Health Information and Quality Authority
Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Camillus Community Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000640</td>
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<tr>
<td>Centre address:</td>
<td>Shelbourne Road, Limerick.</td>
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<tr>
<td>Telephone number:</td>
<td>061 326 677</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:mary.marks@hse.ie">mary.marks@hse.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Lead inspector:</td>
<td>Mairead Harrington</td>
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<tr>
<td>Support inspector(s):</td>
<td>Caroline Connelly</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>72</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>10</td>
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About Dementia Care Thematic Inspections

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: 27 September 2017 10:30
       27 September 2017 19:00
       28 September 2017 09:00
       28 September 2017 16:30

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

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<th>Our Judgment</th>
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<td>Substantially Compliant</td>
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<td>Outcome 02: Safeguarding and Safety</td>
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<td>Compliant</td>
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Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection that focused on six specific outcomes relevant to dementia care. The purpose of the inspection was to focus on the care and quality of life for residents with dementia living in the centre. As part of the thematic inspection process, providers were invited to attend information seminars provided by HIQA. In addition, evidence-based guidance was developed to guide providers on best practice in dementia care and the inspection process. The provider had submitted a completed self-assessment on dementia care, along with relevant policies and procedures, prior to the inspection.

The inspection was unannounced and took place over two days. As part of the process the inspectors met with residents, relatives and visitors, members of staff and management. Staff were observed in the conduct of their daily duties and the
inspectors discussed with them their understanding of the needs of residents. The inspectors also met with the assistant directors of nursing, clinical nurse managers and members of senior management. Throughout the inspection both staff and management were responsive in providing information as requested. The inspectors observed effective and appropriate communication and interaction between staff and residents at all times.

Approximately 25 of the 72 residents in the centre at the time of inspection had either a confirmed diagnosis of dementia, or were presenting with the symptoms of cognitive impairment. The service did not have a specific residential dementia unit and resident care was integrated throughout the centre. The inspectors were satisfied that the centre was well supported by the services of both medical and allied healthcare professionals. The inspectors reviewed a sample of care plans of residents with dementia and the related processes around assessment, referral and the monitoring of care. Relevant documentation such as policies, medical records and staff files were also reviewed. The inspectors observed care practices and interactions between staff and residents during the inspection that included the use of a standardised observation recording tool. Overall, the wellbeing and welfare of residents was found to be maintained by a high standard of evidence-based nursing care, with appropriate access as necessary to medical and allied health care.

The centre was operated by the Health Service Executive (HSE). Care was directed through the person in charge supported on a daily basis by two assistant directors of nursing (ADONs) and a team of clinical nurse managers. The centre management reported to a nominated representative of the service organisation. The provider had submitted a completed self-assessment on dementia care, along with relevant policies and procedures, prior to the inspection. The self-assessment compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People 2016. The self-assessments are referenced in the respective outcomes of the inspection.

The centre was last inspected on 13 December 2016 and a copy of that report is available on www.hiqa.ie. As identified previously the design and layout of the premises did not adequately meet the needs of all residents, and the premises was not compliant with regulatory requirements in relation to the provision of adequate storage and facilities. Personal accommodation did not meet the needs of all residents in providing adequate privacy for the conduct of personal activities and communication. Areas for improvement that had been identified during the previous inspection had not been fully addressed. These issues are further detailed in the relevant outcomes of the report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, assessment and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

Based on observations, feedback and a review of documentation and systems, inspectors were satisfied that there were suitable arrangements in place to meet the health and nursing needs of residents. These arrangements included the necessary provisions to meet the needs of residents with dementia or a cognitive impairment. A sample of care plans for residents with a cognitive impairment or diagnosis of dementia was tracked during the inspection. Care plans were maintained in hard copy format on two wards and an electronic system was in operation on Shannon ward. Inspectors found that, overall, timely and comprehensive assessments were carried out and appropriate care plans were developed in line with the changing needs of residents. There was no dementia specific unit in the centre and care for residents with dementia or a cognitive impairment was integrated throughout the service. An admissions policy was in place and pre-admission assessments were undertaken by an appropriately qualified person. Residents underwent a further full assessment within 48 hours of admission. Care plans were developed in line with these admission assessments and included relevant information about the residents’ health, medication and communication needs. Nursing and care staff had access to hard-copy resident care plans as appropriate.

The centre provided effective access to relevant services including a medical officer, pharmacist and allied healthcare professionals, such as a speech and language therapist, dietitian and physiotherapist. A care plan audit took place to monitor and review assessments and included a section for recording specific issues to be addressed, and any corrective or preventative action to be implemented. The care planning process utilised a range of validated tools to assess residents in relation to risk of falls, nutritional status, level of cognitive impairment and skin integrity, for example. The care plans reviewed contained relevant information to guide staff in their delivery of care, and were updated routinely on a four monthly basis or to reflect the residents’ changing
care needs. Regular referrals for dentistry took place as necessary. Residents were provided with access to optical services also. Correspondence relating to hospital transfer arrangements was in place on the files reviewed. Consultancy services in gerontology were available on referral and the services of the community mental health team were also accessible as necessary.

Nursing notes accurately reflected the circumstances of resident care. Moving and handling charts were in place. Mobility care plans recorded the number of staff required to provide assistance, and any specialist equipment required, such as a hoist. Wound management plans of care were in place that included photographic monitoring. Consent forms had been completed as required. Nursing staff were able to describe the individual circumstances of residents with wound care plans in place, and also any arrangements for managing pain. The centre also had access to the services of a tissue viability nurse.

The inspectors met with the regional manager responsible for catering and reviewed systems around communication and consultation with residents. Residents were seen to be provided with a regular choice of freshly prepared food. Menu options were available and residents on a modified diet had the same choice of meals as other residents with appropriate consideration given to the presentation of these meals. Nutritional care plans were in place that detailed residents' individual food preferences. Recommendations by a dietitian or speech and language therapist were clearly recorded for reference. A record of residents who were on special diets such as diabetic and fortified diets, or fluid thickeners was available for reference and kept under review. Inspectors observed that a routine of trolley service for snacks and drinks took place between meal times in the course of the day. All residents were appropriately assessed for nutritional needs on admission and were subsequently reviewed regularly. Records of weight checks were seen to be maintained on a monthly basis and more regularly where significant weight changes were indicated. Nutritional and fluid intake records were appropriately maintained where necessary and records indicated weight gains for residents subject to monitoring. Particular consideration around needs in relation to food and nutrition were evident where residents had a wound or issue with skin integrity. Residents who were insulin dependent had their blood sugar levels checked each morning.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised and care plans were reviewed. Of the care plans reviewed inspectors noted that discussion with residents and their families about end of life care arrangements had taken place and were recorded. Measures were in place to prevent unnecessary hospital admissions and included regular attendance and review by the GP and access to palliative care services.

Centre-specific policies on medication management were made available to inspectors. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were comprehensive and evidence based. Medicines for residents were supplied by an on-site pharmacy. Medicines were stored in a locked cupboard or medication trolley which were kept in secure clinical rooms. Trolleys were generally stored in locked clinical rooms when not in use. Controlled drugs were stored
in accordance with best practice guidelines and nurses checked the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

Nurses wore red tabards when administering medicines to ensure that they were not disturbed during this duty. The inspector reviewed a sample of residents’ medicine prescription records that were well maintained and clearly labelled with photographic identification of each resident in place. Medication administration was observed and the inspectors found that the nursing staff generally adhered to professional guidance issued by An Bórd Áltranais and adopted a person-centred approach. However, inspectors were told that nurses were administering medications in a crushed format to a resident when they were not all prescribed in a crushed format by the prescriber. There was evidence that residents’ medicine prescriptions were reviewed at least every three months by a medical practitioner. The maximum daily dosage for PRN medicines (taken only as required) was recorded. Medication audits were undertaken by nursing staff. Medication errors and near misses were recorded and monitored by the clinical nurse manager (CNM) on each unit. Medicines for residents were supplied by an on-site pharmacist who was also available to meet with the staff and to provide ongoing education.

Judgment:
Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
There was a policy and procedures in place for the prevention, detection and response to abuse that was kept under review and referenced relevant legislation and guidelines. Records indicated that regular training on safeguarding and safety was provided. Staff members spoken with by the inspector had received relevant training and understood the recording and reporting systems in place. The inspector met and spoke with residents who said they were comfortable and felt safe and well cared for in the centre.

There was a current policy and procedure in place on the management of residents' accounts and personal property. The inspector spoke with an administrator who explained the related procedures and safeguards, which included a centralised accounting system with both internal and external audit. The centre managed some cash amounts for a small number of residents. A sample of transactions was reviewed. Processes were in keeping with protocols and balances reconciled with records. Documentation of receipts and the recording of balances were maintained and
signatures were in place on receipts for transactions.

Relevant policies were in place that provided appropriate guidance to staff on the approach to managing responsive behaviours. An inspector reviewed a sample of care plans and discussed the management of care for residents presenting with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were able to demonstrate a well-developed knowledge and understanding of residents’ needs in these cases. Staff were seen to reassure residents and divert attention appropriately to reduce anxieties.

Where restraints such as bed-rails were in use, assessments had been undertaken and nursing notes reflected regular monitoring and review. This practice was also subject to regular audit.

**Judgment:**
Compliant

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

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

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

**Findings:**
As described at Outcome 1, the health and wellbeing of residents were well addressed in relation to regular review and access to clinical care and allied healthcare resources. In relation to consultation and social wellbeing there were systems in place to support residents in expressing their views on developments in the centre. Inspectors spoke with many residents who had been made aware of the new building proposals and there was information throughout the centre providing an outline of plans in this regard.

The centre provided access to an independent advocacy service and relevant contact details were available and accessible. Correspondence reviewed indicated that training was in process to support staff awareness of their responsibilities around advocacy. A residents’ committee convened regularly, usually every second month, and minutes of these meetings were available for review. Inspectors met and spoke with a number of relatives and visitors who spoke positively about their experience of care at the centre, and who also confirmed that communication with staff and management was effective and meaningful.

The inspectors reviewed circumstances and resources in relation to the provision of meaningful activation and recreation for all residents. It was evident that issues in
relation to the design and layout of the centre, as summarised at Outcome 5, continued to present challenges in this regard. It was clear from this inspection, as had also been identified previously, that staff continued to demonstrate initiative and commitment in meeting the needs of residents, and to ensure that residents were given a regular opportunity to engage in activities that they enjoyed. The inspectors noted that staff demonstrated an effective understanding of the individual needs and personalities of their residents and that they persevered in providing person-centred care in difficult circumstances.

The inspectors met with the staff responsible for delivering the activation programme and were able to review records that demonstrated how information about residents’ interests was used to inform their activity schedule. Records were also maintained that reflected the kinds of activities residents engaged in and the extent of their participation. On the second day of the inspection the activity centre was available and residents were seen to enjoy bingo and a birthday celebration in the afternoon. The activity centre was not available for use by any residents on the first day of inspection. Staff were able to explain how a regular programme of personalised activities were delivered to individual residents on the days that the activity centre was not available. Many of the activities provided were in keeping with the needs of residents with dementia or a cognitive impairment, and included sensory activation such as music, massage and Sonas, for example.

The centre provided transport for occasional outings and there were photographs of residents having partaken in such events. There were meaningful links with local community groups that regularly attended the centre, and residents were supported to engage in civic responsibilities, such as voting. Pastoral care was provided and there was a regular mass service at the centre and broadcast services were also made available. Residents had regular access to community newspapers and group reviews of local news were part of the activity programme. Multi-occupancy rooms had one, and sometimes two TV’s, to facilitate residents being able to view effectively. However, residents in multi-occupancy rooms were restricted in being able to exercise personal choice around what they chose to watch or volume levels. Arrangements were in place to support engagement with education initiatives and the inspectors met with students participating in an interactive programme who were engaged in activities with residents during the inspection. The centre provided access to a secure outdoor area on the ground floor. However, access to this space, particularly for residents on the first floor, was limited and often depended on the availability of sufficient staff to support residents wishing to go outside.

Constraints remained in relation to the premises. The use of multi-occupancy rooms for up to five residents did not support the receipt of personal care and communication in a manner that promoted or protected privacy and dignity. Limited actions had been taken to address the areas for improvement that had been identified on previous inspection. Efforts had been made to improve the décor and physical environment pending the planned reconfiguration of the premises. However, the day-to-day experience of residents in continuing care at the centre remained compromised in relation to the appropriate provision of privacy for the conduct of personal activities, and the provision of adequate space to engage in communal activities and recreation, or to meet visitors in private.
For example:
• Most wardrobes were very narrow with limited space and inspectors saw that residents' clothing were necessarily stored on chairs, in bags, in plastic boxes and hanging on bed-heads or wardrobe doors;
• Washing bowls and toiletries were stored on top of many individual wardrobes;
• Privacy screens in use in some shared and multi-occupancy rooms did not fully encircle the bed to provide adequate protection;
• In multi-occupancy rooms, telephone facilities could not be used in private;
• The layout of bathroom facilities did not always support appropriate access. For example, in Unit 5 of Thomond ward, residents in a three-bedded room had to travel through the length of an adjacent four bedded-area, which was effectively a corridor, to use the shower or toilet. This was both disruptive and compromised privacy for all residents in the unit;
• Facilities to receive residents in private were not available in the Thomond ward. Inspectors saw that residents received visitors variously in communal areas, next to their beds in multi-occupancy rooms, and in corridors;
• Access to the activity centre was restricted to only two days per week;
• Activities had to be held in the wards and rooms of individual residents;
• Limited dining and communal space, particularly on the Thomond ward, meant that residents were restricted in how and when they could engage and interact;
• Residents were seen to undertake personal activities at their bedside, including personal grooming and receiving visitors;
• Some residents took all their meals from a table at their bedside in a multi-occupancy room;
• The inspectors visited each of the wards between 18.00 and 19.00 on the first evening of the inspection. Many residents were in their rooms, either in or by their beds. Some residents were in communal areas watching TV. However, the limited availability of effectively accessible communal space did not support meaningful personal choice, nor did it promote the privacy and dignity of residents in multi-occupancy rooms which were open to visitors in the evening;
• There was inappropriate placement of residents in multi-occupancy rooms where younger residents had to share with much older residents. Residents spoken with by inspectors expressed a preference for rooms of their own. This was also seen to have been expressed in minutes of residents meetings and relatives spoken with also expressed their requirement for more space and privacy for their family member. Management confirmed that such preferences could not always be accommodated and a current complaint in process related to the lack of options for personal accommodation.
• The provision of a private room for residents with needs in relation to end-of-life care could not always be accommodated.
• A resident in a twin room indicated that she would like to have more of her personal belongings with her but was already conscious of the impact her belongings had on the personal space of her co-resident.

Residents and relatives spoken with by inspectors provided consistently positive feedback in relation to the care and attention they received from staff. The inspectors discussed accommodation with residents, many of whom were aware of the proposed new build in 2021. The inspector spoke with one resident who commented positively on the care he received and his sense of wellbeing. This resident also acknowledged that the room he shared should only have one bed in it but remarked “What can you do?”
Staff and management collectively acknowledged that the environmental shortcomings outlined in the report had an impact on the ability of the service to fully meet the needs of residents in relation to privacy and choice.

Aside from routine observations, as part of the overall inspection, a validated observational tool was used to monitor the extent and quality of interactions between staff and residents. The observation tool used was the Quality of Interaction Schedule, or ‘QUIS’ (Dean et al., 1993). This monitoring occurred during discrete 5 minute periods in 30 minute episodes. Three episodes were monitored in this way. One observation was undertaken during lunch in the communal areas of Thomond, where several residents were taking lunch while watching television. In the course of this observation several members of staff were in attendance at various times and were seen to check appropriately on individual needs and preferences. During this time tea was brought to a resident who requested it and another staff member provided assistance for a resident who wanted to go and use the toilet facility.

A second episode took place on day two of the inspection in the day room of Sarsfield ward. During this observation the inspector noted positive and person-centred care on the part of staff and assistants in their attention to residents’ needs. Staff were seen to take their time and encourage residents with their meals while engaging in conversation and making the mealtime experience sociable. The third episode of observation took place in the activity centre on day two of the inspection. Again it was noted that staff were attentive and took time to ensure that residents who might be experiencing confusion were reassured and assisted to partake in the activity in a way that supported their needs and understanding. The inspector noted that staff and residents were clearly familiar with each other and that engagement around the activities was a regular occurrence. The inspectors noted that personal attention and consideration was typical of the approach by all staff throughout the inspection. A positive result was recorded for all episodes of observation and it was noted that staff engaged meaningfully with residents on a consistent basis.

Judgment:
Non Compliant - Major

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
A site-specific complaints policy and procedure was in place and kept under regular review. A summary of the complaints procedure was on display in communal and access areas of the centre. This information was also summarised in the statement of purpose.
and as part of the information guide provided for residents. The policy cited relevant legislation and set out the procedure to follow in making a complaint, including how to make a verbal or written complaint, and the expected time frames for resolution. In keeping with statutory requirements, the procedure for making a complaint included the necessary contact details of a nominated complaints officer. The procedure also outlined an internal appeal process and identified the appeal officer. Contact information for the office of the Ombudsman was provided.

A record of complaints and concerns was maintained. Relevant information was available on the nature, circumstances, response and outcome of the complaint. The inspector reviewed the complaints system with a member of management and the process indicated that procedures for receiving and responding to complaints were in keeping with the requirements of the regulations. At the time of inspection there were no complaints that had been referred to the appeal process. Further information on advocacy, and facilities to support residents with a cognitive impairment in raising a concern, is recorded against Outcome 3 on Rights, Dignity and Consultation.

**Judgment:**
Compliant

### Outcome 05: Suitable Staffing

**Theme:**
Workforce

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

**Findings:**
Service at this designated centre was provided by the Health Service Executive (HSE). Supervision in the centre was directed through the person in charge. There were two assistant directors of nursing with appropriate experience and qualifications to deputise for the person in charge when necessary. An organisational structure that identified the lines of authority and accountability was set out in the statement of purpose. Management systems were in place to ensure that information was communicated effectively and minutes of staff meetings were available for reference. A schedule of staff appraisals was in place. An appropriately qualified, registered nurse was on duty at all times. The qualifications of senior nursing staff and their levels of staffing ensured appropriate supervision at all times. Supervision was also implemented through monitoring and control procedures such as audit and review. Copies of the standards and regulations were accessible by staff. Staff spoken with were aware of their statutory duties in relation to the general welfare and protection of residents.

The inspectors reviewed the training matrix and identified that training was regularly delivered in mandatory areas such as fire-safety, safeguarding and manual handling. Management monitored staff training renewal dates and all staff members had received
current training in the mandatory areas. Additional training was accessible to staff that was relevant to the care of residents with dementia or a cognitive impairment. Training had been provided on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Regular training was available on the management of infection control. Training in CPR (cardio-pulmonary resuscitation) last took place in August 2017. Nursing staff had access to on-line training modules in relation to medication management.

The centre had appropriate policies on recruitment, training and vetting that described the screening and induction of new employees and also referenced job description requirements, the recruitment process and probation reviews. Records checked, in respect of documents to be held in relation to members of staff, were generally in keeping with requirements. The centre had in place a verification form confirming that related police vetting disclosure documentation was in place for employees. Confirmation of police vetting documentation for the sample of files reviewed was subsequently provided as per Schedule 2 of the Care and Welfare Regulations 2013. Current Bórd Altranais registration was in place for all members of nursing staff. Management understood the regulatory requirements in relation to documentation for volunteers. However, documentation to verify police vetting for all volunteers was not in place.

The inspectors reviewed the staff rota and discussed staffing arrangements with management. The inspectors met a number of caring and dedicated multi-task attendants during the inspection. Many were long-standing members of staff who knew residents well and were very familiar with individual needs and preferences. However, the role of multi-task attendants was unclear. Throughout a shift they might variously undertake cleaning, resident care or catering duties, switching roles as circumstances and staffing levels changed over shifts. There were no dedicated cleaning staff on any of the wards. These arrangements were not in keeping with best practice around infection control. Staff told the inspectors that, at times of staff shortages, multi-task attendants might replace healthcare attendants, or additional nursing staff, on the roster. Management confirmed that most multi-task attendants had not received specific training or education in relation to the provision of resident care. The roles of multi-task attendants were not clearly documented and arrangements for ensuring the necessary competence for the duties of care being undertaken were unclear.

The inspectors discussed staffing arrangements and reviewed the roster for evening and night staffing levels. It was identified that one unit had just one nurse and one member of care staff from 8pm. These arrangements meant that while the night nurse undertook the medication round there was only one other staff member of staff to provide evening drinks, assist residents to bed or meet any other personal care needs. These arrangements were not adequate to ensure medications could be administered safely without interruption, or that residents had access to assistance appropriate to their needs at these times. Inspectors identified that many residents were assisted back to bed before staffing levels decreased or waited until the night staff could assist them later in the evening. These arrangements did not reflect person-centred care. As identified in relation to the provision of activities, access to the activity centre was available on only two days in the week due to lack of suitably qualified supervising staff.
Additionally, access to outside space on the ground floor was limited for residents on the first floor due to lack of suitably qualified supervising staff. Decreased staffing levels from early evening did not allow for adequate supervision of communal areas. Relatives remarked on the lack of staff as an issue.

**Judgment:**  
Non Compliant - Major

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**Outcome 06: Safe and Suitable Premises**

**Theme:**  
Effective care and support

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

**Findings:**  
As identified on previous inspections, the design and layout of some areas of the premises did not conform to the matters listed in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Some of these issues impacted on the privacy and dignity of residents and these areas are outlined in more detail in the related Outcome 3.

Residential accommodation was distributed across three wards and over two floors. Thomond and Shannon ward were on the first floor. Sarsfield was located in another part of the same building on the ground floor. The centre did not provide a dementia specific unit and care for residents with dementia or a cognitive impairment was integrated throughout the service. The centre was registered to accommodate 82 residents. Accommodation throughout the centre was provided in single, twin and multi-occupancy rooms. At the time of inspection 72 residents were registered in the centre. The available accommodation for up to 52 of these residents was in rooms with between three and five occupants. Many of these multi-bedded rooms afforded very limited personal space, privacy or storage for personal belongings and gave an institutional appearance to the residential environment.

Overall the centre was bright with natural light, and areas such as the activities centre and some communal spaces were very nicely decorated and well maintained. The activities centre was spacious, colourfully decorated and well laid out, with homely and comfortable furnishings for group gatherings. This activities centre was located on the first floor, directly adjacent to Shannon ward and across the stairwell landing from Thomond ward. Residents from all three wards were seen to take part in activities here in the course of the inspection. Access to this space was available on only two days of the week. The inspectors noted that consultation processes had identified increasing access to this recreation area from two to four days as an area for improvement, though this had yet to be implemented.
The activities centre comprised a communal seating area with large TV and DVD system. There were also several tables with seating where residents could engage in games or social gatherings for birthdays and events. Adjacent to this space was a kitchen area where baking activities took place for residents, and there were many photo collections on the wall of residents participating in such events. This activities area also provided access to a small sensory room that had been refurbished since the last inspection and now provided a massage chair and foot spa, scented oils and a stereo. Overall, the layout and resources in this space was appropriate to meet the needs of all residents and was notably suitable for residents with dementia or a cognitive impairment.

Sarsfield ward, on the ground floor, provided accommodation for up to 34 residents, both male and female. On the day of inspection there were 29 residents on this ward. Entrance to this ward was through a communal space that included a spacious seating area, which opened onto a large dining area with tables set for groups of up to four residents. There was also a smaller, private sitting area adjacent to this space that was colourfully decorated and furnished. Decoration in these areas was homely and furnishings were comfortable. Accommodation on this ward included 4 single rooms, one of which had an en-suite facility. Five twin-bedded rooms were equipped with wash-hand basins. Two further twin-bedded rooms provided access to shared en-suite facilities. There were also four multi-occupancy rooms for up to four residents in each, all with wash-hand basins. The single and twin rooms were personalised to varying degrees with belongings and photographs. Most rooms had a clock and TV or radio and were provided with the necessary items of furniture such as a chair, wardrobe and bedside locker. However, almost all wardrobes were very narrow and did not provide adequate storage space for sufficient personal clothing. In some rooms the layout was such that a resident’s wardrobe might be on the other side of the room, which made it difficult for them to access and retain control over their possessions and clothing. The extent to which residents in multi-occupancy rooms could personalise their immediate living space was very limited. Additionally, some of the bedside storage lockers were not actually lockable. In one room a hoist sling and incontinence pads were stored in the space between the wall and the wardrobe. In some of the multi-occupancy rooms the space between the beds was narrow and did not provide enough room for a chair or access with assistive equipment, such as a wheelchair. Additionally, while the design and layout of the communal space on this ward was in keeping with the needs of residents with a cognitive impairment, overall the signage and orientation supports on the corridors was very limited. Colours for doors with particular functions such as bedrooms or toilets were not in contrasting colours and there was limited signage to assist residents in identifying dining areas, toilets or communal TV areas.

Shannon ward was on the first floor and provided accommodation for up to 28 female residents. Access to this ward was through the large activities area. Accommodation included one three-bedded and five four-bedded rooms, all with wash hand-basins. There was also a single ensuite room and two twin-bedded rooms with wash-hand basins. Relatives of families who might wish to stay overnight could be accommodated in a comfortable room with facilities to make refreshments. This ward also provided two communal seating areas and a dining space. Again, the single and twin rooms were personalised to varying degrees with belongings and photographs. Some rooms had been personalised to a significant extent, reflecting individual preferences in decoration
and belongings. Most rooms had a clock and TV or radio and were provided with the necessary items of furniture such as a chair, wardrobe and bedside locker. However, all wardrobes were very narrow and did not provide adequate storage space for personal clothing. Additionally, some of the bedside storage lockers were not actually lockable. In some of the multi-occupancy rooms the space between the beds was narrow and did not provide enough room for a chair or access with assistive equipment, such as a wheelchair. Again, signage and orientation supports on this ward were limited and did not adequately meet the needs of residents with a cognitive impairment.

Thomond ward provided accommodation for up to 20 male residents. Accommodation included 4 single rooms, one three-bedded, one five-bedded and two four-bedded rooms, all equipped with wash-hand basins. Again, the single and twin rooms were personalised to varying degrees with belongings and photographs. Most rooms had a clock and TV or radio and were provided with the necessary items of furniture such as a chair, wardrobe and bedside locker. However, the standard wardrobes provided were very narrow and did not provide adequate storage space for personal clothing. Again, some of the bedside storage lockers were not lockable. In some of the multi-occupancy rooms the space between the beds was narrow and did not provide enough room for a chair or access with assistive equipment, such as a wheelchair. Also, the layout was such that the three-bedded unit was only accessible by walking through the adjacent four-bedded unit. Issues in relation to these circumstances are addressed further at Outcome 3.

On entering Thomond ward there were two conjoined communal areas, each with a TV, that served as both sitting and dining areas. These areas could adequately seat a small number of residents, approximately four at any one time, depending on the type of supportive seating in use. Since the last inspection a storage area adjacent to these communal rooms had also been converted for use as a dining space; it was now equipped with two dining tables that could practically accommodate approximately six residents at a time, again depending on seating requirements. However, equipment such as wheelchairs continued to be stored in this space as well. These spaces were not practically suitable for the conduct of group or communal activities. Communal space was available across the corridor in the activities room; however, as referenced previously, access to this space was limited to only two days per week. There was nowhere on this ward for residents to receive visitors in private. Additionally, as identified on previous inspections, storage facilities were inadequate and wheelchairs, hoists and other equipment were stored variously in corridors, communal areas and bathrooms. As identified on other wards, signage and orientation supports were again limited and did not adequately meet the needs of residents with a cognitive impairment.

Call-bells were visible and easy to reach in all rooms. There was appropriate heating and lighting throughout. All meals were prepared centrally and each ward had a kitchenette area to support the provision of meals, drinks and snacks. A secure outside space, with seating and shade, was also available and accessible from the ground floor. However, residents on the first floor had no direct access to outside space. Each ward had access to sluice facilities as required. Laundry facilities that met the needs of the service were provided on-site. Residents on each ward had access to an adequate number of toilets, showers and bathroom facilities.
Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mairead Harrington
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Camillus Community Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000640</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>27/09/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>02/11/2017</td>
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Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Nurses were administering medications in a crushed format to a resident when they were not all prescribed in a crushed format by the prescriber.

1. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
- 90% of Nursing Staff have completed the HSE e-learning medication management and certificates are held in Nursing Management office. Staff who have yet to complete this training have been advised that certificates are required in Nursing Management office prior to December 1st 2017.
- Medication management training by NMPDU is scheduled for Nov 15th and Dec 13th 2017.
- Information on medications that can be crushed is now available on all wards and this will be highlighted at daily safety pause for November and December 2017.
- The Pharmacist has provided guidelines to all wards on crushable medication.
- Peer auditing of medication management has commenced on all wards as of October 2017.
- Results and key learning from peer audits will be fed back at CNM and Hospital Management Meetings.

Proposed Timescale: 31/03/2018

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Many residents were in their rooms, either in or by their bed, by early evening due to the limited availability of effectively accessible communal space; residents were restricted in their opportunities for meaningful personal choice on how and where they could engage and interact.
There was limited dining and communal recreational space on the Thomond ward. Residents in multi-occupancy rooms were seen to undertake personal activities such as grooming, dining and receiving visitors, by their bed.

2. Action Required:
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
- Some residents in both Shannon and Thomond wards choose to remain at their bedside both for meals and for visitors as opposed to going to the dining area or communal spaces.
A comprehensive review of staffing rosters is underway which will support a robust activity programme, in consultation with residents, extended into the evening and the weekend.

Reconfiguration of the Thomond ward is being explored with HSE Estates department to erect partitions to enhance the privacy and dignity of residents, subject to availability of resources. This will also provide communal space for meaningful activities. Reconfiguration of the 1st dining room will allow private space for residents and their families outside of meal times.

**Proposed Timescale:** 31/05/2018

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Residents in multi-occupancy rooms were restricted in being able to exercise personal choice around what they chose to watch on TV, or volume levels. Residents who expressed a preference for a room of their own, or at end-of-life, could not always be accommodated. There was inappropriate placement of residents in multi-occupancy rooms where younger residents had to share with much older residents. Where residents expressed a preference for rooms of their own, such preferences could not always be accommodated, and a current complaint in process related to the lack of options for personal accommodation.

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

**Please state the actions you have taken or are planning to take:**
- A Control Development Plan for the Centre is at an advanced stage, with funding allocated under the Capital Development Programme, which includes a time bound costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6. A design team have been appointed and they are currently completing a stakeholders’ consultation process. This building will be operational by end of 2021 and will meet requirements of privacy and dignity and availability of single rooms. As the Thomond ward is identified as the initial replacement block, residents should commence occupancy in the new build by end 2019, but in any event transfers will be completed in line with compliance by 2021.

- All efforts will continue to meet resident’s preference regarding choice of room.

- Measures have been put in place to minimise restriction on personal choice of entertainment: ear phones and extra TVs will be made available as required.
• Where younger residents have been offered single rooms in the past and refused same, going forward resident’s preference and all offers will be documented.

• At assessment stage potential residents are made aware that there is reduced availability of single occupancy accommodation.

• Single rooms are prioritised for infection prevention and control and end of life residents. In the new building the proposed availability is 80/20 for single/double accommodation.

Proposed Timescale:
Control Development Plan 2021
Other measures will be implemented by end of November 2017

Proposed Timescale: 31/12/2021

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The use of multi-occupancy rooms for up to five residents did not support the receipt of personal care and communication in a manner that protected privacy and dignity.
Privacy screens were not adequate in all shared rooms. Residents in one area of unit 5 of Thomond ward could only access bathroom facilities through the accommodation area of other residents in that unit.

4. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
• A Control Development Plan for the Centre is at an advanced stage, with funding allocated under the Capital Development Programme, which includes a time bound costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6. A design team have been appointed and they are currently completing a stakeholders’ consultation process. This building will be operational by end of 2021 and will meet requirements of privacy and dignity and availability of single rooms. As the Thomond ward is identified as the initial replacement block, residents should commence occupancy in the new build by end 2019, but in any event transfers will be completed in line with compliance by 2021.

• All privacy screens (curtains) have been reviewed and are now fitted to provide privacy for residents in shared rooms.

• Reconfiguration of the Thomond ward is being explored with HSE Estates department to erect partitions to enhance the privacy and dignity of residents, subject to availability
of resources. This will also provide communal space for meaningful activities. Reconfiguration of the 1st dining room will allow private space for residents and their families outside of meal times.

Proposed Timescale:
Privacy screens November 2017:
Reconfiguration of Thomond Ward May 2018
Control Development Plan 2021

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<th>Proposed Timescale:</th>
<th>31/12/2021</th>
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Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
In multi-occupancy rooms, telephone facilities could not be used in private.

5. Action Required:
Under Regulation 09(3)(c) you are required to: Ensure that each resident may communicate freely.

Please state the actions you have taken or are planning to take:
• A Control Development Plan for the Centre is at an advanced stage, with funding allocated under the Capital Development Programme, which includes a time bound costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6. A design team have been appointed and they are currently completing a stakeholders’ consultation process. This building will be operational by end of 2021 and will meet requirements of privacy and dignity and availability of single rooms. As the Thomond ward is identified as the initial replacement block, residents should commence occupancy in the new build by end 2019, but in any event transfers will be completed in line with compliance by 2021.

• Mobile hand sets are available for all residents who wish to make telephone conversation in private and a space has been identified to facilitate such conversation on all wards. For residents who are bed bound, arrangements will be made for private conversation within their bedroom.

• Family rooms are available on the Sarsfield and Shannon wards.

• Reconfiguration of the Thomond ward is being explored with HSE Estates department to erect partitions to enhance the privacy and dignity of residents, subject to availability of resources. This will also provide communal space for meaningful activities. Reconfiguration of the 1st dining room will allow private space for residents and their families outside of meal times.

• A Control Development Plan for the Centre is at an advanced stage, with funding allocated under the Capital Development Programme, which includes a time bound
costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6. A design team have been appointed and they are currently completing a stakeholders’ consultation process. This building will be operational by end of 2021 and will meet requirements of privacy and dignity and availability of single rooms. As the Thomond ward is identified as the initial replacement block, residents should commence occupancy in the new build by end 2019, but in any event transfers will be completed in line with compliance by 2021.

Proposed Timescale:
Reconfiguration of Thomond ward May 2018
Control Development Plan 2021

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<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were limited facilities for residents to receive visitors in private and residents were seen to receive visitors variously in communal areas, next to their beds in multi-occupancy rooms, and in corridors.

6. **Action Required:**
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident’s room, if required.

**Please state the actions you have taken or are planning to take:**
- Choice is available for residents should they wish to meet visitors in private sitting room/ family room in both Sarsfield and Shannon Ward.

- A Control Development Plan for the Centre is at an advanced stage, with funding allocated under the Capital Development Programme, which includes a time bound costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6. A design team have been appointed and they are currently completing a stakeholders’ consultation process. This building will be operational by end of 2021 and will meet requirements of privacy and dignity and availability of single rooms. As the Thomond ward is identified as the initial replacement block, residents should commence occupancy in the new build by end 2019, but in any event transfers will be completed in line with compliance by 2021.

- Reconfiguration of Thomond ward is being explored with HSE Estates department to erect partitions to enhance the privacy and dignity of residents, subject to availability of resources. This will also provide communal space for meaningful activities. Reconfiguration of the 1st. dining room will allow private space for residents and their families outside of meal times.
### Proposed Timescale: 31/12/2021

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Most wardrobes were very narrow with limited space and inspectors saw that residents’ clothing were necessarily stored on chairs, in bags, in plastic boxes and hanging on bed-heads or wardrobe doors. Washing bowls and toiletries were stored on top of many individual wardrobes.

**7. Action Required:**
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

**Please state the actions you have taken or are planning to take:**
- Two rooms in Sarsfield ward (single and twin room) will be reconfigured, which will allow additional personal space for clothes and storage space.
- An audit of wardrobe requirements will be undertaken and extra space allocated as required.

### Proposed Timescale: 31/12/2017

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Staffing arrangements were not adequate to ensure medications could be administered safely without interruption, or that residents had access to assistance appropriate to their needs at all times.
Residents had limited access to the activity centre, or outside space, due to lack of suitably qualified supervising staff.

**8. Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.
**Please state the actions you have taken or are planning to take:**

- A bespoke recruitment campaign has been undertaken to recruit appropriate grades of staff – Nursing, HCA/MTA.

- All options are being explored to recruit appropriately qualified Nursing staff including international recruitment. Five Staff Nurses are scheduled to commence in December 2017.

- Expressions of interest are being progressed locally to fill Clinical Nurse Manager positions.

- Review of roster is underway in consultation with staff and union representatives, to ensure appropriate levels of staffing throughout the day. This will support a robust activity programme extending to the evening and the weekend in consultation with residents.

- Scheduling of work and tasks will be reviewed, linking all staff available on the ward at a given time.

- A local standard operation procedure for medication rounds will be implemented.

**Proposed Timescale:** 31/12/2017

**Theme:** Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The roles of multi-task attendants were not clearly defined and many had not received specific training or education in relation to the provision of resident care.

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

**Please state the actions you have taken or are planning to take:**
- Review of rosters is underway which will support the specific role of all grades including Nursing, Health Care Assistants, Housekeeping and Catering.

- Employees who choose to work as Health Care Assistants will work closely with Nursing staff providing personal care. Role separation will be agreed within the roster review arrangements.

**Proposed Timescale:** 30/06/2018

**Theme:** Workforce
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Documentation to verify police vetting for all volunteers was not in place.

10. **Action Required:**
Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
- All regular volunteers will have Garda clearance documentation available on site for inspection.
- The Garda Vetting Data Controller has been requested to progress outstanding documentation.

**Proposed Timescale:** 31/12/2017

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**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The premises did not provide accommodation and facilities for all residents that was appropriate to their needs in accordance with the statement of purpose prepared under Regulation 3.

11. **Action Required:**
Under Regulation 17(1) you are required to: 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.

Please state the actions you have taken or are planning to take:
- The Statement of Purpose has been reviewed and an amendment has been inserted to indicate limited availability of bed choice and single rooms at this time.
- All potential residents are assessed to ensure that their needs can be met within the Centre. Prior to completing a ‘contract of care’ all potential residents are informed of the accommodation available including multi occupancy rooms and the limited availability of single room at this time.

**Proposed Timescale:** 30/11/2017

**Theme:**
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The registered provider had failed to provide premises that conformed to the matters set out in Schedule 6 of the regulations, having regard to the needs of the residents of the designated centre.
- Standard wardrobes provided were very narrow and did not provide adequate storage space for personal clothing.
- Some bedside storage lockers were not lockable.
- In some of the multi-occupancy rooms the space between the beds was narrow and did not provide enough room for a chair or access with assistive equipment, such as a wheelchair.
- A three-bedded ward was only accessible by walking through an adjacent four-bedded ward on one unit.
- There was no designated space for residents to receive visitors in private on Thomond ward.
- Storage facilities were inadequate and wheelchairs, hoists and other equipment were stored variously in corridors, communal areas and bathrooms.
- Signage and orientation supports were limited and did not adequately meet the needs of residents with a cognitive impairment.

12. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
• A Control Development Plan for the Centre is at an advanced stage, with funding allocated under the Capital Development Programme, which includes a time bound costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6. A design team have been appointed and they are currently completing a stakeholders’ consultation process. This building will be operational by end of 2021 and will meet requirements of privacy and dignity and availability of single rooms. As the Thomond ward is identified as the initial replacement block, residents should commence occupancy in the new build by end 2019, but in any event transfers will be completed in line with compliance by 2021.

• Two rooms in Sarsfield ward (single and twin room) will be reconfigured, which will allow additional personal space for clothes and storage space.

• Reconfiguration of the Thomond ward is being explored with HSE Estates department to erect partitions to enhance the privacy and dignity of residents, subject to availability of resources. This will also provide communal space for meaningful activities. Reconfiguration of the 1st dining room will allow private space for residents and their families outside of meal times.

• An audit of wardrobe requirements will be undertaken and extra space allocated as required.
• All personal lockers will be reviewed and any defective latches will be replaced.

• A storage area has been identified in Thomond ward, which will be refurbished and utilised.

• Signage and orientation support will be improved with emphasis on dementia specific decoration i.e. paintwork, signage to be upgraded and areas to be refurbished in keeping with specific guidelines.

Proposed Timescale:

Lockers November 2017:
Signage December 2017:
Reconfiguration of Thomond Ward May 2018:
Control Development Plan 2021

**Proposed Timescale:** 31/12/2021