Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

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:	16 January 2019
Centre ID:	OSV-0000667
Fieldwork ID:	MON-0025588

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.

Current registration end date:	02/06/2017
Number of residents on the date of inspection:	138

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
16 January 2019	18:00hrs to 21:15hrs	Ann Wallace	Lead
17 January 2019	08:00hrs to 18:00hrs	Ann Wallace	Lead
16 January 2019	18:00hrs to 21:15hrs	Helen Lindsey	Support
17 January 2019	09:15hrs to 17:30hrs	Helen Lindsey	Support
17 January 2019	08:00hrs to 18:00hrs	Susan Cliffe	Support
16 January 2019	18:00hrs to 21:15hrs	Gearoid Harrahill	Support
17 January 2019	09:15hrs to 18:00hrs	Gearoid Harrahill	Support
17 January 2019	08:00hrs to 18:00hrs	Paul McDermott	Support

Views of people who use the service

Overall those residents and families who spoke with inspectors were positive about the care and services that they received in the designated centre. However residents and families commented on the lack of continuity of care for residents due to staff changes and the use of agency staff. In addition a number of residents said that they did not have enough opportunities to attend activities of their choice.

Residents told the inspectors that staff were kind and respectful towards them and that they worked hard to ensure that the residents were looked after. However a number of residents and families expressed concerns that staff changes and the ongoing reliance on agency staff had disrupted their care and daily routines, and in some cases this had negatively impacted on the quality of care provided.

Residents told the inspectors that they felt safe in the centre and that they could talk to a member of staff if they had any concerns. Families said that nursing and care staff on the units were approachable and kept them up to date if there were any concerns about the resident and their care. However, some families who had raised issues or who had made a complaint were not satisfied with how this had been managed by senior staff and managers.

The feedback from residents was that they enjoyed their meals and that the catering staff would accommodate special requests where possible. Residents said that there was plenty of food and that snacks and drinks were served throughout the day.

In relation to the premises, a number of residents said that they were satisfied with their personal accommodation and that they were comfortable and their needs were met. However some residents who occupied the multi-occupancy rooms and the open bays on the Nightingale type units, said that the accommodation did not meet their needs for privacy and quiet space. Also that they were often disturbed by the activities and noise from other residents and visitors.

Residents enjoyed the activities that were on offer in the centre and that the range of activities had improved since the last inspection. However a number of residents said that there was not enough to do and that they did not have regular access to trips out of the centre.

Capacity and capability

While inspectors found that improvements had been made in relation to the

cleanliness and maintenance of the premises, significant improvements were still required in the governance and management of the designated centre. A number of actions from previous inspections had not been adequately addressed, and the provider had failed to act effectively to address fire safety concerns raised in a recently commissioned fire safety report. Inspectors also found that complaints were not being managed in line with the centre's own complaints procedure and that the high use of agency staff and the regular movement of staff between different units did not provide continuity of care for residents.

Inspectors found that the current staff resource was not being managed to ensure that there were sufficient staff with the right skills and knowledge to provide safe and appropriate care for the residents. The centre was overly reliant on agency staff to fill short notice absences and staff vacancies. Inspectors observed, and staff confirmed that considerable amounts of the clinical nurse manager's time was spent each day in organising staff to fill in gaps in the rosters. Rosters were often changed at short notice and as a result the rosters were not accurate on some units. For example, on the second day of the inspection an agency health care assistant was allocated to one unit where they received the morning handover, however following this handover the care assistant was moved to another unit where they had not attended the handover report. In addition this member of staff was not shown the layout of the unit and was not made familiar with the fire exits and the emergency procedures. Inspectors also noted that the shifts worked by the person in charge and the assistant director of nursing were not included on the rosters and that there was no record of senior staff on call rosters for out of hours and at weekends. Staff in the units did not know who was on call when asked, but had access to a phone number that would contact the relevant person.

Whilst there was a well-established core of staff who had worked at the centre for more than two years there had been a number of staff changes and the centre had undergone a comprehensive process to select and recruit suitable staff. Records showed that appropriate staff selection procedures had been followed. Inspectors reviewed a sample of staff records and found that two written references and Garda vetting were in place for staff, however two files did not provide a satisfactory record of gaps in employment history.

Staff had good access to training opportunities including mandatory training in fire safety and safeguarding for the staff who had worked in the centre for a while. However, training records showed that a number of staff were not up to date with their moving and handling training. In addition, more recently appointed care staff had not attended mandatory training in fire safety, moving and handling and safeguarding in line with the centre's induction and training policies. Some of these staff had been working in the centre for more than five months and the oversight had not been identified by managers.

There was a policy in place to manage complaints, and both residents and relatives said they were familiar with the procedure. However inspectors reviewed a sample of these complaints and were not assured that they had been progressed in line with the centre's complaints policy and that the final outcome had been communicated to the complainant. These findings were in line with information

provided by residents and their families who said that they had tried to discuss a complaint or concern with managers but that they had found it difficult to engage with the appropriate manager to resolve the issue.

There were some well organised quality assurance systems in place to monitor the quality and safety of care and services provided. These included regular audits and review of key performance indicators such as incidents, falls, pressure sores and infections. However clear action plans were not in place to address the areas identified for improvement and recurrent under-performance in key areas such as care planning were not being appropriately managed by the management team.

There were also areas of significant risk identified during the inspection for example in relation to fire safety processes. Inspectors found that the provider did not have appropriate arrangements in place to mitigate against these risks.

Regulation 14: Persons in charge

There was a person in charge who was a registered nurse. The person in charge had more than three years' experience in management of a long term health and social care service and held a post-registration qualification in management. The person in charge was engaged in the governance and operational management of the centre.

Judgment: Compliant

Regulation 15: Staffing

While there was always a registered nurse on duty in the centre, there were times when there were insufficient staff numbers to meet the needs of residents. In addition the designated centre's over reliance on agency nurses and care assistants to fill gaps in the rosters meant that the knowledge and skill mix of the staff was not always appropriate to meet the needs of residents.

Inspectors spoke with staff and relatives who said that the frequency of agency staff impacted on the regular staff and the quality of the care and services that were provided for residents. Inspectors were told that regular staff spent a significant part of their time supervising agency staff and that staff handover reports took more time as nursing staff needed to ensure that agency staff had sufficient information about each resident and their needs to provide safe and appropriate care. These concerns were verified during the inspection. For example inspectors noted that on one unit rosters showed that one or more shifts were covered by agency staff nearly every day in January 2019.

Inspectors also observed that some shifts or a part of a shift went uncovered. For

instance during the first part of the morning shift on the second day of the inspection one unit was covered by one nurse and a carer until an agency member of staff was moved from another unit. As a result, residents' breakfasts and personal care provision were delayed. In another unit rosters showed that one night nurse worked across two units as it had not been possible to find an agency nurse to cover the second nurse night shift.

In another example; although there was a full staffing compliment on night duty on the unit, out of the three staff on duty for the shift, two were agency, one of whom had not been in the designated centre before.

In one unit during lunch time inspectors observed that all staff on the unit were busy assisting residents with their meals in the dining room and as a result there were no staff available on the rest of the unit to adequately supervise those residents who were not in the dining area.

In addition on the first evening of the inspection rosters showed that there was no clinical nurse manager on duty for the designated centre during the night shift. When this was discussed with the registered provider representative inspectors were told that the arrangement in place was that a staff nurse on one of the units would act up into this role while also being the nurse in charge for that unit. A subsequent review of the records showed that this arrangement was regularly in place on the night roster.

Judgment: Not compliant

Regulation 16: Training and staff development

Whilst staff had access to appropriate training, records showed that a number of staff had not attended moving and handling training in line with the centre's training policy.

Records showed that a number of staff who had been recruited since August 2018 had not attended mandatory training in safeguarding, moving and handling and fire safety.

The current systems for staff supervision and the management of under-performance were not effective. For example, there was an ongoing issue in relation to the quality of care care plans and in ensuring that care plans were up to date and were person centred. Inspectors found that managers had the information but had failed to put into place the processes required to bring about the changes needed.

Clinical nurse managers had been allocated supernumerary hours to complete management tasks and to supervise staff however on some units the clinical nurse managers reported that owing to staff shortages they were unable to avail of these

hours and complete their management responsibilities.

Judgment: Not compliant

Regulation 21: Records

Documents held in respect of members of staff did not contain all of the information as required in Schedule 2 of the regulations.

Staffing rosters on some units were not up to date and rosters did not include the roster for the person in charge, the assistant director of nursing or details of the senior person on call out of hours and at weekends.

Complaints records were not made available to the inspectors when requested. Those records that were available did not meet the requirements of Schedule 4 of the regulations.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that whilst there had been some improvements in the centre since the previous inspection in relation to the cleanliness of the premises and infection control the provider had failed to adequately address a number of non-compliances from the previous inspection. In addition the provider had not addressed the known fire safety risks and in discussions with inspectors they did not take responsibility for this failure of governance. As a result inspectors were not assured that there were effective governance and management arrangements in place in the designated centre to drive the improvements required and to ensure compliance with the regulations and standards.

Inspectors were not assured that resources in the designated centre were appropriately managed to ensure the effective delivery of safe and appropriate care in accordance with the centre's statement of purpose. This was evidenced by the ongoing issues in relation to:

- maintaining safe and appropriate staffing levels and staff skill mix,
- the overall maintenance and decor of the building
- the provision of person centred care such as the activities programme.

While there was a management structure in place, the arrangements around some management processes did not clearly identify roles and responsibilities. For example it was not clear to inspectors who was in charge of the centre at any given time as staffing rosters did not set out the hours worked by the management team,

or clearly state the cover arrangements that were in place when managers were absent. For example the effective management of complaints was impacted due to lack of arrangements for cover when key personnel were absent.

Systems were inadequate to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example, the current quality assurance systems focused on key clinical areas which meant that there were gaps in the general oversight arrangements of the service. As a result the improvements required in areas such as fire safety management, staff recruitment processes and complaints which were identified during this inspection had not been previously identified by the provider.

There was a comprehensive range of clinical audits in place however in some important areas the findings were not used to identify clear action plans for improvement. For example on one unit, a nurse had done an audit of care plans and identified the need for improvement however records showed that no actions had been taken to address the issues identified in the audit. Inspectors found that there was no clear management process in place to ensure that the relevant staff were informed about what changes were needed following these audits and how key staff would be supported and supervised to make the required changes in practice. As a result a number of care plans continued to be non-compliant and did not reflect the resident's current needs and preferences for care and support.

There was an annual review completed for 2017 and one was in development for 2018. It covered details on staffing arrangements, overall budget, and quality improvement initiatives. The document had been prepared in consultation with the residents who had been invited to submit their feedback in a satisfaction questionnaire.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1 of the regulations. The statement of purpose had been reviewed in July 2018.

The statement of purpose had not been updated to include the details of the acting Assistant Director of Nursing who is listed as a person participating in management (PPIM) in the centre. In addition the current document did not record the correct number of beds available in Tibradden Unit.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The current management systems in the centre did not ensure that that all complaints were managed in line with the centre's own policies and procedures. It was not clear from the records made available to the inspectors that those complaints received by staff on the units were being recorded and progressed in line with the centre's complaints policy and were being monitored by senior staff in the centre.

Complainants told the inspector that they had not been informed about the outcome of their complaint and that issues often went unresolved. This was verified by information that was received into the Office of the Chief Inspector prior to the inspection.

Inspectors found that the effective management of complaints had been impacted by the failure to provide a clear process for the management of complaints in the absence of the complaints officer.

Judgment: Not compliant

Quality and safety

While some areas of good practice were noted, improvements were required to ensure residents' needs were being met, and to ensure the delivery of care was person centred.

Inspectors found that the provider had failed to progress the actions required from the previous inspection in relation to premises and residents' rights to privacy and dignity in all aspects of their care. Significant improvements were also required in relation to the storage of personal possessions and the opportunities residents had to participate in meaningful activities. These were also outstanding actions required from the previous inspection. In addition serious non-compliance was found in fire safety arrangements in the designated centre, and following the inspection the provider was issued with an immediate action plan to be completed within the dates specified by the Office of the Chief Inspector.

The inspectors found that there was a good standard of evidence-based nursing care in a number of areas such as end of life care planning and the use of psychotropic medication. Residents had access to a range of health and social care professionals to meet their needs. However significant improvements were required to ensure that care was person centred and that care plans were tailored to meet the needs and preferences of individual residents.

The centre took appropriate actions to ensure that residents were safeguarded from

harm. All staff and volunteers working in the centre had Garda vetting in place and most staff had attended mandatory training in relation to the centre's safeguarding procedures. However training records showed that staff who had commenced working in the centre since August 2018 had not attended this mandatory training. Records showed that a recent concern had been appropriately investigated by the person in charge. Residents who spoke with the inspectors said that they felt safe in the centre and if they had any concerns that they were able to talk to a member of staff.

Residents had access to independent advocacy which was organised through the social work team on request. There was an arrangement in place for residents' council meetings but that had not met recently.

There was a comprehensive activities programme in place and inspectors noted that improvements had been made in the range of activities that were on offer for residents. However records showed that further improvements were required to ensure that all residents were able to take part in activities and entertainments in line with their preferences and capacities. This was further evidenced by a number of residents who told inspectors that there were long periods each day where they had nothing to do and that they were often bored.

There was an open visiting policy in the centre and visitors were observed coming and going throughout the day of the inspection. Visitors said that they were made welcome when they visited. However some visitors and residents said that they found it difficult to meet in private.

Accommodation is provided across eight units. Clevis unit has 29 beds and was not inspected during this inspection. The other seven units were inspected. Whilst some improvements had been made since the last inspection, inspectors found that the current premises did not meet the needs of the residents in relation to privacy and dignity, access to communal lounges and quiet spaces. In addition a number of units did not have adequate storage space both for personal possessions and for the range of assistive equipment that residents required to meet their needs.

A review of the fire safety processes was completed as part of the inspection and significant non-compliances were found in relation to fire safety procedures and fire safety equipment. As a result the provider was required to complete a number of immediate actions in relation to fire safety within the timescales specified by the Office of the Chief Inspector.

Regulation 11: Visits

There was an open visiting policy in the designated centre. Visitors were observed coming and going throughout the inspection days. Visitors aid that they were made welcome by staff.

Some units of the centre had no suitable private area in which resident could receive

visitors in private.

Judgment: Substantially compliant

Regulation 12: Personal possessions

The systems in place did not ensure that each resident had access to and could retain control over their personal property. This was an outstanding non-compliance from previous inspections.

Residents in Enniskerry, Tibradden, Kilgobbin and Kiltiernan units had limited space to personalise the space around their beds as they only had one small locker and a slim single wardrobe allocated to them to store personal clothes and belongings such as books, photographs or radios. In some units, residents' clothing was kept in storage areas away from their personal space due to the lack of available storage in their bedspace.

Judgment: Not compliant

Regulation 17: Premises

Inspectors found that the current layout of the multi-occupancy rooms, especially the open bays on the nightingale type units did not ensure that the privacy and dignity of residents could be met at all times. Although curtains and screens were arranged around the resident's bed when care was being given, inspectors found that the interactions between staff and the resident receiving personal care could be clearly heard by the other people in the room. In addition residents who were in bed or sat by their beds during the day were regularly disturbed by other residents and their visitors.

In addition the shower and toilet facilities on three of the Nightingale type units did not provide adequate privacy for residents. The toilet facilities did not have full doors in place and the front walls of the cubicles did not extend from floor to ceiling. The walk in showers in these areas did not have doors but were screened from view by pull out screens which did not give adequate privacy for the residents when using the shower.

Although there were pleasant dining rooms shared between Enniskerry and Kiltiernan and between Tibradden and Kilgobbin there were no communal lounges on these four units. Inspectors observed that residents who wanted to watch television had the choice to remain sitting at the dining tables in the dining rooms or to sit in more comfortable chairs in small seating areas at each end of the

wards. These areas were open and within hearing of other residents in bed on the unit and could be intrusive to those residents who wanted to rest or to sleep.

Residents on these four units could use a range of communal areas across the hospital campus including a concert hall, a chapel, an art room, a library, and a coffee dock. However these facilities were at a distance from the units and could not be readily accessed by residents who were not independently mobile.

In addition on these units the size and layout of a some of the single rooms did not provide adequate space for the safe use of assistive equipment such as hoists.

There were systems in place for routine and other maintenance. However further improvements were required in the general maintenance and upkeep of the premises where doorways, walls and skirting had been damaged and not repaired. In addition a number of areas including those identified as fire escape routes were cluttered with equipment.

Storage facilities were not adequate to store equipment such as hoists, wheelchairs and specialist chairs. As a result these were stored in bathrooms and in the communal areas on the units.

There was a comprehensive range of assistive equipment such as hoists and specialist chairs available for residents. Records showed that equipment was serviced regularly.

Judgment: Not compliant

Regulation 18: Food and nutrition

There was a sufficient supply of food and drink in the centre for residents, including snacks and sandwiches available throughout the day. Residents were offered choice at mealtimes, though the menus on display did not fully reflect the options available to residents.

Each unit had a dining area which was suitable in size and layout for the number of residents. Inspectors observed meals being delivered to the units and served hot and on time during lunch. However on one unit breakfast was served late and there was no appropriate equipment to keep the meals hot. As a result some residents were served porridge, tea and toast that were cold. This was an outstanding action from the previous inspection.

Residents were served their meals with required dietary modifications based on their needs and assessments.

Judgment: Substantially compliant

Regulation 27: Infection control

Significant improvements had been made in relation to infection control processes since the last inspection. Overall the premises were clean including the bathroom and toilet areas.

Personal protective items such as gloves and aprons were available in each unit, and hand washing facilities were available throughout the centre. Staff were seen to follow best practice guidelines in hand washing practices.

Regular audits were taking place to oversee the standards of infection control management in the centre, and there was a lead clinical nurse manager was delegated with the responsibility of overseeing any outbreaks and for training and raising awareness of updates in infection control practices.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire or to ensure that adequate systems were in place to ensure the safe and effective evacuation of residents.

There was no documented process, or Fire Safety Risk Assessment, to identify and manage fire risks in the centre.

- In some locations, the fire extinguisher signage did not correspond with the extinguisher located beneath it which may result in an inappropriate fire extinguisher being used.
- Oxygen supplies were stored along two escape corridors that increases the risk of fire occurring along escape corridors.
- Escape routes were not adequately subdivided which may result in long sections of escape corridors becoming smoke filled and unusable.
- Non fire protected storage presses were located along some bedroom corridors which increases the fire load and risk of fire along escape routes.

The fire detection and alarm systems and emergency lighting systems in the centre were inadequate. It was noted that the fire detection and alarm certification dating back to 29 May 2017 identified that the "Alarm system does not fit category, additional detection required". While the emergency lighting certificates dating back to May 2017 stated that the emergency lighting installation "Does not conform to any standard, Emergency lighting inadequate throughout the site, recommend complete survey and upgrade". The provider was unable to provide a date by which the systems would be updated to the required standard.

Adequate arrangements had not been made for maintaining all fire equipment, a report dated 11 December 2018, issued following the inspection of the fire extinguishers installed throughout the centre, stated "This site does not comply with I.S. 291:2015" and scheduled repair, upgrade or replacement works for 106 fire extinguishers with works including the replacement of some fire extinguishers that were more than 10 years old.

A procedure was described to inspectors whereby a regular review of fire precautions was to be carried out by external consultants; however, the last documented report available for inspection was dated 6 February 2017.

Inspectors were not assured that persons working in the centre were adequately prepared for the procedure to be followed in the case of fire and for the safe and timely evacuation of residents.

- Some staff spoken with were unclear of the appropriate resident evacuation procedures to be followed during an evacuation of the premises.
- Some staff had never participated in a simulated compartment evacuation drill.
- No evacuation drill records were available to provide assurances of the adequacy of the evacuation plan for the largest compartments in the centre, or for the evacuation of the 11 bedded rooms in each of the Enniskerry, Kilternan, Kilgobbin and Tibradden units.
- While it was acknowledged that further assistance could be provided by staff from other parts of the centre if evacuation of a unit was required, Inspectors were not assured that the night time staffing levels within each unit were adequate to ensure the safety of residents.

Inspectors were not assured of the likely fire performance of all door sets (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery). Most doors intended to perform as fire doors were not fitted with plates or tags confirming their fire performance. It was observed that in some cases store room doors were not closing properly and some doors along escape routes were held open with hooks, while other doors along escape routes had no door closers fitted at all.

Inspectors were not assured that adequate arrangements had been made for the safe placement of residents or for their evacuation.

- Some of the Personal Emergency Evacuation Plans (PEEPS) were found to be inconsistent between the residents assessed evacuation needs recorded in the electronic care system, the evacuation methodology sheets on the ends of beds and the understanding of staff of the evacuation procedures to be followed.
- It was observed that some residents were not located where their evacuation may be most easily conducted.
- It was unclear if some beds would fit through the doors of bedrooms from which Bed Evacuation was proposed.

The procedures to be followed in the event of fire have not been prominently displayed in the designated centre.

- The fire procedures on display in the centre were out of date, and described procedures, such as the use of walkie talkie \ radios, that are no longer used during evacuation.
- Zone floor plans were not displayed next to the fire alarm panel.
- A floor plan showing the location of break glass units was left on the window cill of a store room in the Enniskerry unit.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Prior to admission residents were assessed to ensure their needs could be met in the centre. On admission a more detailed assessment was completed setting out the residents health and social care needs in to care plan documents. The assessment was completed by the social worker and assistant director of nursing to assess both health and social care needs.

Inspectors found that significant improvements were required in the care plans to ensure that they were person centred and reflected each resident's individual needs and preferences for care and daily routines. Generic phrases were often used such as 'take action to reduce constipation' and 'identify and reinforce coping strategies resident has used in the past' without stating what the action would be for each individual those cases.

There were also gaps in care plans where secondary problems may need to be managed, for example stoma care. Care plans did not set out what to do if there was a change in the wound, or the stoma did not function and required attention.

The lack of clarity in care plans meant that agency staff were reliant on the regular staff to inform them verbally about each residents care needs. This increased the workload for the regular staff and created the risk that agency or new staff did not have the correct information to care for the residents.

While care plans were not sufficiently clear to guide staff, those staff who spoke with inspectors did know the residents needs well and were able to verbalise the residents current needs, their preferences for care and daily routines and what self care abilities the resident did have. Staff were seen to support resident appropriately, for example when residents became anxious or upset.

Overall residents and families said that they were well looked after and that they felt well supported by the established nursing and care staff on the units. Residents told

the inspectors that they were kind and caring. Inspectors observed that staff interactions with the residents were marked by genuine empathy and respect. However some residents told the inspectors that when staff were busy they may have to wait for their care needs to be met which they found difficult, for example in relation to toileting needs. In addition residents and family members commented on the high use of agency staff who did not know the residents and told the inspectors that this had a negative impact on the resident's care.

Records showed that care plans were reviewed regularly and that the resident and their families were involved in the reviews. There was a good use of multidisciplinary team input to the review process.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

There was a policy in place that set out the process to be followed in identifying and managing responsive behaviours of residents. While the policy was clear and provided guidance in line with good practice recommendations, it was not being followed in practice.

Care plans and other records for residents who had been identified as having responsive behaviours or behavioural and psychological symptoms of dementia (BPSD) did not set out the detail of how they may respond in different situations, what may trigger them to become anxious or upset, or how to respond and de-escalate a situation. The records available on the day of inspection were similar for each resident, showing a lack of a person-centred approach.

While the records did not give clear information and would not guide practice, established staff were able to provide clear details of residents needs and how they would be met. This knowledge extended in to when PRN (as required) medication would be given, however instructions in care plans and in the medication records were not specific and would not support a consistent approach. While records did not give clear direction, the use of PRN medication was low and was being closely monitored in the centre.

Where restrictive practices were used in the centre, for example bed rails, or lap belts on wheelchairs, they were used in line with best practice guideline. There was a interdisciplinary team who reviewed any requests, and then reviewed the use on a regular basis to ensure it remained appropriate for the resident. Alternative measures were being trialled prior to any restrictions being used, and a number of residents were seen to be using things such as low beds or soft mats by beds. There was also a register of all restrictions being used in the centre, and this was used to audit practice in the centre.

Judgment: Substantially compliant

Regulation 8: Protection

There were reasonable measures in the centre to protect residents from abuse.

There was a clear policy in the centre setting out the procedure to follow where safeguarding concerns were raised. Staff spoken with were clear of their responsibilities to ensure the resident was protected, and also of the requirements to report to management. They were able to describe the signs of abuse to be vigilant for, and the ways they may become aware of concerns, for example by witnessing an incident, having it reported to them, or by residents disclosing to them. There was a social worker working full time in the centre who worked with the person in charge to ensure initial stages of the policy were followed in relation to reporting the concern to other agencies and reviewing the steps taken to safeguard residents.

Staff training required improvement to ensure all staff had received appropriate training, this is set out under Regulation 16.

Judgment: Compliant

Regulation 9: Residents' rights

While there were arrangements in place to ensure that residents' rights were respected significant improvements were still required. Inspectors found that the actions from previous inspections in relation to resident's privacy and dignity and the provision of meaningful activities had not been adequately addressed by the provider.

Residents were supported to practice their religion as they chose. There were services provided in the centre for different faiths, and clergy were available for residents who wanted to meet with them.

Residents' communication needs were addressed in their care plans and provided key information in relation to the residents' sight and hearing including any aids they required. Care plans needed to improve in order to provide sufficient information about the resident's ability to understand information and whether the resident was able to communicate to make their wishes known.

Residents had access to an advocacy service and information about services was displayed around the building. The social worker was also able to support access to these services.

There was a residents' council in place however records showed that the council meetings had not been held quarterly in line with the centre's statement of purpose. In addition it was not clear how the minutes of these meetings were circulated to those residents who were unable to attend the meetings and therefore how these residents were able to participate in the process.

The resident experience questionnaire had been circulated to residents in 2018 and the results were collated in to a report. The report set out areas for improvement including residents rights, food and mealtimes, activities and care and support. The questionnaires were completed between January and February 2018 but no action plan was available during this inspection to evidence the progress being made to implement the improvements identified as being required.

There was access to televisions, radios, CDs, and newspapers. While some residents had access to televisions in bedrooms, others said the location of the television in the room meant that it was difficult to watch in comfort. In some of the multi-occupancy rooms residents said that due to the space available and the layout of the room they were often interrupted by the sound of others watching television or listening to radios .

Cordless phones were available for residents to make personal calls, and others had their own mobile phones.

Visitors were seen to be in the centre during both days of the inspection, and reported the arrangements for visiting were flexible and that they were made welcome by staff.

A number of improvements had been made to the the activities programme since the last inspection. Inspectors observed residents mobilisng around the campus to attend activities over the two days of the inspection. On the first evening of the inspection there was a social gathering in the day hospital which some residents attended with their families alongside members of the local community. The revised program also included activities such as art, quizzes, movement to music, flower arranging, and baking. Residents were supported by staff to attend the sessions they enjoyed however inspectors noted that a number of residents did not participate in any activities during the two days of the inspection. Some residents who spoke with the inspectors said they did not have enough to do during the day and that they would like the opportunity to participate in those activities that they had enjoyed before moving to the centre, for example; gardening, shopping and going out into the local community. In addition inspectors noted that arrangements in place to provide meaningful occupation to those residents who had higher levels of cognitive impairment and were not able to participate independently were not adequate.

Although some improvements had been made following previous inspections the inspectors found that the size and layout of some of the multi-occupancy rooms did not ensure that the privacy and dignity of residents could be maintained. For example in the large units where up to 11 residents were accommodated in an open plan area, screening and the lack of space between residents' beds meant that when

residents were receiving personal care the interactions between staff and residents, including intimate conversations about care, could be heard by other residents, staff and visitors in the area. Where three residents were accommodated close together in the bay areas on the nightingale type units staff were unable to provide person centred care in a way that respected the resident's privacy and dignity. For example where one of the residents needed to use assistive equipment such a hoist staff were not able to adequately uphold the resident's privacy and dignity despite the careful use of bed screens and additional mobile screens.

Inspectors also noted that the arrangements for storing personal clothes and items in some four bedded rooms rooms meant that the wardrobes for two residents were placed within the screened bedroom area of the other two residents. This meant that residents or staff would need to access the other resident's personal space to reach their belongings.

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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Leopardstown Park Hospital OSV-0000667

Inspection ID: MON-0025588

Date of inspection: 17/01/2019

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:
This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations.

Staffing is a key element of service delivery to our residents. In order to ensure compliance with the regulations the Hospital has taken a number of specific measures detailed below to ensure this key matter is addressed in a comprehensive manner and that effective systems are in place to in order to provide effective governance over staffing and ensure that there is a coherent approach to staffing levels, and management of absence, including short term and vacancy related.

1. The Hospital has a designed roster which designates the staff skill mix required to meet the care needs of residents. Dependency levels are kept under ongoing review - In place 27/2/19
2. In assessing potential new residents, consideration is taken to the care needs of the new resident and also the care needs of the rest of residents in the Hospital/unit. This is to ensure that the staff skill mix and number are in a position to manage the care needs of all residents. In place 27/2/19
3. CNMs have responsibility for the rostering of staff to ensure safe levels of staffing and balance leave requirements. In place 27/2/19
4. Director of Nursing (DON)/Assistant Director of Nursing (ADON) have oversight of staffing levels on a daily basis and support CNMs in management of same: In place 27/2/19
5. Staffing levels in place allow for planned absence without recourse to agency staffing, yet allowing for safe care to residents - In place 27/2/19.
6. In event staffing levels on a specific day drop below safe staffing levels escalation protocol detailed below is deployed. In place 27/2/19
7. Escalation protocol in place in event that planned and unplanned leave occurrences results in a drop in anticipated minimum staff staffing levels on a particular unit. This requires identification of staff redeployment either from staff on duty or staff off duty in

first instance. In event that above not possible, agency backfill is requested. Fill rates for agency now (w/c 11th March 2019 reaching 81% for HCAs and 94% for nursing). Many of the agency staff are familiar with the Hospital. In event that not possible to source agency staff, CNMs provide direct clinical care as part of their role and supporting direct supervision of staff. In place: 27/2/19.
8. Additional electronic reports to further assist in monitoring agency usage provided to DON/ADON, HR Manager, CEO and CFO by email from 19/2/19. Reliance on agency has been dropping incrementally and in particular significant improvements have been delivered since the start of February 2019.
9. Recruitment: - --
- Additional staff to fill vacancies is ongoing and 4 additional staff nurses have been commenced work since the start of 2019.
- Additional recruitment in progress: 5 carers will be commencing work within next month – All in place on or before 19th April 2019.
- 4 nurses are in the recruitment process and, subject to being deemed suitable at interview and required employment checks, they will be appointed on or before 19th June 2019.
10. Relief Panel: The Hospital has advertised for a relief panel that will allow for Hospital directly employed staff to provide cover instead of agency in event of requirement. This will facilitate provision at short notice of cover from directly employed staff and reduce further requirement for agency usage. Recruitment process in train and anticipate commencing appointments in early summer, subject to required employment checks following suitability determined at interview. A full comprehensive panel in place by 30/10/2019. Please note that staff will be employed and operational in advance of this date but this is date anticipated that panel will be fully in place.
11. There is always a designated senior experienced member of nursing staff, with many years of relevant experience, is designated to be the nurse in charge at all times, 24/7. They have the additional support of the Person in Charge, Assistant Director of Nursing and Chief Executive as required: In place 27/2/19
12. DON/ADON have reinforced with CNMs the requirement to have at least one staff member in the general area of the unit while dining room is in operation at CNM meetings and also raised at catering and nutrition meetings. Further reinforcement during DON/ADON walkarounds: In place: 22/3/19

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Staff training and development is a key priority for the Hospital.
1. There is a comprehensive suite of both mandatory and additional training in place for staff. In order to ensure visibility on mandatory training requirements the Hospital has in place a training matrix which is updated post training dates. In place 27/2/19.
2. The Hospital trains its own staff to provide mandatory training across many areas. A

review by the Hospital had taken place on 15th January in advance of the January inspection which had identified additional capacity requirements in a number of training areas for 2019 and plans are in train to provide additional trainers to ensure consistency and resilience in the provision of training. Training of additional internal trainers for CPR & Moving & Handling is in progress and will be completed and fully deployed on or before August 31st 2019.
3. New care and nursing staff are all coming from other organisations and have been trained previously in mandatory training elements. The provider aims to complete all mandatory training within at the earliest but within 4 months of commencement of employment. This will be in place by 16th May 2019, with the exception of M&H and CPR, where additional trainers are undergoing training. Target 30/9/19 for full deployment of new trainers
4. In order to provide additional governance over mandatory training this will be a standing item on monthly CNM meetings and quarterly agenda item on senior management team agenda, regular agenda items on weekly management operational circles. Target commencement date: CNM meetings – 15/4/19, SMT- 12/3/19, Weekly circles – 25/3/19
5. In order to provide for staff supervision each unit has 2 nurse managers who have responsibility for both staff supervision and performance management. The role of management and supervision of staff, including the oversight of care planning process has been discussed with nurse managers and role reinforced along with different forms of supervision including side by side working with direct clinical care. In place 27 2 19 (and ongoing)
6. The ADO/PPIM has been providing additional support to Clinical Nurse Managers (CNMs) in relation to aspects of their roles while vacancy rates were higher, facilitating CNMs to focus on care planning and other supervisory duties – In place 27/2/19 and requirement to be kept under review.
7. The Quality and Patient Safety Manager has provided additional one to one sessions with the Unit CNMs in relation to assessments and care planning, particularly in the context that the Hospital introduced a new electronic record system in Quarter 4 2018. Complete 27/2/19 and ongoing
8. Additional support from the Director and Assistant Director of Nursing has also been provided. Complete 27/2/19 and ongoing
9. Care plans have been reviewed and additional detail, where necessary, provided to fully reflect the knowledge the staff have of the resident and to provide additional clarity. Care plans updated - 14/3/19 and ongoing.
10. Audits will continue be carried out regularly and feedback provided to DON/ADON and CNMs for follow up and closing the loop as necessary. In place 27/2/19 and ongoing

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. Schedule 2 records are kept securely in Human Resources. While the Schedule 2 aspect referred to (career history gaps) is recorded as part of interview process

currently, in order to improve the visibility of any career history gaps following feedback from the Authority, HR has implemented an enhanced process including guidance on CVs for applicants and additional specific documentation at interview stage which will be retained on the employee's personnel file. Commencement: 27/2/19 for all new applicants for positions
2. Staff were previously notified on an exception basis as to when senior staff were on leave and not available. Specific phone numbers including speed dials were and are available to all staff. Following feedback from the Authority the roster for the DON/PIC, ADON/PPIM and senior contact out of hours is now being provided weekly by email - In place 27/2/19
3. Due to the unscheduled leave of complaints officer, with regret, the full complaint file records were not available to the inspectors during inspection and limited the Hospital's ability to supply the inspectorate with the detail requested. We can assure the Authority that this absence in no way lessened the Hospital's response to received complaints. Arrangements have now been made to access the complaints records in the event of an inspection. In place 27/2/19

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations.

Significant management and governance systems are in place to ensure effective delivery of safe and appropriate care. In addition to existing arrangements the following additional systems have been introduced or enhanced as part of the action plan:
1. A staffing/recruitment strategy has been developed which clearly identifies the systems and approaches the Hospital is taking to address staffing issues within a very competitive recruitment environment – submitted to the Authority 24/1/19. The work associated with same which was ongoing has resulted in the following:
- Recruitment of additional staff to fill vacancies is ongoing
- 4 additional staff nurses have commenced since the start of 2019 up to 25/3/19
- Additional recruitment in progress: 5 carers will be commencing work within next month – All in place on or before 19/4/19.
- 4 nurses are in the recruitment process and, subject to being deemed suitable at interview and required employment checks, they will be appointed on or before 19/6/19
- The Hospital has advertised for a relief panel that will allow for Hospital directly employed staff to provide cover instead of agency in event of requirement. Recruitment process in train and anticipate commencing appointments in early summer, subject to required employment checks following suitability determined at interview. A full

comprehensive panel in place by 30/10/2019.
- Escalation protocol in place in event that planned and unplanned leave occurrences result in anticipated minimum staff staffing levels. This requires identification of staff redeployment either from staff on duty or staff off duty in first instance to ensure staff familiar with the Hospital. In event that above not possible, agency backfill is requested. Many of the agency staff are familiar with the Hospital. In event that not possible to source agency staff, CNMs provide direct clinical care as part of their role and supporting direct supervision of staff. In place: 27/2/19.
2. Additional electronic reports to further assist in monitoring agency usage provided to DON/ADON, HR Manager, CEO and CFO by email from 19/2/19. Reliance on agency has been dropping incrementally and in particular significant improvements have been delivered since the start of February 2019. In place 19/2/19
3. Director of Nursing/Assistant Director of Nursing have oversight of staffing levels on a daily basis and support CNMs in management of same: In place 27/2/19
4. Maintenance and décor: Full repainting of the Glens Units is completed and at snagging stage. Completion date 20/4/19.
5. A maintenance ticketing system is in place and staff have been reminded to utilise same in order to ensure prompt resolution of maintenance issues. Reinforcement complete - 27/2/19 and ongoing.
6. The effectiveness and utilisation of the maintenance ticketing system will be kept under review by the Health & Safety Committee. In addition weekly management operational circles and Senior Management Team provide opportunity for escalation of key matters. Commenced 14/3/19.
7. There are a wide range of activities available to residents. Meetings are held regularly with nursing, residents service and occupational therapy to keep under review activity provision to ensure ongoing governance and review of activities in place.
8. Residents forum will have as a standing item 'activities'. In place - 22/3/19 and ongoing.
9. To enhance clarity for all staff the staffing roster for the designated person in charge at any given time is now being circulated to the Hospital weekly. This includes the person in charge 'on the house' as well as the roster for the DON/PIC and ADON/PPIM - Commenced 25/1/19 and ongoing. The existing arrangements of designated phones and speed dials so that staff have clear contact details remains in place and ongoing
10. Access to complaints records in absence of the complaints officer has been resolved and clarification of cover in absence of complaints officer has taken place -In place 27/2/19
11. Additional documentation has been introduced in HR to facilitate clear demonstration of compliance – Commenced for new entrants 27/2/19 and ongoing
12. Additional care plan training along with clarification of roles/responsibilities of nurse managers has been carried out 27/2/19 and ongoing
13. DON/ADON have instituted ward management meetings with individual ward managers to close the loop in relation to unit specific areas for improvement - Commenced by 27/2/19 and ongoing

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of Purpose will be updated and submitted to the Authority on or before 29/3/19

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Due to the unavailability of records for the inspection, due to the leave of complaints officer, the Hospital was unable to demonstrate its compliance with own policy and procedures. However complaints are managed in line with the current policy. To further enhance the process the following action plan has been put in place:

1. While the PIC in practice was carrying out the role designated under 34 (3), policy to be updated to add in the role of PIC in oversight of the process and role in absence of the complaints officer: Policy completion date on or before 1/4/19 to allow for internal approval processes.
2. Introduction of option to utilise complaints/concerns section on Electronic Resident Record to record local complaints/concerns with closure of these only to be authorised by DON, ADON or Complaints Officer. Option in place - 27/2/19
3. Policy does clearly state the process in the absence of the Complaints officer. This is being updated in line with 1. above to align with the PIC/DON role in oversight of the complaints process. Policy completion date on or before 1/4/19 to allow for internal approval processes
4. Any unresolved complaints at local level are referred to complaints officer and any unresolved complaints at complaints officer are referred to HSE or Ombudsman in line with policy. The Hospital has currently 1 complaint escalated to the complaints officer for review which is in progress. Over past 4 years a very small number of complaints have been escalated by complainants to HSE or Ombudsman. No adverse findings have been found against the Hospital in the last number of years following external review. Action: To continue to apply complaints policy and ensure that signage within the Hospital is visible to residents, families etc. In place 27/2/19
5. Arrangements have been made to ensure that complaints records are available for future inspections – In place 27/2/19

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits: This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations. Action Plan: To create additional private visitor area in Kilgobbin/Tibradden Unit by reconfiguring existing rooms. Completion date 24/3/19	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations. t has been identified that the smaller wardrobes in Tibradden/Kilgobbin & Enniskerry/Kiltiernan can be reconfigured to provide additional storage of personal possessions. Works have commenced and some of Kilgobbin have been reconfigured. Full reconfiguration to be completed on or before 12/8/19. 2. Where different season (eg summer clothes during winter) clothing not required this is able to be stored safely within the unit. – Complete 27/2/19	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations. 1. The Hospital is currently carrying out a capital redevelopment project that will deliver 125 beds capacity, purpose built fully compliant accommodation for 125 residents on a green field site onsite. The design team tender evaluations are complete and, following required processes under public procurement, these contracts will be issued and formal design will commence taking into consideration the relevant regulations and best practice	

for a development of this type. Target date: 1/1/2020.
2. In the interim the following actions will be put in place:
- Upgrade of toilet/shower room facilities in Tibradden/Kilgobbin & Enniskerry/Kiltiernan: To be completed on or before 15/7/19
- An additional resident/visitor room provided on Kilgobbin/Tibradden Unit : Complete 24/3 19
- For future new admissions certain specified single rooms will, due to space requirements, not cater for more heavily hoist dependent residents. This will be considered at pre assessment stage of admission– In place for all new admissions effective from 27/2/19.
- In consultation with residents one resident has changed room. Completed by 11/3/19
- One other resident & their family are considering a change in location. Decision to be made on or before 22/4/19.
- A maintenance ticketing system is in place and staff have been reminded to utilise same in order to ensure prompt resolution of maintenance issues. Complete 27/2/19 and ongoing.
- Staff have been reminded to utilise existing designated storage areas effectively - complete 27/2/19 and ongoing.
- Additional areas for storage has been identified within Tibradden/Kilgobbin –converted additional store for hoists – Complete 22/3/19.
- Options for additional storage area being scoped in Enniskerry/Kilgobbin. If viable to be completed on or before 22/8/19.
- Ongoing focus on decluttering. In place 27/2/19 and ongoing

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations.

Food and nutrition are a key consideration for all residents. The following is action plan in relation to inspection findings:
1.Catering Managers identified the use a hot trolley for transporting the porridge, which is to be left in the trolley until staff ready to start breakfast. Staff have been reminded not to remove lid from the porridge container until ready to use and to replace lid each time they give a bowl of porridge to help maintain temperature control. The new procedure been reviewed and observed, including temperature probing in unit to ensure temperature control was maintained. Complete 27/2/19 and ongoing

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations.

Fire safety is a key priority for the Hospital and the Hospital has proactively identified areas of improvement and is working to address these while continuing to manage fire safety including maintenance of fire safety systems, fire training, fire drills, fire evacuation drills, fire alarm testing and training of staff. Action plan is as follows:

1. Fire safety risk assessment completed and submitted to the Authority - 15/2/19
2. All priority A items identified on fire risk assessment completed by 15/3/19 with exception of 2 elements which had a contractor lead in time. These will be completed on or before 12/4/19.
3. All priority B items identified on fire risk assessment are being tendered. A detailed invitation to tender document to specialist contractors will be issued on or before 25/3/19. Until appointment of a contractor the specific timelines for delivery/schedule of these works cannot be finalised. In order to provide a specific date to the Authority at this time it is proposed that the totality of the works would be completed by the latest by 30/9/19. Clearly as this is a programme of works various aspects of the works would be completed well in advance of this date. Until a contractor is appointed the specific schedule cannot be finalised
4. All fire extinguisher signage has been updated, where required. Complete 15/3/19
5. Removal of oxygen cylinders along escape routes – complete 21/1/19
6. Fire risk assessment has included a review of any requirement for further subdivision. Assessment completed 15/2/19
7. All hooks have been removed from escape routes – Complete 24/1/19
8. Static non fire protected storage presses have been removed from escape corridor. Built-in press has been decommissioned and locked shut. Completed - 27/1/19
9. Fire alarm upgrade of all bed room areas (Priority A) completed to current L1 standard in all bedroom areas. Completed 15/3/19
10. All fire extinguishers are in compliance with IS 291:2015. Complete 18/2/19
11. Personal Emergency Evacuation Plans (PEEPs) have been fully reviewed and staff had attention drawn to same at each shift change – Complete 15/3/19.
12. It has been confirmed that where bed evacuation was the identified evacuation method, bed can be evacuated along both primary and alternative evacuation route. Complete - 28/1/19
13. Additional evacuation drills completed, including night simulated evacuations (12/3/19 & 25/1/19) have been carried out to complement existing fire training where evacuation training is a core component of the training.
14. Night staffing levels have been confirmed as sufficient to allow for safe evacuation of residents from a compartment as demonstrated by the fire evacuation drills. Complete –

12/3/19
15. Fire procedures have been reviewed and where required updated in fire notices – Complete 15/3/19.
16. Fire policy updated and referred to external expert for review/input prior to final approval. To be completed on or before 30/4/19

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations.

1. Quality and Patient Safety Manager has provided additional one to one sessions with the Unit CNMs in relation to assessments and care planning so that they reflect the knowledge of the staff of the resident in a comprehensive manner. Complete 27/2/19 and ongoing support
2. Additional support from the Director and Assistant Director of Nursing has also been provided. Complete 27/2/19 and ongoing
3. Care plans have been reviewed and additional detail, where necessary, provided to fully reflect the knowledge the staff have of the resident and to provide additional clarity. Completed 27/2/19 and ongoing

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations.

1. Quality and Patient Safety Manager has provided additional one to one sessions with the Unit CNMs in relation to assessments and care planning so that they reflect the knowledge of the staff of the resident in a comprehensive manner. Complete 27/2/19 and ongoing support
2. Additional support from the Director and Assistant Director of Nursing has also been provided. Complete 27/2/19 and ongoing
3. Care plans have been reviewed and additional detail, where necessary, provided to fully reflect the knowledge the staff have of the resident and to provide additional clarity. Completed 27/2/19 and ongoing

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations.

1. Quality and Patient Safety Manager has provided additional one to one sessions with the Unit CNMs in relation to assessments and care planning so that they reflect the knowledge of the staff of the resident in a comprehensive manner. Complete 27/2/19 and ongoing support
2. Additional support from the Director and Assistant Director of Nursing has also been provided. Complete 27/2/19 and ongoing
3. Care plans have been reviewed and additional detail, where necessary, provided to fully reflect the knowledge the staff have of the resident and to provide additional clarity. Completed 27/2/19 and ongoing
4. A review of circulation of the minutes of the residents' forum has taken place and new procedure instituted which will result in all residents receiving an individual copy of the minutes following all future meetings. Forum will be held at a frequency in line with the statement of purpose. Completion date 29/4/19
5. There are a wide range of activities available to residents.
- Meetings are held regularly with nursing, residents services and occupational therapy to keep under review activity provision. Additional meeting held to review. Completed by 8/3/19 and ongoing
- Activities to be placed as standing item at all resident fora. In place 22/3/19
- Activities do include gardening (including a 'vegetable patch') which is facilitated by the grounds staff and is popular, however as the inspection took place in January unfortunately there was limited opportunity at this time of the year but as the growing season approaches this will commence again. To be recommenced/completed on or before 20/5/19.
- Families are encouraged to engage with their relative and facilitate and accompany on outings such as shopping. In the event that resident does not have family members

engaged with them, the Hospital makes arrangements for shopping on an individual as requested/need identified basis – Complete 27/2/19 and ongoing. The Hospital works with residents in relation to their interests on an ongoing basis but must respect resident's wishes when they do not wish to partake in specific activities.
- The Hospital does cater for some residents with significant cognitive impairment and we continue to look to find connection and meaningful occupation for individuals taking into consideration their physical and cognitive status. This can be as simple as specific music or reminiscence boards that have been developed in areas. Review of ideas for this cohort will be completed by 31/6/19.
6. The Hospital is currently carrying out a capital redevelopment project that will deliver 125 beds capacity purpose built fully compliant accommodation for 125 residents on a green field site onsite. The design team tender evaluations are complete and following required processes under public procurement these contracts will be issued and formal design will commence taking into consideration the relevant regulations and best practice for a development of this type. Enhanced privacy and dignity will be provided with the full replacement of the units with purpose built modern accommodation. This is currently in the design phase of the project and specific consideration to this regulation will be incorporated into the design of the new building. Target date: 1/1/2020.
7. Electronic access in place in library for all residents, and in some specific units, but to further enhance currently procuring final phase roll out of wifi to all units to enable digital access for all residents across the Hospital. Target completion of installation: 31st July 2019
8. Resident experience surveys have resulted in the improvement in activities schedule. Menu reviews carried out during the year were followed up by the Catering and Nutrition Group. Tracking of recommendations is in place and kept under review by Catering and Nutrition Group. Complete 24/2/19 and ongoing

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 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	24/03/2019
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	Substantially Compliant	Yellow	12/08/2019

	finances and, in particular, that a resident uses and retains control over his or her clothes.			
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 adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	27/02/2019
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	30/10/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/08/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	14/03/2019

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	15/07/2019
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	22/08/2019
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	27/02/2019
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	Yellow	22/03/2019
Regulation 21(1)	The registered provider shall	Not Compliant	Orange	27/02/2019

	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.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	27/02/2019
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	30/10/2019
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	30/10/2019
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Not Compliant	Orange	30/10/2019

	appropriate, consistent and effectively monitored.			
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.	Not Compliant	Orange	30/09/2019
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2019
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.	Not Compliant	Orange	30/09/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/04/2019
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre	Not Compliant	Orange	12/03/2019

	and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2019
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	30/09/2019
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	15/03/2019
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	15/03/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated	Substantially Compliant	Yellow	29/03/2019

	centre concerned and containing the information set out in Schedule 1.			
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	01/04/2019
Regulation 34(1)(f)	The registered 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.	Not Compliant	Orange	01/04/2019
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform	Not Compliant	Orange	01/04/2019

	the complainant promptly of the outcome of their complaint and details of the appeals process.			
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 for improvement in response to a complaint.	Not Compliant	Orange	01/04/2019
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.	Not Compliant	Orange	01/04/2019
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre	Not Compliant	Yellow	01/04/2019

	to ensure that all complaints are appropriately responded to.			
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).	Substantially Compliant	Yellow	01/04/2019
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	27/02/2019
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	27/02/2019
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and	Substantially Compliant	Yellow	27/02/2019

	skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/06/2019
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/06/2019
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	30/06/2019
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	Yellow	30/06/2019
Regulation 9(3)(c)(i)	A registered provider shall, in so far as is reasonably practical, ensure that a resident information about	Substantially Compliant	Yellow	30/06/2019

	current affairs and local matters.			
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident radio, television, newspapers and other media.	Substantially Compliant	Yellow	30/06/2019
Regulation 9(3)(c)(iv)	A registered provider shall, in so far as is reasonably practical, ensure that a resident voluntary groups, community resources and events.	Substantially Compliant	Yellow	30/06/2019
Regulation 9(4)	The person in charge shall make staff aware of the matters referred to in paragraph (1) as respects each resident in a designated centre.	Substantially Compliant	Yellow	30/06/2019