspectors they also spent time doing nothing or lying on their beds, and the hours in the day could be long.

Evidence relating to poor practices relating to privacy and dignity found on the last inspection in the four Nightingale-style multi-occupancy areas had not yet been fully addressed by the provider. Overall, many residents accommodated in multi-occupancy rooms, and using communal shower and toilets at the centre were not fully afforded privacy or supported in how they chose to go about their day. The provider was not found to be adhering to best practice in terms of the regulations, and major improvements were required to ensure that each resident’s right to privacy was respected.
The layout of the large open plan units did not fully promote residents' rights to privacy, in particular during end-of-life care. Where residents indicate a preference as to their location at end-of-life, evidence that efforts were made to facilitate this. However, there were only two to three single rooms in the four units inspected. Staff said residents may be accommodated in these rooms but only if there were vacancies at that time. Therefore, residents' preferences for a single room during end-of-life care could not always be facilitated, and this was also confirmed by relatives who responded to HIQA questionnaires. Relatives also confirmed to inspectors that they had been facilitated to be on a list for single accommodation or to be transferred to another unit where the multi-occupancy rooms were smaller.

The design and layout of the units, along with some staff practices observed by inspectors, meant residents could not always be afforded privacy and dignity. For example, the lights were on in the entire unit, the room was not sound-proofed and noise at night was cited by residents as a problem. Some conversations and telephone calls held in the nearby nurses' station could be heard by residents and visitors in the area. In addition, some residents' beds were opposite the toilet area and along the corridor in the room. The screen was the only barrier between each bed and these areas.

The arrangements around privacy and dignity of residents living in the four units required improvement. As reported in Outcome 12, some beds in each unit were in very close proximity and only one metre in distance apart. Due to such close proximity, there was inadequate space for a chair and for both residents to sit out of their bed at the same time. Inspectors found that when residents required personal or intimate care, screens were pulled around their beds. Odours and noise from the shower rooms was observed in a number of areas, and when intimate care took place behind curtains this impacted the dignity of all present in the area. Some areas of curtain tracking were not found to be in place to ensure privacy or were found to touch the surrounds of the beds in these areas - for example, in the Tibradden unit. Prior to the conclusion of the inspection this area was re-visited and staff demonstrated how an additional portable screen could be used. However, works were required to address the screening in place around a number of beds in the centre including one seen in the Djouce unit. The person in charge confirmed this work would take place and had arranged for the adjustments to be made to the existing screening by an external provider.

The shower and dirty utility areas in all units were inspected. The design and layout of the bathrooms would not ensure residents' privacy and dignity was respected at all times. These bathroom areas consisted of an open-plan shower and toilet area with two toilet shower rooms off it. Since the last inspection privacy locks and a portable screen could be made available for privacy. Furthermore, staff or residents had to pass through the area to access another two toilets. Any residents utilising the toilet shower rooms could be viewed entering and leaving this area by all staff and other residents and visitors present in the general area. Equipment was also stored in the area, making the area inaccessible.

**Judgment:**
Non Compliant - Major
**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:**
The findings of this inspection were that provision and the management of residents’ personal possessions in some of the units visited requires improvement. For example, on Glencree, the clothes storage and hanging space in the multi-occupancy rooms was not beside each bed, but was located along one wall which may restrict residents' access and control over their personal belongings. Space and the amount of storage in some units were seen to be very limited. The amount and access to personal storage is reported in more detail in Outcome 12.

Staff confirmed that there was a written policy in place guiding staff as to how personal property and possessions were to be cared for. However, this policy was not readily available at the time of the inspection for review. Records were generally well maintained; however, some property records viewed by inspectors were not found to be up-to-date.

Inspectors visited the laundry facilities at this inspection and found it to be well organized. Staff working there maintained the laundry service well and in a hygienic condition. All sheets and towels were laundered off-site, and personal clothing was taken care of within the laundry on-site. Overall, residents told inspectors that they were satisfied with the laundry service provided. A list of residents’ personal property was maintained in residents' records, and each piece was identifiable. However, some feedback received from residents and relatives related to lost items of personal clothing, or poor storage available for soiled and clean clothing. Inspectors saw evidence that when reported to staff, all efforts were made to find clothing and any items which were mislaid. Nonetheless, the storage systems, limited space and records maintained may contribute to difficulties tracking some personal clothing.

**Judgment:**
Non Compliant - Moderate

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**Outcome 18: Suitable Staffing**

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

Theme:
Workforce

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

Findings:
Overall, staff were observed to interact in a warm, respectful manner with residents. Inspectors observed a good relationship between the residents and staff in the centre. Care and assistance was seen to be provided to residents in a friendly, respectful and discreet manner. The resident dependency levels were reviewed for each unit. Residents in the Clevis unit were independent and low dependency and this was in line with the admissions policy. Dependency levels varied and were higher on some units where staffing was commensurate with this.

Overall, the supervision, staffing levels and skill-mix in the centre was sufficient to meet the assessed needs of the residents. All staff spoken to had a good knowledge of policies and procedures surrounding fire and emergency, protection of vulnerable adults, infection control and manual handling.

A large number of volunteers worked at the centre and were involved in a variety of social activities, and this was co-ordinated by a member of staff, who supervised the volunteer staff in line with the volunteer policy. The staff files viewed and all documentation was as per Schedule 2 of the regulations. A recruitment policy was read that clearly outlined the procedures of assessing and screening potential staff. Agency staff were also used and a detailed service level agreement was in place. The agreement confirmed the documentation and information required by the regulations was in place for example, the registration, Garda Síochána Vetting disclosures, qualifications, and references.

Mandatory staff training was up-to-date with a clear means of identifying where gaps existed in the mandatory training for individuals. A detailed training programme was seen by inspectors. Records of training confirmed all staff completed training and where refresher training was required, a schedule of dates was in place for specific staff. All staff completed training on safeguarding and responding to reports of abuse; manual handling; fire safety; infection control; and CPR. A culture of learning and development was also evident with senior management encouraging a number of staff to pursue further third-level education.

Judgment:
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:

Leone Ewings
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
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<tr>
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<tbody>
<tr>
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<td>Date of response:</td>
<td>03/05/2017</td>
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</tbody>
</table>

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 provider had not yet put in place systems to ensure that the annual review for 2016 was prepared in consultation with residents and their families.

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:
Annual review is currently in progress, the consultation with residents and families has been completed and the annual review is being finalised

**Proposed Timescale:** 31/05/2017

### 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:**
A number of environmental risks were identified on inspection which had not been fully mitigated by the provider:
- risks associated with the use of a passenger lift for storage of a mobile hydraulic hoist
- recurrent risks associated with the inappropriate storage of oxygen cylinders in the centre
- storage of clinical equipment such as fridges, shelving and portable weighing scales in residents' accommodation
- review of risks associated with absence of handrails in some areas to promote mobility and independence
- review risks associated with the storage of moving and handling equipment in communal space.

#### 2. 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:
The CNM on a daily basis will alert the PIC/Provider of any concerns in this area. In addition, the PIC performs a daily walk about and is observant for any transgressions in complying with these regulations.

Since 1 March’17 a new I.T. based system for logging and recording options to deal with identified problems/concerns has been effectively introduced. The PIC and Engineer also perform checks on at least a monthly basis.

The six bed unit identified in Djouce ward as being “a room within a room”, has now been remedied by the construction of a corridor to divide the area into two rooms. A risk assessment and fire assessment has been conducted and no issues arose. Hand rails have been fitted to promote mobility and independence.

An application to vary is being submitted by the Provider nominee.

Oxygen cylinders have been replaced with portable oxygen concentrators and all large
cylinders have been removed.

Passenger lift has been risk assessed and currently control measures are being examined and to be completed by June 2017.

**Proposed Timescale:** 30/06/2017

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors identified risks in terms of infection prevention and control where the dirty utility facilities on Djouce were not found to be suitable or sufficient in terms of layout. The proximity and spacing of beds in some clinical areas needs review to ensure that the risks associated with any outbreak could be managed to control and reduce spread any healthcare associated infections.

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

**Please state the actions you have taken or are planning to take:**
A review of proximity and spacing of beds has been completed and amendments made as required. Ongoing mandatory infection prevention and control training is in place. A review of the options relating to the dirty utility in identified ward is underway.

**Proposed Timescale:** 30/06/2017

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of a two-bedded room within a larger multi-occupancy four-bedded room in Djouce had not been risk-assessed in terms of fire safety and ensuring adequate means of escape.

**4. Action Required:**
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
Risk assessment has been carried out. Remedial works have been identified and are currently underway.
Proposed Timescale: 28/04/2017

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:
The times of administration of medicines did not consistently reflect the prescribed times in all cases.

5. 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:
Therapeutics Committee has reviewed the documentation and have recommended changes to bring this fully into compliance. These proposals are being currently actioned

Proposed Timescale: 31/05/2017

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:
Care plans were not consistently updated in line with the residents' changing healthcare needs or in line with advice and guidance from other professionals involved with each resident's care.

6. 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:
The Quality & Patient Safety Manager has conducted audits of the Care plans and has held meetings with staff and attached is the most recent matrix which shows an improved compliance rate.
An education programme is being finalised to deliver ward based sessions and will be completed by September 2017.

Audits will continue on a monthly basis. The introduction of a new I.T. system on a pilot basis in Djouce ward has also led to improvements not only in compliance but with improved content.

**Proposed Timescale:** 31/05/2017

**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:**
Schedule 6 failings observed on inspection included:
The design and layout of the centre did not consistently meet the needs of all residents as outlined in the statement of purpose.
Adequate private and communal accommodation was not in place.
Multi-occupancy rooms were not suitable and sufficient to meet residents' need for privacy and dignity or spatial requirements
Suitable storage for residents' personal possessions and clinical storage was not in place.
Ventilation in the shower rooms and toilet areas was not sufficient.
Communal lighting arrangements in multi-occupancy areas were not satisfactory.
Insufficient number of showers, toilets and wash basins having regard for the dependency of the persons in the designated centre.

7. **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:**
There has been consultation on the development of a detailed plan for the refurbishment of the Nightingale wards and the current iteration reflects these.

In the meantime, greater use of day spaces is happening and staff have been encouraged to reduce sound and light pollution within these areas.

The revised plans have provided for more day space, additional appropriate storage space with improved toilet provision.

A Protected Control Development Plan for the site incorporating the total replacement of current hospital buildings is at an advanced stage and a copy can be supplied to HIQA if required.
The completion date of the replacement project is Q4 2020.

The refurbishment project is planned to commence January 2018, with two wards completed by end of May 2018, and all will be completed by September 2018.

Proposed Timescale: Timeframes outlined by the provider were not accepted by the Authority

Proposed Timescale:

Outcome 14: End of Life Care

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents' preferences for a single private room at end of life could not be consistently put in place at the centre.

8. Action Required:
Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

Please state the actions you have taken or are planning to take:
Every effort is made to facilitate requests for a private room at and of life. Highlighted by CEOL (Care at End OF Life) Group in the organisation the importance facilitation of same where reasonably practicable.

CEOL group are currently auditing the trends from the last cohort of deaths and will provide an action plan for 2017 based on their findings.

Proposed Timescale: 03/05/2017

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:
Personal activities which took place in multi-occupancy rooms and in shared communal shower and toilets areas of the units did not ensure privacy at all times.
Screening provided around bed spaces in multi-occupancy rooms was not adequate in some areas.
9. **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:**
Please see response to outcome 8. A preliminary review has been conducted and consequently an architect has been engaged to produce costed solutions to these difficulties.

Djouce ward is currently having screens refitted and a plan is being developed for Kilternan ward.

The shower and toilet facilities in Djouce are currently being tendered for by approved contractors.

Proposed Timescale: June 30th 2017 – Curtain enhancements
Timeframes outlined by the provider were not accepted by the Authority.

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**Proposed Timescale:**

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Noise at night was communicated to inspectors and identified as a concern in multi-occupancy rooms.

10. **Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**
Every effort is made to minimise noise disruption at night through effective care planning and in particular behavioural care plans to address the cause of the noise at night. Support is available to staff in relation to care planning for behaviours that challenge within the expertise of the organisation and if required from external supports. Reduction in multi-occupancy rooms with the refurbishment should reduce the opportunity for disruption.

Proposed Timescale: Timeframes outlined by the provider were not accepted by the Authority
### 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:**
Space to store and manage residents' personal property and possessions was limited.

**11. 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:**
These wards have been reviewed and alternate bedside combinations are being sourced for the Glens units. Alternate bed layouts in these units are also being investigated.

The Nightingale units will be dealt by the refurbishment with timescales for completion of May and September 2018.

**Proposed Timescale: 30/06/2017**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Access and location of storage space for personal belongings reduced residents' ability to retain control over their own belongings.

**12. Action Required:**
Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

**Please state the actions you have taken or are planning to take:**
Review in progress to consider options in relation to access and location of storage and resident's ability to retain control over possessions

**Proposed Timescale: 30/06/2017**