

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St Vincent's Care Centre
<b>Centre ID:</b>	OSV-0000483
<b>Centre address:</b>	Coosan Road, Athlone, Westmeath.
<b>Telephone number:</b>	090 648 3153
<b>Email address:</b>	julie.butler2@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Lead inspector:</b>	Sonia McCague
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	22
<b>Number of vacancies on the date of inspection:</b>	14

## **About Dementia Care Thematic Inspections**

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
19 February 2019 12:00	19 February 2019 18:50
20 February 2019 08:40	20 February 2019 12:15

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Substantially Compliant	Compliant
Outcome 02: Safeguarding and Safety	Substantially Compliant	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 09: Statement of Purpose		Substantially Compliant

## Summary of findings from this inspection

This inspection was focused on specific outcomes relevant to dementia care. However, a major non-compliance was found resulting in an urgent action requirement. This was because details and documentary evidence of each staff members Garda vetting/declaration, professional qualifications, training records, relevant experience and employment history was not available in the designated centre. Therefore, some staff working in the centre were removed from rostered duty until the necessary documents and evidence was available to management and in the centre. A written assurance by the provider was requested and subsequently given that all staff on duty would have a vetting disclosure in the centre in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

As part of the thematic inspection process, providers were invited to attend information seminars delivered by the Office of the Chief Inspector and the Health Information and Quality Authority (HIQA). In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. The provider and staff had completed a self-assessment to judge the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended). The table above compares the self-assessment and inspector's judgment for each dementia specific outcome.

The centre is registered to accommodate 36 residents and is laid out over two floors. It does not have a dementia specific unit. During the inspection the inspector was informed that eight of the 22 residents (36%) had a diagnosis of Dementia or Alzheimer's disease. The inspector met with residents, relatives visiting and staff members on duty, and reviewed the care and services provided to residents including those with Dementia. The person in charge was on leave.

Care practices were observed and interactions between staff and residents were rated using a validated observation tool. Documentation such as care plans, medical records, operational procedures, recruitment and staff training records were reviewed. The inspector also followed up on the non-compliances found on the previous inspection of December 2017 and found that further improvement was required within three of the four actions required.

The centre was homely and welcoming but some aspects of the premises required review and improvement. In addition, the evidence and previously reported findings in relation to the negative impact on residents privacy associated with the deficiencies of the building and limited sanitary facilities remains unchanged. The registered provider has agreed to provide a new purpose built centre by July 2020 as a condition attached to the current registration granted in 2018 for three years.

In the main, positive connective care was observed during the formal observation periods. Residents were consulted with and had opportunities to participate in the organisation of the centre. Residents' rights were promoted and facilitated but the

allocation, use and management arrangement of bedrooms required improvement.

Adequate staffing numbers and skill mix were available for resident numbers (22) during this unannounced inspection, and the provision of activities and access to the wider community was satisfactory. A programme of staff training was on-going but some gaps were identified for addressing.

Timely access to the general practitioner (GP), pharmacist and allied health care professionals was available and provided. Appropriate systems and arrangements to ensure assessments and care plans were complete was in place. Data and information was shared with and between services providers to ensure that residents needs were met in a consistent, safe and effective way. Plans were described to transition from hard to soft copy recording, the inspector was told that an electronic recording system was in place and this change was to be implemented when all relevant staff had completed training.

Staff were working towards a restraint free environment. There was evidence of good approaches to residents with communication difficulties. The assessment and management of residents with identified behavioural and psychological symptoms of dementia also known as responsive behaviours was well maintained.

Arrangements were available to promote choices, well-being and independence of residents. Responses received from residents and relatives were complimentary of the staff, food, activities and service. Opportunities for consultation and feedback from residents and family were afforded but the complaints procedure was not displayed and the management of complaints required improvement.

A further review of the statement of Purpose and function was also required to ensure accurate information in relation to all matters within Schedule 1 were accurate/included.

The findings are discussed within the body of the report and areas for improvement are outlined within the action plan for response.

**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: Health and Social Care Needs***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is discussed in Outcome 3.

There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Comprehensive assessments were carried out and care plans developed in line with residents changing needs. Residents and their families, where appropriate were involved in the assessment and care planning process, including end of life care plans. Systems were in place to prevent unnecessary hospital admissions. The nutritional and hydration needs of residents with dementia were met and residents were protected by safe medication policies and procedures.

Residents had the option to retain the services of their own general practitioner (GP) if they wished to do so. Eight GPs were providing a service to residents on a regular basis and when required. Residents also had good access to acute and out of hours medical services, and to allied healthcare professionals including dietetic, speech and language, dental, physiotherapy, occupational therapy, ophthalmology and chiropody services. A local palliative care team and mental health service was available upon GP referral. A pharmacist visited the centre regularly and participated in the review of medicine management. The pharmacist had developed a separate individualised pharmaceutical care plan for each resident following a review of their medicines prescribed in conjunction with staff and the GP. This care plan was reviewed as changes occurred and periodically. The pharmacist was available to meet with residents as required.

The inspector focused on the experience of residents with dementia and reviewed specific aspects of care and supports available in relation responsive behaviour, interventions and activities, mobility, nutrition and falls prevention.

There were systems in place for communications between the resident/families, the acute hospital and the centre. The person in charge or deputy visited prospective residents in hospital prior to admission. Residents' files held relevant information on

discharge letters from hospital. Arrangements were in place to ensure appropriate information about resident's health, medicines and their specific communication needs were included in the transfer documents examined. The pre admission assessment of each resident prior to their admission to the centre was accompanied with a copy of the common summary assessment (CSARS) for residents admitted under the Nursing Home support Scheme. There was evidence that the staff and multidisciplinary team involved in care delivery had received appropriate information about the resident's medical history and current needs. Residents had a holistic assessment soon after admission that informed the development of an individual and personalised care plan. A range of validated assessment tools were used to assess physical and mental health needs, and current level of functioning and abilities. Emotional and spiritual needs, previous occupation and life history, social hobbies and family circumstances were all explored and reflected within the written plan of care and supports available.

Resident clinical records were maintained in hardcopy format. The inspector was informed that plans to transition to a computerised system that was installed and ready for use had been delayed due to staff turnover. It was anticipated that this system would be introduced later this year with training to be provided to all staff.

Residents including those living with dementia had the opportunity to discuss and make decisions, together with their family/carers with staff involved in planning their health care and social outcomes. Engagement and assessments with residents began at an earlier stage to elicit their wishes and preferences for their future care needs including end of life care. Their choices and preferences in relation to moving within or from the centre to a hospital for acute interventions and at the end of life had been considered and recorded within a detailed care plan that was subject to regular reviews.

Communication requirements were outlined in the care plans examined and picture aids were available in rooms occupied by residents to promote their communication and engagement with others.

Residents were routinely assessed for their risk of developing pressure related ulcers. Care plans to manage the risk were in place and specialist pressure relieving equipment was provided. None of the residents had a pressure sore or ulcer at the time of inspection.

There were arrangements in place to review accidents and incidents within the centre, and residents identified risks were regularly assessed with control measures put in place. Care plans were in place and reviewed following all incidents, accidents or changes in need/ability, the risk assessments were revised, medicines reviewed and care plans were updated to include interventions to mitigate the risk of injury and harm and to support independent functioning. Many residents had modified chairs to promote comfort and ease of movement having been assessed by a physio and or an occupational therapist.

There were systems in place to ensure residents' nutritional needs were met, and to prevent poor hydration or malnutrition. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a weekly or monthly basis depending on the risk identified. Nutritional care plans were in

place that detailed residents' individual food preferences, and outlined the recommendations of dietitians and or speech and language therapists where appropriate. Nutritional and fluid intake records when required were maintained. The inspector observed residents having their lunch in one dining room and saw that a choice of meals, diets and food options was available. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Regular reviews of the menu and dining experience was carried out between a dietician and staff within catering and nursing. They met regularly to ensure nutritious wholesome diets were provided within an appropriate focused environment. A small number of residents chose to dine in their bedrooms and this was also facilitated.

**Judgment:**

Compliant

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse.

There was a comprehensive policy in place which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. Staff had received safeguarding training and those who spoke with the inspector displayed sufficient knowledge of the different forms of abuse and were clear on reporting procedures. Effective safeguarding plans were in place following incidents investigated and reported. There were policies in place to safeguard residents' money. The inspector was informed that the provider was not a pension agent of any of the existing residents.

There was a national and local policy in place which gave guidance to staff on restraint use. The inspector highlighted where some improvement could be made in relation to the local policy to ensure each form of restraint in use or likely to be used in the centre was outlined and defined with the practices in place and agreed procedures outlined to aid evaluation and guide new staff.

A low level of restraint was in use and its use was in line with national guidelines following an assessment and decision by the multidisciplinary team, resident and or relative. Equipment such as low beds, half rails, mats, levers and alarms were used to reduce the use of bedrails and physical restraints. A good level of staff supervision, structured activities and meaningful engagement had eliminated the use of chemical



restraint or PRN (a medicine only taken as required) medicines in association with the GP and pharmacist. The inspector was told that the use of PRN psychotropic medications as a form of restraint was not in use by any of the current residents. Two (9%) of the residents had full/both bedrails in place for safety. Appropriate risk assessments had been carried out and care plans were in place to monitor the safety and welfare of resident.

Staff adopted a positive, person centred approach towards the management of responsive behaviours. Because of an underlying condition some residents had previously displayed behavioural and psychological signs of dementia (BPSD). Staff were familiar with appropriate interventions for individual residents. During the inspection staff approached residents in a sensitive and appropriate manner and the residents responded positively to the care and supports deployed by staff.

**Judgment:**

Compliant

***Outcome 03: Residents' Rights, Dignity and Consultation***

**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:**

Residents living in the centre had opportunities to exercise their rights and achieve their personal goals. In the main, they were supported to make choices and were actively involved in care decisions and in the services they received. The evidence and previously reported findings in relation to the negative impact on residents privacy associated with the deficiencies of the building and limited sanitary facilities remains unchanged. In order to address the non-compliances previously reported, the registered provider has agreed to provide a new purpose built centre by July 2020 as a condition attached to the current registration granted. Therefore, the actions associated with ensuring the privacy and dignity of residents associated with the premises outlined in previous inspections is restated.

Residents were facilitated to make choices about how they spent their day and what activities they attended. However, the arrangements for short stay residents being admitted and allocated to a three bed bedroom where long stay residents resided required review and improvement to promote the rights of all residents as seven vacant bedrooms were available in the centre. This allocation and management arrangement was considered institutional and not in residents' best interests.

Residents were consulted regarding the services offered within the centre. For example,

a residents' meeting was held every two to three months, with the most recent meeting taking place in January 2019. The Inspector reviewed the minutes of these meetings and found that items such as staffing levels, the menu and food, and activities provided were discussed.

Daily gatherings of resident groups routinely formed on each floor. One group was coordinated by the activity staff member. The group discussed specific news topics, current affairs and local events. The other resident group were assisted and supported by care staff to engage in activities that interested them and their abilities. Overall residents, including residents with dementia, were supported and assisted to enjoy a meaningful quality of life in the centre.

Residents were facilitated to exercise their civil and political rights, by way of voting either in the centre or their electoral area. Residents were supported to practice their respective faiths. A chapel adjoined the centre and mass was celebrated weekly either in the chapel or day room dependant of residents preferences.

Residents' privacy and dignity was respected by staff supporting them to undertake personal care, screening curtains were in place within shared bedrooms, call bells and privacy locks were available in communal bathrooms/toilets.

An open visiting policy was in place, with the exception of protected time for residents at mealtimes. This information along with the specific meal times were advertised in the reception area above the visitors register. A family room was available on each floor that was adequately equipped for gatherings and refreshments.

A spacious central courtyard with winding paths, a range of table and seating arrangements along with attractive garden features was available and accessible from parts including via the patio doors of the ground floor sitting room.

The sitting room on each floor had a range of accessible occupational and activity equipment to support residents' engagement in activities. Two activity staff members were rostered and a minimum of one worked daily. Activities and events were informed by assessments of residents' preferences, interests and capabilities that was outlined in a care plan. Staff were familiar with residents likes, interests and preferences and they tailored the activity programme to suit all. Activities were varied and meaningful. For example, mass, bingo, live music, sensory stimulation sessions, exercise, art, crafts, knitting, quizzes and baking were scheduled. A sonas programme was also advertised but staff required refresher training in this regard to further develop the programme for residents' living with dementia and communication needs. Residents expressed satisfaction with the activities and staff support available to them. Staff told the inspector they provided one-to-one sessions with residents on a regular basis. Residents had access to daily newspapers, to internet and telephone facilities, and to local media.

As part of the inspection, the inspector spent periods of time observing staff interactions with residents including those with dementia or Alzheimer's disease. A validated observational tool was used to rate the quality of interactions between staff and residents in the communal areas on both units/floors. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care, 0 (neutral care),

-1 (protective and controlling), -2 (institutional, controlling care).

Overall, the inspector found for the majority of the observation period (total observation period of 60 minutes) the quality of interaction score was +2 (positive connective care). Staff knew the residents well and they connected with each resident on a personal level. Staff greeted the residents by name when they came to the day and dining rooms, they ensured that they were socially engaged and had opportunities to actively engage or listen. There was an activity programme but residents determined what and which activities they were involved in. Those co-ordinating activities were knowledgeable of resident's life histories and therefore incorporated reminiscence and stories to ensure that all residents benefitted and contributed from the activities. Positive language such as well-done and complimenting the residents when sharing lifetime stories with other residents was used. Staff sat with a resident and offered appropriate assistance, choice and company with residents as they chatted during activities and in the meal time observed.

Overall, staff presence with residents was good, and ensured that they were socially engaged, supported and responded to in a timely manner. Staff sat beside residents to help or talk to them and initiated conversation to keep them engaged. Groups talked about local and national news items, programmes on the television and radio that they had interest in and discussed the visitors due in on particular days.

Residents were well-groomed and dressed in accordance with their preferences. Residents' property, laundering and return of clothing was well maintained in the centre.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

A complaints policy and process was in place to ensure the complaints of residents including those with dementia were managed.

The complaints process was summarised within the residents guide and in the statement of purpose. The complaints policy was seen to be referenced and included in the residents' committee agenda of a meeting held last year.

Residents and relatives who spoke with the inspector were clear about who they would bring a complaint to. However, the complaints procedure and person responsible for the

management of complaints was not prominently displayed in the centre, as required.

The Inspector reviewed the complaint records maintained since the previous inspection carried out in December 2017. While the two complaints were managed promptly using the complaints process, the records within one did not show the satisfaction level of the complainant nor did the template used to record the process seek to ascertain this view.

**Judgment:**

Substantially Compliant

***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

No actions were required from the previous inspection.

**Findings:**

An urgent/immediate action requirement was issued to the provider as a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was not available in the designated centre for each member of staff on duty.

The Inspector found deficiencies within the provider's recruitment systems and arrangements that required immediate action. The Inspector learned that following the recruitment and selection of staff at a national level, management of the centre were notified of staff commencement date. However, details and documentary evidence of each staff members Garda vetting declaration, professional qualifications, training records, relevant experience and employment history was not provided in advance or by the commencement date, and was therefore not available in the designated centre, as required. As a result, management were unable to demonstrate if all Schedule 2 documents were available for staff members working in the centre. Consequently some staff working in the centre were removed from rostered duty until the necessary evidence was made available. This measure was required and taken to ensure that the delivery of care and the service provided was safe. The provider representative, by request, provided written assurances that all remaining rostered staff had complete staff files and a declaration of Garda vetting in the centre, as required.

The recruitment policy required review to ensure it was implemented in practice.

There was a planned staff roster available. The staffing in place on the days of inspection was reflected within the roster. There was a full complement of staff on duty as planned and determined for 22 residents. New staff were being inducted and supervision arrangements were described.

Staff and residents spoken with were satisfied that there were adequate staff on duty over a 24 hour period and at weekends for the number of residents. Residents and relatives confirmed the staff team were kind and responded quickly when they were needed.

An on-going training programme for staff was in place. The provision of mandatory and relevant staff training was evident. However, some gaps were identified. Staff were able to provide feedback on what training they had completed and what was due in relation to their role and responsibilities. Staff spoken with were familiar with the policies and procedures related to their area of work, and also the importance of effective communication with residents living with dementia and their families.

A number of volunteers worked in the centre. Records in relation to volunteers agreed role and responsibilities along with a declaration of Garda vetting was available for the sample reviewed.

**Judgment:**  
Non Compliant - Major

### ***Outcome 06: Safe and Suitable Premises***

**Theme:**  
Effective care and support

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

**Findings:**  
The centre has been in operation as a nursing home prior to 2009. The premises has been described and reported on in previous inspections. As a result of deficiencies identified and previously reported, the registered provider plans to provide a purpose built centre that is to be completed by July 2020 which is a condition attached to the current registration.

Overall, much effort has been made to make this centre homely, welcoming, safe and comfortable for residents. It was clean throughout, warm, well maintained and ventilated. There was suitable equipment, aids and appliances available to support and promote the full capabilities of residents; however, areas for improvement were identified. These included the excessive/hot temperature of water in wash hand basins that did not have mixer taps, and the radiators throughout were remarkably hot to the touch on the first day of the inspection. The regulation of these matters received attention during the inspection when highlighted but required further review and auditing to mitigate risks while ensuring adequate heat.

The centre is laid out over two floors. While it is registered to accommodate 36

residents, occupancy has not increased from 22 residents since the previous inspection. This was attributed to staff shortages.

A description of the accommodation, bedroom and bathroom facilities was described in the previous inspection report of December 2017. Previously the maximum occupancy in bedrooms was reported as two residents. However, on this inspection, up to three residents shared a bedroom while vacant bedrooms with nearby sanitary facilities existed in the centre.

Some bedrooms and bed spaces had been personalised to each individual's preference. Personal items, artefacts and family photographs, contrasting colours and signage were in place to support residents with dementia. A passenger lift was available between floors in addition to the main stairs. Access to the centre was via one main entrance that was key coded beyond the main reception area.

Security measures and CCTV on entry and exit doors was in place. However, the inspector found that access to an adjoining but separate service was not controlled and a review of this was required due to the profile of residents and risks identified.

The inspector noted that up to 50% of residents used modified chairs that were suitable for their individual needs. While windows had been designed to provide good levels of daylight, the view and outlook to the outdoors was limited for residents in modified/personalized chairs they used daily due to the position of windows at an elevated height in rooms they occupied. Access and a view and outlook to the central enclosed courtyard was available via the double patio doors of the ground floor day room.

Resident's had good access to obvious handrails in circulating areas. Corridors and landings were wide to promote unimpeded movement. Corridors had been decorated with art and photographs from local events and group outings attended by residents, and signs were in place to support residents, including those with dementia, to find their way around.

Service and maintenance records were available and maintained accordingly. Adequate storage facilities were seen and suitable equipment was in place.

The centre had a laundry facility and main Kitchen within where food was prepared, cooked and served from.

While the atmosphere was calm and unhurried, the volume and level of noise generated by building work nearby beyond the centre and from the catering trolley servicing the first floor required review and management with adequate control measures put in place.

**Judgment:**

Non Compliant - Moderate

## ***Outcome 09: Statement of Purpose***

### **Theme:**

Governance, Leadership and Management

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

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

### **Findings:**

A further review of the statement of Purpose and function was required to ensure accurate information in relation to all matters within Schedule 1 were accurately detailed.

Particular attention was required in relation to:

- the conditions of registration
- a description (either in narrative form or a floor plan) of the rooms in the designated centre including their size and primary function
- the total staffing complement and whole time equivalents
- the fire precautions and associated emergency procedures in the designated centre.

### **Judgment:**

Substantially Compliant

## **Closing the Visit**

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

### **Acknowledgements**

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

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

Sonia McCague  
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 report<sup>1</sup>

<b>Centre name:</b>	St Vincent's Care Centre
<b>Centre ID:</b>	OSV-0000483
<b>Date of inspection:</b>	19/02/2019
<b>Date of response:</b>	26/03/2019

### Requirements

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

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

### Outcome 03: Residents' Rights, Dignity and Consultation

#### Theme:

Person-centred care and support

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

Short stay residents were admitted and allocated to a three bed bedroom where long stay residents resided despite the availability of seven vacant bedrooms in the centre.

This management arrangement was considered institutional and not in residents' best interests.

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



**1. 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:**

In order to promote each resident's best interests, rights and privacy, the three bedded bedroom will revert to a two bedded room. A single room is being made available for future short stay residents.

**Proposed Timescale:** 01/04/2019

**Theme:**

Person-centred care and support

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

The evidence and findings in relation to the negative impact on residents privacy associated with the deficiencies of the building and limited sanitary facilities remains unchanged.

The registered provider has agreed to provide a new purpose built centre by July 2020 as a condition attached to the current registration granted.

**2. 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:**

Plans for a new build as part of the Public-Private Partnership project are at an advanced stage, with an application for planning permission due to be submitted in early May 2019. The new build will provide residents with the option of en-suite toilet and bathroom/shower facilities and greater communal and personal space, thus promoting each resident's privacy. It is expected that the new centre will be operational by first quarter of 2021.

**Proposed Timescale:** 31/03/2021

**Outcome 04: Complaints procedures****Theme:**

Person-centred care and support

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

The complaints procedure and person responsible for the management of complaints was not prominently displayed in the centre.

**3. Action Required:**

Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

A summary of the complaints procedure is displayed on the three complaints boxes situated in prominent places throughout the centre. The name of the person responsible for managing complaints is detailed on this summary.

**Proposed Timescale:** 21/02/2019

**Theme:**

Person-centred care and support

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

The records of a complaint did not show the satisfaction level of the complainant nor did the template used to record the process seek to ascertain this view.

**4. Action Required:**

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

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

A review of the centre's policy for management of complaints has been carried out. This has included a review of the template used to record the process and a section is being included to seek and record the satisfaction level of the complainant.

**Proposed Timescale:** 17/04/2019

**Outcome 05: Suitable Staffing****Theme:**

Workforce

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

The recruitment policy required review to ensure it was implemented in practice.

**5. Action Required:**

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

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

As a result of the immediate action notice the recruitment policy was reviewed and all schedule 2 documentation is now in place for all staff members working in the centre and available on site. The Provider has put a process in place with local Human Resources department to comply with this regulation in practice and according to the centre's policy.

All policies and procedures referred to in regulation 4(1) are reviewed and updated at intervals not exceeding 3 years in accordance with best practice.

**Proposed Timescale:** 01/03/2019

**Theme:**

Workforce

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

Gaps were identified in staff training.

**6. Action Required:**

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

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

The areas of staff training identified by the Inspector have since been completed. A programme of staff training is on-going throughout the year, to ensure that all staff have access to appropriate training.

**Proposed Timescale:** 19/03/2019

**Theme:**

Workforce

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

A vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was not available in the designated centre for each member of staff on duty.

Documentary evidence of each staff members professional qualifications, training records, relevant experience and employment history was not provided in advance or by their commencement date, and was therefore not available in the designated centre at the commencement of this inspection.

**7. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in

Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

Further to the issue of the immediate action notice, all Schedule 2 documentation is now in place for all staff members currently working in the centre and is available on site. This includes a Garda vetting disclosure for all current staff.

A process has been put in place to ensure that all Schedule 2 documentary evidence is in place in the centre, prior to the commencement of new staff.

As per Regulation 21(1) Schedules 2, 3 and 4 records are available onsite for inspection by the Chief Inspector.

**Proposed Timescale:** 01/03/2019

**Outcome 06: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

As a result of deficiencies identified and previously reported, the registered provider plans to provide a purpose built centre that is to be completed by July 2020 which is a condition attached to the current registration granted in 2018.

The excessive/hot temperature of water in wash hand basins that did not have mixer taps, and the radiators throughout were remarkably hot to the touch on the first day of the inspection. The regulation of these matters received attention during the inspection when highlighted but required further review and auditing to mitigate risks while ensuring adequate heat.

The view and outlook to the outdoors was limited for residents in modified/personalized chairs used daily due to the position and elevated height of room windows.

Access to an adjoining but separate service was not controlled and a review of this was required due to the profile of residents and risks identified.

The volume and level of noise being generated by building work nearby but beyond the centre and from the catering trolley servicing the first floor required review and management with control measures.

**8. 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:**

1. Plans for a new build as part of the Public-Private Partnership project are at an

advanced stage, with an application for planning permission due to be submitted in early May 2019. The new build will provide residents with the option of en-suite toilet and bathroom/shower facilities and greater communal and personal space, thus promoting each resident's privacy. It is expected that the new centre will be operational by first quarter of 2021.

2. A full audit of the hot water temperature is being undertaken and any outstanding tap sets with no Thermostatic Mixing Valves (TMVs) will be replaced with same.

3. A review by Estates of the Building Management System controls for heating is being undertaken with a view to managing radiator temperatures and mitigating risks for the residents while ensuring adequate heating is available.

4. All residents who use modified/personalised chairs during the day are offered and have the option to view and enjoy the outdoors from the large patio doors in the dayroom, to which they have access at any time. The proposed new build will provide residents with access to views and outlooks of the outdoors, with windows at an optimal height for this.

5. Keypad access control is being installed as a measure to control access to the adjoining but separate service.

6. The building work nearby the centre is due to be completed by April 2019. Control measures have been put in place to reduce the volume and level of noise experienced by the residents.

7. The catering trolley has been serviced and rubber wheels put in place to reduce noise. The use of plastic food covers has further reduced the level of noise.

**Proposed Timescale:** 31/03/2021

## **Outcome 09: Statement of Purpose**

### **Theme:**

Governance, Leadership and Management

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

The statement of Purpose and function required review and updating in relation to:

- the conditions of registration
- a description (either in narrative form or a floor plan) of the rooms in the designated centre including their size and primary function
- the total staffing complement and whole time equivalents
- the fire precautions and associated emergency procedures in the designated centre.

### **9. Action Required:**

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

Residents in Designated Centres for Older People) Regulations 2013.

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

The Statement of Purpose has been amended to include the above information

**Proposed Timescale:** 28/03/2019