Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	Leopardstown Park Hospital
Name of provider:	Leopardstown Park Hospital
Address of centre:	Foxrock, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	02 March 2020
Centre ID:	OSV-0000667
Fieldwork ID:	MON-0028869

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The centre provides care for adults who have long term needs for residential care. The centre provides services for residents with low dependency through to those residents who are maximum dependency and require full time nursing care, including care for residents who have dementia and for residents who need end of life care. Accommodation is provided across eight units. Clevis unit has 29 beds and provides accommodation and services for those residents who have low dependencies. The unit is located in a period built house and separate from the main hospital premises. The other seven units provide accommodation and services for residents with higher levels of need and are located within the main hospital building. Enniskerry has 13 beds, Kiltiernan 14 beds, Kilgobbin 13 beds and Tibradden 12 beds. Three of these units have two single rooms and the fourth unit Kiltiernan has three single rooms. The remaining accommodation is provided in a nightingale type open ward with five bay areas accommodating two or three residents in each. Glencullen and Glencree commonly known as the Glens units are more recently built and provide accommodation for 27 residents on each, in a mix of single and multi-occupancy rooms. Djouce unit provides accommodation and services for eight respite residents and two long term residents in a mixture of single, twin and multi-occupancy rooms. Each unit has its own shower rooms and toilet facilities, most of which are wheelchair accessible. Communal dining rooms are available on all units, and in addition Djouce unit and the Glens have separate communal lounges. There are garden areas to the front and rear of the property with seating available for residents. There is a large car park to the front of the building with some disabled parking spaces available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	139

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 2 March 2020	08:15hrs to 17:00hrs	Helen Lindsey	Lead
Tuesday 3 March 2020	09:15hrs to 14:45hrs	Helen Lindsey	Lead
Monday 2 March 2020	08:15hrs to 17:00hrs	Mary Dunnion	Support
Monday 2 March 2020	08:30hrs to 17:00hrs	Michael Dunne	Support
Tuesday 3 March 2020	09:15hrs to 14:45hrs	Michael Dunne	Support
Monday 2 March 2020	08:15hrs to 17:00hrs	Susan Cliffe	Support

What residents told us and what inspectors observed

While residents in the Clevis unit and Djouce (respite unit) were very positive about the service they were receiving, a range of different views were expressed in the other units, four of which are nightingale type wards.

Activities:

Some residents from the Clevis unit who spoke with inspectors said they enjoyed the activities available in the main hall, and in their unit. A range of activities were provided there that were meaningful to them. Some residents also enjoyed gardening and taking care of the plants in the grounds. In Djouce unit, inspectors observed residents staying on a respite basis enjoying a tea break together, chatting and joining in a quiz which provided pleasant social engagement opportunities for them. Other residents were reading or had personal activities they enjoyed such as knitting.

Inspectors observed that in other units, and especially in the multi-occupancy wards and rooms residents were limited in their opportunities to engage in meaningful activities as they were unable to leave the units independently to join in larger groups. A number of residents were seen to be in the same position, sitting on their bed, or in a seating area by the sleeping areas, on both days the inspectors visited. It was noted that in one communal room residents were sitting in a group at a dining table, with no staff supervision, and the TV show playing was not being watched by any of them. There was one dementia focused unit, but there was also no activity program being provided to support residents with different cognitive abilities, and some residents were seen to be occupied in repetitive routines with no options for wider engagement.

Premises:

While some residents, mostly those in Clevis, were positive about their bedrooms and accommodation, a number of residents expressed their concerns which included light levels, privacy, and storage.

Inspectors noted there were some single rooms, and residents had personalised them with their own belongings. There were bedrooms accommodating up to four residents in Djouce and Glenncullen/ Glencree. Space was seen to be limited in these rooms with access to wardrobe space in other residents bedspace, and also insufficient space for chairs for each of the residents to sit in their own bedspace. In the nightingale type wards wards with bays for two or three residents, it was noted that many residents didn't have a chair they could sit on near their bed, seating that was available looked directly in to other residents bedspace. Space restrictions meant that bedside lockers belonging to some residents could not be beside their beds. This meant that personal items would not be kept close and within easy reach. In all units it was observed that some people had items stored on the floor or in

carrier bags under their bed.

The nightingale type wards had multiple large windows that flooded the area with light, this meant that even if residents pulled the curtains around their beds they could not reduce the light in the area. The blinds on some of the windows were broken and so could not be pulled down. Many residents were seen sleeping without pulling the privacy curtains, and so were on full view to anyone walking through that area. Residents had no say about who was in their bedroom space as it was part of the overall ward, and it was noted there was regular traffic through the area carrying out a range of tasks, some related to residents and some not. For example, people doing maintenance moved around in the area and were directly in residents bedspace with no explanation provided to residents about what they were doing. Simply put, people did not see these large multi-occupancy areas as the residents home.

A number of beds were positioned close to the main door in to the unit, meaning people were in close proximity to them every time they entered the ward. A number of beds were positioned in the bay so that one side of the bed was directly on the walkway through the unit, again with no control over those people in such close proximity to what should be their personal space. Residents accommodated in these wards were not afforded control of their own environment and as a result their privacy and dignity was being impacted each day.

In six of the units there was little or no comfortable seating area, just a dining area. A number of seats were available in the large unit, but they looked straight in to other resident's bedspace. This meant there was no area where residents could be away from their beds, and just relax, perhaps enjoying the television which is a way many people would choose to spend some of their time.

Residents told inspectors that they did not feel comfortable using the commode at their bedspace as there were so many other people in close proximity to them. Overall the nightingale units resembled a hospital ward and not a home.

Meals and mealtimes:

Residents reported that the quality of meals provided was good and there was a choice at each meal time. Residents described some of their favourite meals to inspectors, for example fish or chicken dishes.

It was observed in the unit for people with dementia there was limited options in what was available as a modified diet option, and residents were not asked what they would prefer, or shown options to support their decision-making.

Staffing:

Residents reported that the staff were very kind and helpful with some describing them as 'lovely', and offered support respectfully. Inspectors observed positive relationships overall between the residents and staff. Many interactions showed that staff knew the residents well and were able to engage in topics that were relevant

to them.

Residents and their relatives reported that staffing levels could be low at times leaving you waiting for support.

While staff were seen to be kind and engaged with residents, there were times when there were insufficient numbers to meet their needs, for example at meal time residents were seen waiting until staff had finished supporting other residents. In one area there were two staff to support 17 residents, a number of who needed one-to-one support.

Capacity and capability

This inspection was carried out following the receipt of a representation made by the provider in relation to the notice of proposed decision to renew the registration in the designated centre. The provider was questioning a condition proposed by the Chief Inspector that required the occupancy of the open bays in the nightingale type units to be reduced to improve the lived experience of residents.

During this inspection it was confirmed that residents accommodated in the open bays continued to be provided with a service that did not meet their needs, and did not respect their privacy and dignity. While some improvements had been made to décor and bathrooms, there had been no significant improvement for residents being accommodated in premises that are not fit for purpose. The provider had committed to improving or replacing the premises by 2014 and then 2017, but these commitments were not followed through. The provider's governance and management arrangements have failed to substantively address key areas of concern, namely:

- Premises
- Staffing
- Residents Rights and Dignity

While there was a core of staff who had worked in the centre for a period of time and knew the residents well, the provider still relied on agency staff to cover shifts on a regular basis. Examples were seen in the roster where up to 50% of staff working a shift in a unit were agency staff, and so this did not provide consistency for residents in who was delivering their care. Inspectors also saw examples of shifts set out as part of the normal staffing levels that were not covered, and so leaving the staff on the unit to manage residents needs with reduced resources.

An area where improvements had been made was fire safety. A significant programme of fire safety improvement work was nearing completion. The management team had overseen the project to replace the major systems in the centre, and staff training and knowledge had also been addressed.

Other areas where improvements had been made were complaints management, staff training and record management.

Regulation 15: Staffing

Inspectors were not assured that there were sufficient staff available at all times throughout the centre. A review of rosters indicated that not all shifts were covered, and in some cases units had no clinical management available to them. The review showed full cover, as per the planned roster, had not been available for 50% of the shifts in the two weeks preceding the inspection. Examples were also seen where planned absences, training for example, were not covered. Inspectors observed that reduced staffing levels were impacting on the quality of care being provided in some units, for example, timely support with nutrition at mealtimes. The provider confirmed that they were recruiting staff, but agency staff were being used on a regular basis.

This is an outstanding non-compliance from the last inspection in January 2019.

Judgment: Not compliant

Regulation 16: Training and staff development

There were clear records in place that set out what training had been completed by staff. All staff had completed fire safety training, safeguarding, and manual handling. There were a range of other courses available such as dementia care, wound care, infection control, and medication management.

Judgment: Compliant

Regulation 21: Records

All records requested were available to review. The majority of records were completed, for example staff files held the required information relating to recruitment, and records of staff induction showed the planned programme had been completed by new staff. However, an example was seen where rosters seen did not accurately reflect the staffing that had worked a shift.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were governance structures in place, including a board and senior management team. A review of meeting minutes of these groups showed that topics relevant to the delivery of the service were discussed on a regular basis such as staffing levels, policies and procedures, and finances.

While there was a governance system in place, the provider had failed to ensure resources were used to drive improvement for people using the service. Changes made in the centre had not adequately addressed areas of non-compliance with regulations. There continued to be resource issues that had not been fully addressed:

- provision of adequate staffing levels at all times
- lack of progress in addressing issues relating to dignity of residents
- premises that meet the needs of residents and requirements of the regulations

A range of audits were being carried out of practices in the centre and monitoring clinical performance indications, and a variety of information was provided, however evidence was not available to show the results of audits were analysed and improvements identified and implemented.

Judgment: Not compliant

Regulation 30: Volunteers

A review of records showed that each volunteer working in the centre had a clear description of their role and a Garda Vetting report.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a policy in place that set out the arrangements in place for making and managing complaints. There were accessible posters around the centre explaining for residents and visitors how to make a complaint, and residents confirmed they knew who they would speak to if they had an issue to raise. It was noted the policy was specific about who could make a complaint, and this required review to ensure

issues of concern could be raised and managed appropriately in the centre.

A review of complaints that had been made showed they were recorded, and processed as per the procedure. They provided information on the steps taken, and whether the complainant was satisfied with the outcome. It was noted however that three records were not completed as another person in the process held a selection of the documents.

Judgment: Substantially compliant

Quality and safety

While residents healthcare needs were being met to a good standard, there continued to be poor facilities that significantly impacted on residents privacy, dignity and social needs.

Inspectors again found that the provider had failed to make the improvements required to the premises. The layout of the premises in the nightingale style wards and other multi-occupancy rooms meant residents did not have a private space accessible to them. The only option for some residents was to pull a curtain around their bedspace, but this did not impact on the light, sounds, and general activity going on around them. In the large units, some residents were seen sitting on beds as they did not have a chair in their bed space. In some bedrooms for four residents, the wardrobes were stored in the bedspace of other residents, meaning some could not access their clothes and belongings freely. While staff tried to provide personal care to residents in a way that respected their privacy, due to the layout of multi-occupancy rooms and the number of residents accommodated there, privacy during the delivery of care was not always maintained and personal conversations could be heard by anyone in the area.

Residents had reported previously that they did not have sufficient space to store their belongings. The provider had responded by reconfiguring the inside of the narrow wardrobe, and offering storage of seasonal clothing in other areas of the centre, but no additional space had been provided. Consequently on this inspection, residents continued to report insufficient personal storage space, and residents had to resort to storing items in bags around their bedspace. Despite giving this feedback through internal mechanisms, the lack of storage was not comprehensively addressed.

An area of improvement found during this inspections was in the quality of care records. There were clear records in place showing that residents needs were assessed prior to admission to the centre, and when residents arrived detailed care plans were put in place to describe how residents identified needs were to be met, and these were reviewed every four months or sooner if required. Those reviewed provided clear advice for staff about how residents needs were to be met. They were person-centred in nature, for example setting out residents preferred routines,

activities, and meal choices.

There were arrangements in place to safeguard residents from harm. There was a policy in place, and staff were clear of what action to take if they became aware of an allegation of abuse. Any investigations that had been carried out followed the expected procedures, and resulted in improvement plans being in place for the residents affected. There was also access to advocacy for residents, and the social work team could support residents with this request.

Residents views were gathered on the quality of the service, and meetings were held on a regular basis to give updates on plans to improve the service and to ask for feedback. However, inspectors were not assured the issues raised by residents in the most recent meeting had been addressed.

A significant programme of works to improve fire safety in the centre was underway, and due to be completed in the weeks following the inspection. A new fire alarm system had been fitted with emergency lighting and other equipment being upgraded or replaced.

Regulation 12: Personal possessions

As had been found on previous inspections in the centre, in some units residents did not have sufficient space to store their personal belongings. Many residents only had a narrow wardrobe and a locker to store their belongings. While walking around the units inspectors saw many examples where residents lockers were not by their beds, and belongings were stored in bags or other containers under their chair, bed or on top of the wardrobe.

Judgment: Not compliant

Regulation 17: Premises

The premises did not meet the needs of residents. This issue has been raised with the provider over the last two inspections in January 2018 and January 2019, but very limited improvement had been made. As per the findings on the previous inspections, inspectors observed that there is:

- large multi-occupancy rooms with a layout that does not promote privacy or dignity
- insufficient communal spaces in units for residents to spend time away from their bedroom/ bedspace
- lack of blinds or curtains, as a result some residents could not keep their

bedspace dark when the sun came up (5am in summer months)
- storage of equipment in bathrooms meaning the access to bathrooms was restricted
- lack of space to meet visitors in private
- lack of furnishings, such as chairs, available for residents due to the space available to them.

There had been a programme of work to decorate many areas in the centre, and a number of bathrooms had been reconfigured and full doors added, however one toilet still had a door that was open at the top and bottom and could not be locked, impacting on residents privacy.

Judgment: Not compliant

Regulation 18: Food and nutrition

A menu was in operation that provided a varied selection of meals, and there was a choice available at each mealtime. Breakfast for example was cereals, porridge, toast with an option of a cooked breakfast if residents requested it.

Meals were cooked in the main kitchen and then transported to each unit to be served. Both meal options set out on the menu were available, however it was noted in one unit residents were not offered a choice, either by asking them, or showing the options to support decision-making.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a policy and procedure in place that set out the identification and management of risks in the centre. There were a number of systems in place to record and monitor any identified risks such as a risk register and incident management recording system. There were also risk assessments in place at an individual levels covering areas such as restrictive practices and behaviours and psychological symptoms associated with dementia (BPSD).

The provider also had a service level agreement in place to escalate high rated risks to the Health Services Executive. This process was managed at the Board level. The Board had oversight of the risk management in the centre and they were discussed in regular meetings, including a Health and Safety Committee.

Judgment: Compliant

Regulation 27: Infection control

All areas of the centre were found to be clean, and arrangements were in place for ancillary staff to work in each unit and the shared areas of the centre. However, the physical premises increased the risk of contamination as a result of the numbers of residents living in close proximity and the requirement to store items such as hoists in bathrooms which increased the risk of contamination.

There were hand sanitizers available throughout the centre, and personal protective equipment was available in each of the units visited.

There was an infection control policy in place and this was seen to be followed in practice.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider commissioned a Fire Safety Assessment which identified a large programme of work that needed to be completed to ensure there are appropriate fire safety arrangements in place. All priority works had been completed, and the remaining phase of works was due to be completed in the weeks following the inspection.

All records were in place to show the servicing of the fire alarm, the emergency lighting, fire extinguishers and other fire safety measures were being carried out at appropriate intervals.

All staff were completing training annually, and those spoken with were clear of the action to take if the alarm went off. Drills had been completed in each unit, and different scenarios were being tested. There was an emergency evacuation plan in place for each resident and staff had a copy with them so it could be accessed easily if required.

During the inspection testing of the electric facilities were being carried out by people who showed no respect to the residents, many of whom were in bed. There were loud noises without explanation, and examples were seen where a person was leaning over a resident in their bed without explaining what they were doing. This was an invasion of their privacy and is another example of residents not being treated with dignity and respect.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

There was a clear process in place for assessing residents needs prior to admission, and this included a specific process were residents were being considered for a respite service.

There was a policy in place that set out time lines for producing and reviewing care plans, and this was seen to be followed in practice. The care plans reviewed provided clear guidance for staff in how to meet residents identified needs, and reflected the persons preferred routines and preferences, for example preferred food and drink.

Judgment: Compliant

Regulation 6: Health care

Residents had good access to a general practitioner and allied health professionals such as social worker, physiotherapy, occupational health and speech and language therapy without delay.

Records showed that where residents healthcare needs changed referrals were made appropriately, and any recommendations made by the healthcare professionals were implemented, and care plans were updated.

Judgment: Compliant

Regulation 8: Protection

There was a policy in place that set out the approach to be followed if staff were told about, suspected or witnessed abuse. The policy was brief and did not contain definitions of abuse as it stated it was to be read in conjunction with the Health Services Executive policy, which was not provided with the policy. This non-compliance is addressed under regulation 4 Written Policies and Procedures

Staff spoken with were well informed and confirmed they had completed training that they found informative. It was repeated every two years.

A number of investigations had been carried out, and they followed the expected processes. Where required safeguarding plans were put in place and were seen to be effective for residents. A team were allocated to manage issues that included the social worker and the person in charge.

Judgment: Compliant

Regulation 9: Residents' rights

Residents continue to be significantly impacted by the poor quality of the premises in many of the units in the centre. Due to the layout of multi-occupancy rooms, especially the large units, residents could not undertake personal activities in private. While there were privacy curtains in place, residents privacy was not always maintained during the delivery of personal care and all discussions between residents and staff or visitors could be heard by others in their vicinity, meaning their right to privacy could not be upheld.

Staff confirmed that privacy was a challenge and an ongoing concern, and were seen to be working to optimise peoples rights, but the layout of the premises mitigated against this. Despite the best efforts of staff it was not possible to uphold people's privacy when so many people were being supported in the same open plan areas.

For those residents in multi-occupancy rooms, the noise of others activities could be heard throughout the day and night. In areas where 13 residents were accommodated, there were a range of sounds that would mean residents could not experience a quiet environment even if they wanted to. For example the sound of televisions and radio's where they were both on at the same time, and residents calling out for support or due to behavioural and psychological symptoms of dementia BPSD. There were also people walking through the large units regularly, with the doors being very close to the beds at each end of the units. There were also beds that were side on to the corridor area in the large units meaning people were walking past frequently and only inches from their bed.

There were arrangements in place for a range of activities in the large activities room, however there was little time for staff to engage in one-to-one activities for residents who required support in smaller groups or on a one-to-one basis. One area specifically supported residents with dementia, but there were no arrangements in place to support those residents with activities appropriate to their abilities. Inspectors noted the only activity in the units was residents sitting listening to the radio or watching the television.

Visitors were seen attending the centre during the inspection, and some enjoyed walking around the grounds, and corridors for exercise and found quiet places to sit, however there were limited options to meet visitors in private in the units.

It was also noted that there were inconsistent arrangements to support residents from different cultures, with some staff being very clear of specific arrangements in place to support language and interests, however others were unaware of the arrangements leaving residents without meaningful engagement.

The provider was holding resident meetings on a four monthly basis, and residents

had been supported to provide feedback. Feedback from the March meeting included feedback about not being able to reach shelving in a wardrobe, not being able to access a bathroom due to hoist storage and the range of cereal available. The records showed actions to be carried out following the meeting, but inspectors observed the issues residents raised were still present.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Leopardstown Park Hospital OSV-0000667

Inspection ID: MON-0028869

Date of inspection: 03/03/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Rosters are in place that exceed the base staffing requirement as assessed having regard to dependency levels, geography and occupancy. This allows for a level for a reduction of staffing without compromising resident safety and welfare. Clinical Nurse Managers are rostered and in their absence (due to scheduled or unscheduled leave) a senior experienced staff member ('senior staff nurse'/'enhanced nurse' grade) is in charge of the unit. CNMs and nurse in charge of units always have access to senior nursing management for support, input and guidance and a system of 'house nurse in charge' is also in place on a 24/7 basis. Action: Since June 2020 a CNM3 has been appointed to provide additional clinical management support to all units. A review of the CNM roster has taken place to allow for more continuous CNM presence. Action on recruitment: Recruitment has continued in a very challenging recruitment environment both pre and during COVID-19 pandemic. Since the previous inspection in 2019 and as described in that action plan LPH has introduced a staff 'bank' providing directly employed staff instead of agency staff for some planned and ad hoc vacancies. A total of 8 staff have been recruited to this bank over the past year with a further 1 in the recruitment process. LPH has since March 2020 inspection also begun to be able to access some agency staff for full rosters (rather than individual shifts) in the event of defined and ongoing absence/ vacancy. These staff are therefore familiar with the workings of the units and residents and are considered part of the staff complement for the duration of their contract (just as a temporary directly employed staff member might be). At the time of the 2020 inspection there had been a 46% reduction in use of agency staff compared to time of previous inspection in 2019. 51 staff in total have been recruited since previous inspection in 2019 including 11 since March 2020 inspection. Inspite of the fact that recruitment and retention has been even more challenging during Covid19 LPH has continued to prioritise this work over the period. In addition a further 11 staff (all nursing and carers) are in the recruitment process having been offered positions in June and July 2020. Action: Conclude these recruitment processes. In 2020 YTD 69 interviews were carried out for staff nurses and carers alone. Unfortunately a significant number of applicants were not deemed suitable for employment based on	

interview. Recruitment continues on a rolling basis for positions as they arise in a dynamic and difficult employment environment. Action: Ensure continued active recruitment for vacancies as they arise. LPH believe there will always be a requirement for some level of ad hoc agency to ensure safe and suitable care provision but the aim is always to ensure that this is kept to a minimum or provided on a continuous roster basis through agencies where at all possible. The no of hours face to face training has reduced with the availability of blended learning including part or full online training for various programmes. Most training now is for short periods on 1-2 hours. Action: If short training taking place CNMs to review allocation of duties around this period to meet residents needs

LPH acknowledge that the 2 weeks rosters reviewed by the Authority relating to the 2 weeks prior to the inspection were lower than other periods and this was due to unplanned short notice sick leave where bank and agency were not in a position to fully meet the need. While staffing did not drop below minimum staffing levels having regard to dependency levels, geography and occupancy it is acknowledged that it was lower than we would like and every effort was made to fill the relevant shifts including looking at internal as well as external options.

LPH are committed to a pleasant and appropriate dining experience for all residents. LPH are looking at options in relation to implementing change based on a collaborative approach including residents, nursing/carers, speech & language therapy, occupational therapy & dietetics and catering department. Recent research carried out by dietetic students is informing some of these considerations, including staffing allocations and variance of mealtimes to ensure that residents requiring assistance have a good dining experience and are exploring the introduction of specialised furniture that may promote greater independence for residents around their mealtimes and dining experience. A review and reorganisation of staff around mealtimes has taken place to support nutrition at mealtimes (reference food and nutrition regulation response also).
The Catering and Nutrition subcommittee of the Integrated Quality, Risk & Safety Committee of the Board reviews aspects of the dining experience. Action: Finalise proposal for specialised furniture and implement as appropriate. Keep under ongoing review staffing allocations around mealtimes.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Timely updating of the rosters is a requirement and reminders of the importance of timely updating have been emphasised with relevant staff. – Complete and ongoing

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: As there is overlap between other action plans for other Regulations reference will be made directly to these to avoid duplication of documentation where this duplication arises: • Provision of adequate staffing levels at all times – Please reference response to Regulation 15: Staffing • Lack of progress in addressing issues relating to dignity of residents - Please reference response to Regulation 9: Residents Rights • Premises that meet the needs of residents and requirements of the regulations – please reference response to Regulation 17: Premises Subcommittees of the Integrated Quality, Safety & Risk Committee of the Board, e.g. Medication Safety & Therapeutics Committee, Falls Committee, Infection Control Committee, Catering & Nutrition Committee & Health & Safety Committee, along with the IQS Committee itself, all review results from relevant audits and consider what actions, if any, are required. The initial audit reports do not have recommendations in advance of that review. Action: LPH will look to add a reference in any audit report, which committee/group will be reviewing the audit with a view to finalising and documenting any agreed improvements from same, if relevant. This will allow LPH to more easily demonstrate to the Authority that the loop is closed in relation to matters emerging from audits and that improvements are identified and implemented	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • LPH will review the complaints procedure in line with best practice to incorporate concerns. • LPH has highlighted the importance of prompt provision of documents to ensure that complaints records can be completed in a prompt manner - Complete	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal	

possessions:
Action: A review of arrangements and optimal usage of wardrobes is in progress with residents. This includes a review of seasonal clothing and the provision additional storage for items not being used during current season, thereby freeing up space for residents to access their clothes for current season. There are a small number of residents who like using plastic bags and we will continue to work with them with a view to reducing this use.

Action: There are a small number of residents who for safety reasons lockers have been relocated away from side of bed but within the bed spaces. These will be reviewed with a view to reverting within the bed space where appropriate.

Action:As part of the full capital redevelopment of the centre (which is at design phase at this time), particular consideration is being given to storage solutions for residents personal possessions in line with the Regulations.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
It is identified and fully accepted that a modern purpose built infrastructure is required to support our residents and LPH has an active capital replacement project in place for the provision of replacement 125 beds in full compliance with regulations. This project is being carried out in conjunction with, and with support of, the HSE and a full design team is in place and progressing the project as a matter of urgency. A project manager and project liaison officer are in place. There is and will continue to be engagement with residents and staff in relation to the future design to ensure that it not only meets the regulations but that it provides an environment that residents feels reflects a home environment (while still being able to provide the high level of existing clinical care) and works for residents and their care needs. Action:Progress capital redevelopment. Action: In the intervening period staff will continue to prioritise residents privacy and dignity

• Blackout blinds have been previously introduced throughout the centre. Staff have been reminded to ensure that blinds are closed at night. A review of blinds carried out to identify any issues. Action: Awaiting contractor to repair any blinds found to be broken.
• Previously had added additional storage for equipment in the nightingales and further storage of equipment in bathrooms in the Glens is being addressed by the conversion of an office to store room. Delays experienced completing works due to Covid-19 restrictions: Action: Complete as soon as contractor available
• At the time of inspection a number of chairs had just been removed due to wear and tear and potential infection control risk and the centre was awaiting delivery of replacement chairs which were delivered shortly after the inspection - Action Complete
• The works on the toilet door, including the extension to the ceiling have been completed. - Complete

• Action: Positions of beds remain under ongoing review. A very small number of residents have insisted, inspite of many conversations, that they want their bed to remain in the position and will not accept any other location. In one of these cases the resident has recently been discharged and the bed will be reconfigured for future admissions. In the other case, inspite of multiple requests to change, the resident and family have steadfastly refused to permit any change from current arrangements and we are obliged to respect their choice

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
LPH is committed to facilitating resident choice and this is includes around meals. Residents make choices the day before from a broad and varied menu. A recent initiative to introduce a pictoral representation of the meal to assist in choice was implemented across the centre as a quality initiative of the Catering and Nutrition subcommittee. Within this specific unit referenced all residents have a level of dementia and even with such tools, while every effort is made to identify choices, it is challenging and not always possible to get a definitive indication of choice. However staff are very familiar with resident's individual likes and dislikes (as per care plan with information gained from resident where possible and family/friends) and use nonverbal indictors in relation to whether the resident is enjoying the meal, if other methods of indicating choice are not effective. Choice is facilitated taking into consideration nutritional, special diet and consistency requirement. On the day there were 3 mains options, however 9 other alternatives were available in the event that any resident verbally or non-verbally indicated that they did not like the chosen meal. Weights are kept under ongoing review and a nutritional review is activated if any concerns around nutritional intake. In addition any issue with difficulties with mealtimes are discussed at the quarterly interdisciplinary reviews or more frequently if required. Action: To remind staff to ensure choice where able to be expressed/indicated and to continue to use other methodologies to support choice including nonverbal indicators.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Previously have added additional storage for equipment in the nightingales and further storage of equipment in bathrooms in Glens is being addressed by the conversion of an office to store room. Delays have been experienced completing works due to Covid-19

restrictions. Action: Complete works bring additional storage capacity into use

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The fire safety works as identified in the fire safety assessment have been completed in full which included full upgrade of fire alarm, emergency lighting and fire doors. – Complete

• It is noted that an electrical contractor acted in a manner that treated a resident without respect and this is completely unacceptable and is not in compliance with standard procedures within the centre. Action: The maintenance manager has been advised and all contractors and maintenance staff are reminded of the requirement to engage with the nurse in charge on the unit prior to works being initiated (as part of the normal existing process for contractors and maintenance staff) to ensure that all residents' privacy and dignity is respected at all times throughout any essential maintenance works. Further emphasis on the importance of explaining to residents in the vicinity of any works is also emphasised.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
It is identified and fully accepted that a modern purpose built infrastructure is required to support our residents and LPH has an active capital replacement project in place for the provision of replacement 125 beds in full compliance with regulations. This project is being carried out in conjunction with, and with support of, the HSE and a full design team is in place and progressing the project as a matter of urgency. A project manager and project liaison officer is in place. There is and will continue to be engagement with residents and staff in relation to the future design to ensure that it not only meets the regulations but that it provides an environment that residents feels reflects a home environment (while still being able to provide the high level of existing clinical care) and works for residents and their care needs. In the intervening period staff will continue to prioritise residents privacy and dignity. While there are a number of areas for residents to carry out activities in private it is recognised that the redevelopment will provide much greater options in this regard. Action: Progress Capital development project

• In relation to activities, unfortunately the inspectors did not interview any of the broad range of staff involved in and having oversight to the programmes of activities both

group (large and small) and 1:1 activities. These staff include ADON in charge of activities, unit based activity HCAs, Occupational Therapy, Resident Services Manager, activity coordinators and Physiotherapy, who would have been able to provide a more comprehensive overview of the range of large scale and small but important to individuals, activities. Every effort is made to identify activities of interest appropriate to the capabilities and capacities of individuals, including the levels of stimulation tolerated, if applicable. Activity HCAs are rostered across the full day including evenings including to facilitate those with sundowning behaviours and input titrated to individual needs, including titrated to sensory issues and activity HCAs have a particular focus on the dementia focused unit in view of their challenges in engaging with some activities. There are ongoing reviews of general activities timetable to take into consideration seasonal options and resident preferences and variety. The Residents Forum has as a standing item 'Activities' and every effort is made to support needs identified in this area. All activities held in house are provided free of charge to residents, avoiding the situation where ability to pay would compromise access to activities and ensure an equality of access for all, if they choose. During Covid-19, due to the limitation necessitated by pandemic protocols, a move away from large group to 1:1 or very small socially distanced groups was required. We hope that the larger scale activities will be permitted to be recommenced at the earliest but keep the programme of activities under review and individual quarterly IDTs also look at individual interests. Recent additions of Smart TVs in all units has allowed for a more titrated TV offer for residents and has been very well received. This along with a significant increase in technologies eg Facetime/WhatsApp,iPads, Youtube etc facilitates greater choice. Action: Continue to keep under ongoing review the activities offers both on an overall basis and individual needs based on care plans

• Significant work has gone into supporting and securing appropriate, relevant and interesting content (both in relevant language, religious choices and general interest in that context) that meets the interests of those from a culturally diverse background. The care plans fully reflect this. It is disappointing on the day that staff did not indicate their knowledge of this. Action: Following inspection a reminder took place with staff to ensure they were aware of these specific supports, they confirmed they were aware of supports where to identify them in the care plan and would continue to facilitate access to same.

• General privacy: Action: A reminder to all staff in relation to importance of maintaining privacy, including speech privacy, took place at unit level. Ongoing vigilance and staff commitment to maintaining privacy and dignity of residents

• Residents Forum was held very shortly prior to this inspection relating to engagement on the new capital development. All feedback has been encompassed within the design brief and further engagement will take place as part of this development.

• Use of headphones where tolerated has been facilitated.

• Positions of beds remain under ongoing review. A very small number of residents have insisted, inspite of many explanations, that they want their bed to remain in the position and will not accept any other location. In one of these cases the resident has recently been discharged and the bed will be reconfigured for future admissions. In the other case inspite of multiple requests to change the resident and family have steadfastly refused to permit any change from current arrangements and we are obliged to respect their choice

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	01/02/2023
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has	Not Compliant	Orange	01/02/2023

	adequate space to store and maintain his or her clothes and other personal possessions.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2020
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	01/02/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	01/02/2023
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered	Substantially Compliant	Yellow	16/03/2020

	choice at mealtimes.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant		30/04/2020
Regulation 21(1)	The registered provider shall 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.	Substantially Compliant	Yellow	16/03/2020
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	01/02/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/12/2020
Regulation 27	The registered provider shall ensure that	Substantially Compliant	Yellow	30/09/2020

	procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	23/07/2020
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	23/07/2020
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	23/07/2020
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	23/07/2020
Regulation	The registered	Substantially	Yellow	30/03/2020

34(1)(f)	provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall 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.	Compliant		
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Substantially Compliant	Yellow	31/12/2020
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required	Substantially Compliant	Yellow	31/12/2020

	for improvement in response to a complaint.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	31/08/2020
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	30/03/2020
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant		20/07/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in	Not Compliant	Orange	20/07/2020

	accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	20/07/2020
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	01/02/2023