

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Anna Gaynor House
Centre ID:	OSV-0000465
Centre address:	Our Lady's Hospice & Care Services, Harold's Cross Road, Harold's Cross, Dublin 6w.
Telephone number:	01 406 8700
Email address:	info@olh.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Our Lady's Hospice Limited
Lead inspector:	Ann Wallace
Support inspector(s):	Gearoid Harrahill
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	81
Number of vacancies on the date of inspection:	8

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:
27 February 2019 10:00	27 February 2019 16:15
27 February 2019 10:00	27 February 2019 16:15
28 February 2019 08:00	28 February 2019 15:30
28 February 2019 09:30	28 February 2019 15:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Substantially Compliant
Outcome 02: Safeguarding and Safety	Substantially Compliant	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant
Outcome 07: Health and Safety and Risk Management	Not applicable	Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of an unannounced thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also followed up on actions required from the previous inspection and considered information received by the Health Information and Quality Authority (HIQA) in the form of notifications and other relevant information.

The provider and person in charge had made a number of improvements in line with the findings of the previous inspection in September 2017. However the inspectors

found that improvements were still required in relation to fire safety precautions. The inspectors also found that a number of staff interactions with residents were task focused and did not support person centred care. In addition improvements were required in the administration of medications to ensure that all staff followed policy in this area.

Those residents who were able to articulate their experiences expressed high levels of satisfaction with the care and services they received in the centre. The inspectors also spoke with a number of residents who, although unable to explain their level of satisfaction with the service, demonstrated behaviours associated with feeling safe and content.

The inspectors found that there were sufficient numbers of staff on duty on the day of the inspection and that the staff on duty matched the planned rosters. Staff had the appropriate knowledge and skills to provide safe and effective care and services for the residents with a diagnosis of dementia and had attended training on dementia and managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Care and services were found to be in line with the centre's statement of purpose. Inspectors found that care was person centred and that staff had received training in providing person centred care and services. The inspectors found that residents had good access to a range of health and social care services to meet their ongoing needs. This was a particular strength of the service. Residents had access to physiotherapy, occupational therapy, dietician, speech and language therapy, chiropody, optician and dental services. Residents were seen regularly by the in-house medical team. A sample of residents' care plans was reviewed as part of the inspection. The inspectors found that care plans were reviewed regularly and were kept up to date to reflect the residents' current needs and preferences for care.

Overall the premises were designed and furnished to offer resident's comfortable accommodation. Bedrooms were appropriately furnished and there was adequate wardrobe and storage space for clothing and personal possessions. Communal areas were comfortably furnished and were well used by residents on the day of the inspection. The centre is set in landscaped grounds and residents also had access to a number of pleasant garden areas which were nicely laid out with safe paving and seating. The inspectors found that there was good use of appropriate signage and points of interest to help residents with cognitive impairments to navigate the premises.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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:

Inspectors found that each resident's health and well-being was maintained by a high standard of evidence based nursing care and appropriate medical and allied health care. However improvements were required to ensure that all nursing staff followed the correct policy and procedures when administering medications.

Residents had good access to a range of health and social care services. These included; physiotherapy, occupational therapy, dietitian, speech and language therapy, social worker and palliative care medical and nursing specialists. Inspectors noted that this was a particular strength of the designated centre.

In addition chiropody, dental and optical services were accessed for residents in order to maintain their optimum health and independence. Health promotion services such as the annual flu vaccinations were made available for residents to ensure that potential health problems could be prevented. Where residents were eligible for the national screening programmes the resident was supported to participate if they wished to do so.

Residents were seen regularly by the in house medical team. The medical team reviewed each resident's medication every three months or if their health changed. Out of hours medical services were organized for after 6 pm and at weekends. Specialist medical services were also available including psychiatry of later life. Records showed that referrals were made appropriately and where specialist interventions were prescribed these were implemented by nursing and care staff.

Nursing care was evidence based and nursing staff were encouraged to maintain their skills and knowledge of best practice in key areas such as dementia care, end of life care and wound management. Specialist input was available from the tissue viability nurse in the hospice. A new programme to reduce the incidence and prevalence of pressure sores had been introduced in the designated centre. as part of the quality improvement programme for 2019. End of Life care was provided through the CEOL programme, incorporating a multi-disciplinary approach to providing end of life care for residents whilst ensuring that the resident and their family are able to make informed decisions about the care they receive at this vulnerable time. In addition the nursing team had

introduced recently published guidance in order to reduce the number of topical emollients and anti-histamine products used by residents.

The occupational therapy team were implementing a clinical care pathway for cognitive impairment which was ensuring that residents with cognitive impairment had access to the appropriate levels of interventions from the multi-disciplinary team to assess their needs and their capacities and to identify key services and strategies to manage their care.

There were comprehensive admission policies and procedures in place. Records showed that each resident had a pre-admission assessment carried out by an experienced senior nurse prior to their admission. This helped to ensure that the centre could meet the new resident's current needs and potential needs in the future. Following admission, a further assessment was completed by nursing staff on the units. The inspectors reviewed a sample of admission and care plan documentation. Records showed that the admission assessments included information about each resident's current needs, their life story and their self-care abilities as well as their preferences for care and daily routines. This information was used to develop a care plan which was agreed with the resident and where appropriate with the resident's family.

Care plans were reviewed every four months or more often if the resident's needs changed and most of the care plans reviewed by the inspectors were up to date and reflected the resident's current needs. However a number of care plans were very general and did not include sufficient detail about the individual resident to support person centred care. Inspectors observed that care and support was provided for residents in line with their care plans. Where a resident declined care and services this was respected by staff.

Where a resident was transferred to another care facility records showed that nursing staff provided written and up to date information about the resident, their current needs and medications.

There were comprehensive policies and procedures in relation to the safe administration of medications. Nursing staff attended medication training and pharmacy updates. However improvements were required to ensure that all staff followed the correct policies and procedures in relation to the administration of medications. For example; that medications were not signed as given until the resident had taken the medication and that medications were not left in communal areas for the resident to take at a later time.

Judgment:

Substantially 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:

There were appropriate measures in place to safeguard and protect residents. Residents told the inspectors that they felt safe in the designated centre and that staff were kind and courteous. The inspectors also spoke with a number of residents who, although unable to explain their level of satisfaction with the service, demonstrated behaviours associated with feeling safe and content.

Inspectors found that overall care and services were person centred and took into account the needs and preferences of the resident. Some improvements were required in a small number of staff interactions with the residents they were caring for to ensure that the interactions were meaningful and upheld the dignity and rights of the residents. This is discussed under outcome 16.

There were clear policies and procedures in place in relation to the prevention, detection and response to abuse. All staff received training on these policies during their induction and in regular mandatory updates. As a result staff who spoke with the inspectors were clear about their responsibility to keep residents safe and what to do in the event of an allegation or concern about abuse.

Records showed that the person in charge investigated any concerns appropriately and that safeguarding plans were put into place when required.

There were clear systems in place to protect the residents' monies and valuables. Residents had access to lockable storage space if needed. Where the designated centre acted as a pension agent, clear records were maintained and procedures ensured that residents had access to their own monies as required. All records of financial transaction were audited regularly.

There were clear policies and procedures in place for managing residents who displayed responsive behaviours (how individuals with dementia or other cognitive impairment may react to their environment or other stimuli). Staff received training in the management of residents who displayed responsive behaviours. A number of nurses in the centre had specialist skills in this area and provided on-going advice and support for staff caring for these residents. The inspectors observed staff using appropriate de-escalation techniques to support and reassure residents when they became agitated.

Policies and procedures in relation to the use of restraints in the designated centre were in line with national best practice guidance. Although a number of bed rails, wander alarms and lap belts were still in use in the centre there was clear evidence that the centre was working towards a restraint free environment. Where restraints were in use nursing staff had completed a risk assessment and the resident and/or their representative were involved in the decision to use the equipment. Records showed that alternatives had been trialled with residents prior to introducing the restraint equipment and that when in use the restraint was used for the minimum time possible.

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:

Inspectors found that overall the service was person centred and that it upheld the rights and dignity of the residents who lived in the designated centre. However a number of improvements were required to ensure that resident areas were not used for staff meetings and that staff followed the centre's policies on privacy and dignity when discussing a residents needs with other staff or with the resident in a communal area. In addition improvements were required to ensure that all staff sought a resident's consent before carrying out care practices such as moving a resident's wheelchair.

Inspectors took time to observe the interactions between staff and residents during different periods throughout the day. These observations revealed a mix of interactions with some good meaningful engagements but a number of interactions were supervisory and instructive rather than socially orientated. However, inspectors noted that all interactions were respectful and residents spoken with said all staff were kind and helpful. Inspectors observed a small number of occasions where staff approached residents who were seated in wheelchairs and moved the resident in the wheelchair without talking to the resident as they approached them and seeking their consent prior to the manoeuvre. Inspectors also observed a number of occasions in which staff lacked discretion when speaking about residents' toileting needs in communal areas or in the presence of other residents and visitors.

Staff were familiar with the residents' needs, personalities and backgrounds and tried where possible to ensure that residents could spend their day as they wished. There was a comprehensive range of daily activities that were provided through the centre's well organized volunteer programme. In addition the occupational therapy department had developed a range of specialist activities for those residents with dementia and other cognitive impairments. This programme was available to a limited number of residents at the time of the inspection but there were plans in place to increase the number of sessions available in 2019 as part of the designated centre's business improvement plan.

Residents were offered discreet encouragement with activities of daily life and were supported to participate in the activities programme and entertainments that were on offer in the designated centre. However, inspectors observed there were significant

periods of time from late morning onwards in which residents not requiring direct attention from staff sat without any meaningful engagement with a member of staff or with each other. This was verified in the unit records where it was documented that planned activities did not happen due to staff shortages on two occasions and due to a new resident admission on another occasion. Although this was recorded in the unit records there was no clear oversight of how these issues had been reported to managers or the measures that had been put into place to address them.

The premises was well laid out to support the privacy and dignity of individual residents and to ensure that residents could move about freely and spend their day as they wished. Access to the garden areas was unrestricted and several residents were observed spending time in the gardens either by themselves or with their visitors. Residents in shared bedrooms had privacy curtains which were oriented to allow one person close their curtain without obstructing their neighbour's use of the bedroom. Staff were observed using the privacy curtains when attending to residents. There were sufficient en-suite and communal bathrooms and showers which were located close to resident's bedrooms and communal areas. All bathrooms and toilets were wheelchair accessible and facilitated residents to be as independent as possible.

Residents had access to television, newspapers and wireless internet. Communal areas were nicely laid out and comfortably furnished. These areas were well used by the residents during the two days of the inspection however the inspectors noted that the lounge areas on some units was closed off to residents during the afternoons to facilitate staff meetings.

Residents were consulted on the running of the service through feedback and suggestions which were followed up on by management and fed back to residents. The 2018 annual quality and safety review of the service included feedback and comments from residents and their families. There was a clear complaints procedure in place and residents said that they could talk to staff on the units if they had any concerns or complaints. Residents had access to a social worker and to an independent advocate in the centre.

Residents were facilitated to observe their religious practices and a regular mass was held in the centre. Residents who wished it were registered to vote and facilitated to do so on the premises if unable to attend their polling station.

Judgment:

Substantially Compliant

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:

There was a complaints policy in place which identified a complaints person. The designated centre used the HSE Your service Your say procedure for making complaints. This information was available in a number of places throughout the designated centre. Although the complaints person was based on site the current policy did not include their contact details. In addition the complaints procedure in the Resident's Guide provided different information about who to contact regarding complaints.

Residents and families who spoke with the inspectors said that they were aware of how to make a complaint if they had any issues or concerns and that when they had raised any complaints that these had been addressed promptly by staff on the units. Records showed that formal complaints were investigated by the person in charge and that the complainant was kept informed about the outcome of the investigation.

Judgment:

Substantially Compliant

Outcome 05: Suitable Staffing**Theme:**

Workforce

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

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

Findings:

Inspectors found that overall there were sufficient staff with the right knowledge and skills to meet the needs of the residents. However the reception area was often left unattended when staff were carrying out clerical duties on the units. As a result there was no record of visitors to the designated centre and access to the building was unsupervised. The issues in relation to the management of staff breaks which was found at the last inspection had been resolved and residents were not waiting long periods of time for staff to respond to call bells and requests for care and support.

The centre employed an experienced staff team many of whom had specialist skills in palliative care and care of the person with dementia. Recruitment and selection procedures were well established and helped to ensure that suitable individuals were recruited to the staff team. New staff received a comprehensive induction to their role which included knowledge of relevant policies and procedures in key areas such as safeguarding, fire safety and moving and handling. All new starters had to complete a probationary period which could be extended if they did not meet the required competencies and standard of work. All staff working in the designated centre had Gardai vetting in place.

Professional staff were supported by a well-organized team of volunteers. All volunteers

working in the designated centre had Gardaí vetting in place and were supervised by two volunteer coordinators and nursing staff on the units.

Staff worked well together across disciplines to ensure that residents had appropriate care and supports in place to meet their needs. Staff skills and knowledge were kept up to date with good access to on-going training opportunities. Records showed that staff were up to date with their mandatory training and that most staff had received training in caring for residents who had dementia. Staff demonstrated knowledge and skills when working with residents who had dementia and other cognitive impairments.

Senior staff provided effective support and supervision for their teams. Records showed that staff had access to regular supervision and annual performance reviews. Staff received regular feedback on their performance and were clear about what was expected of them in their work. As a result staff demonstrated responsibility and accountability in their roles.

Judgment:

Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

Findings:

Overall the premises was suitable in size and layout for the number and needs of the residents. The building was clean, warm and had a lot of natural light and views. Residents said that the premises was comfortable and that it met their needs. Multi-occupancy bedrooms had reduced in occupancy since the last inspection. There was now a maximum of three residents sharing a bedroom. However the storage of equipment had not been fully resolved since the last inspection. Inspectors noted that the provider had organized temporary storage areas as an interim measure and that hoists and specialist chairs were now stored in or close to resident's bedrooms and not in the communal areas and corridors. This remained an outstanding action from the previous inspection.

Accommodation was provided in four distinct units comprising of single and multi-occupancy bedrooms a communal lounge/dining area, small seating areas and a kitchenette. The central foyer provided additional seating space. In addition there was a large multipurpose activities room, a therapy suite including a physiotherapy gym, a small oratory and a main reception area. There was a visible and ventilated smoking area for residents to use and be supervised if necessary. All accommodation was provided at ground floor level.

There was good access to pleasant and green outdoor spaces and inspectors observed residents sitting out in the fresh air or strolling around the grounds alone or with assistance. For residents in areas which were further away from external paths, there were safe and nicely decorated balconies available. There were parking facilities for family and other visitors onsite and disabled parking spaces were situated close to the entrance.

There were good examples of dementia-friendly design in effect on the units. Pictorial signage led residents to the dining room or bathrooms. Each communal area had a large whiteboard and clock displaying the correct time and date as well as scheduled activities on that day. Floors were free of trip hazards and were simple in their layout to allow residents to stroll around the building without reaching dead ends. There was no unnecessary internal locking of doors seen that may frustrate or restrict residents.

The premises was clean and tidy. Accommodation was well maintained inside and externally in the garden areas which helped to ensure the comfort and safety of residents, staff and visitors.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk 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:

There were comprehensive policies and procedures in place for the management of risks in the designated centre. Staff had received training on risk management policies and procedures relevant to their areas of work. Inspectors found that one action in relation to staff training in fire safety had not been adequately addressed since the last inspection.

Staff were trained in proper moving and handling techniques and inspectors observed good practice when transferring residents or assisting them to mobilise. Appropriate infection control arrangements were in place and staff demonstrated good practice in hand washing and infection control procedures relevant to their work. Hazardous rooms such as utility rooms were secured and there were no dangerous objects or substances left unattended. Risk controls were in effect regarding residents who smoked or those who were at risk of going missing.

Fire safety precautions were in place for the building and infrastructure. Compartmentalisation was in effect with containing doors which had self-close mechanisms in the event of emergency. There was an appropriate amount of equipment for detecting and extinguishing a fire. The building layout facilitated safe evacuation with multiple exits and a straightforward, single-storey design. Service and maintenance records and certification were available in the centre and there was a log of routine in-house checks of escape routes, equipment and fire doors. However the oversight of fire doors required improvement as the Inspectors found that a fire door was damaged and did not provide adequate protection for the residents in that area. This had not been identified in routine fire door checks and had not been brought to the attention of the risk manager or person in charge.

Each resident had a personal emergency evacuation plan (PEEP) which listed their required assistance and equipment to safely evacuate. Some of these PEEPs required review to clarify the procedure for safe evacuation when the resident was in bed.

Staff had attended training in fire safety. However inspectors found that a significant number of staff working across all units did not have sufficient knowledge about the procedure to follow in the event of fire emergency and the procedure for a safe evacuation. Inspectors asked staff to demonstrate how a resident in a bed or wheelchair would be transferred and safely removed from the compartment by walking with the inspector. Some staff did not use compartmental evacuation and continued to the outdoor assembly point. Some staff simulated evacuating residents in directions that were not suitable or signposted emergency exit routes. Some staff were not aware of residents' evacuation plans. In addition the records of fire drills carried out in the centre did not provide sufficient information in relation to the simulated evacuation of residents in the various parts of the designated centre. As a result the inspectors were not assured that all staff would be able to respond appropriately to keep residents safe in the event of a fire emergency. This was an outstanding action from the previous inspection.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ann Wallace

Health Information and Quality Authority Regulation Directorate



Action Plan

Provider's response to inspection report¹

Centre name:	Anna Gaynor House
Centre ID:	OSV-0000465
Date of inspection:	27/02/2019 and 28/02/2019
Date of response:	18/04/2019

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 01: Health and Social Care Needs

Theme:

Safe care and support

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

A number of care plans were very general and did not include sufficient detail about the individual resident to support person centred care.

1. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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:

- Staff training will be provided to support the writing and development of individualised person centred care plans.
- Clinical Nurse Managers will be focused on in the first instance to provide guidance and support for RGN's in the nursing care plan development, implementation and evaluation; this will then be made available to RGN's.
- The Documentation Champions Group and Practice Development Lead will be a source of expertise for staff on their wards and raise awareness of best practice.
- Multidisciplinary team will guide and support staff in completing individual responsive behaviours care plans in accordance with the changing needs of residents.
- Care plan audit will commence to evaluate the impact of improvement plans.

Proposed Timescale: 30/06/2019

Theme:

Safe care and support

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

Improvements were required to ensure that all nursing staff administered medications in line with the designated centre's policies and procedures.

2. 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:

- Audit will be completed to monitor and evaluate single nurse administration of medication in line with policy and procedures. Recommendations and actions identified will be implemented and reported to the Medication Safety Continuous Improvement Group.

Proposed Timescale: 03/05/2019

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:

Some staff resident interactions did not support person centred care as staff did not explain what they were about to do and did not seek the resident's consent before they commenced a care activity.

3. 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:

- A review of the HSE National Consent Policy in line with OLH-CL-021 Consent Policy.
- Compliance with policy will be actioned as an item for discussion at the Clinical Nurse Managers meeting.
- Clinical Nurse Managers will highlight to ward staff the importance of obtaining informed consent from residents in the course of their duty.
- CNMs will monitor that resident consent is maintained and breaches to this policy will be responsible for reporting breaches in line with the risk management policy.
- The PIC will support CNMs in this role and will monitor compliance in this area.

Proposed Timescale: 30/04/2019

Theme:

Person-centred care and support

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

Inspectors observed several instances of staff lacking discretion when speaking to other staff about residents requiring assistance with personal care, in the presence of other residents and visitors.

4. 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:

- A review of Policy OLH-CL-005 Privacy and Dignity and Provision of Intimate Care will be completed.
- Compliance with policy will be actioned as an item for discussion at the Clinical Nurse Managers meeting.
- Clinical Nurse Managers will highlight to staff the importance of preservation of resident's privacy and dignity in the course of their duty.
- CNMs will monitor that resident's privacy and dignity is maintained and breaches to this policy will be responsible for reporting breaches in line with the risk management policy.
- The PIC will support CNMs in this role and will monitor compliance in this area.

Proposed Timescale: 30/06/2019

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:

Although the complaints person was based on site the current policy did not include their contact details. In addition the complaints procedure in the Resident's Guide provided different information about who to contact regarding complaints.

5. Action Required:

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

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

- The Director of Nursing and Complaints Officer in conjunction with the Communications Department is reviewing processes for resident and family engagement. New signage will be issued to all units highlighting the nominated Complaints Officer and contact details.
- The Patient/Resident Feedback for Comments, Compliments and Complaints Policy OLH-GN-003 will be updated to include the contact details of nominated Complaints Officer and contact details.

Proposed Timescale: 30/06/2019

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:

The storage of equipment had not been fully resolved since the last inspection. Inspectors noted that the provider had organized temporary storage areas as an interim measure and that hoists and specialist chairs were now stored in or close to resident's bedrooms and not in the communal areas and corridors. This remained an outstanding action from the previous inspection

6. 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:

- Refurbishment plans and costings have been submitted to the HSE in early November 2018 for the approval of funding of €6.5 million in order to meet design needs and future regulation.
- Pending funding approval this refurbishment will be a phased process to minimise disruption on residents.
- Interim storage measures will remain in place pending decision.

- Ongoing monitoring will be maintained for impact and risks to residents.

Proposed Timescale: 21/12/2021

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

A damaged fire door at the entrance to the dining room on Marymount Unit had not been identified in the routine checks or brought to the attention of the risk manager or person in charge.

7. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

- Damaged fire door has been repaired the day after inspection.
- Security staffs check the fire doors, they have now been delegated responsibility for the checking of all fire doors to ensure they are not damaged and are in working order.
- If issues or damage are found it will be reported to Facilities and Risk officer in line with Risk Management Policy OLH-GN-021.

Proposed Timescale: 02/04/2019

Theme:

Safe care and support

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

The records of fire drills and practice evacuations did not provide sufficient information in relation to times taken and whether or not the drill/evacuation was carried out in a safe and effective manner.

There were gaps and inconsistencies in staff knowledge on evacuation procedures and exit routes to follow in the event of an emergency, including the methods used to transfer residents out of compartments safely and promptly.

8. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

- The Risk Officer will increase in the number of practical compartmental evacuation training sessions for staff.
- The Risk Officer has commenced compartmental evacuation training sessions are in progress on all units and will also maintain all records.
- The Risk Officer has commenced timing of compartmental evacuations has also commenced.
- Once each unit has completed compartmental evacuation training, unannounced drills will commence ensure staff knowledge on evacuation procedures are maintained and carried out in a safe and effective manner.
- Risk Officer will maintain evacuation drill records.

Proposed Timescale: 30/06/2019