

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Camillus Community Hospital
Centre ID:	ORG-0000640
Centre address:	Shelbourne Road, Limerick, Limerick.
Telephone number:	061 326677
Email address:	majella.cussen@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Maria Bridgeman
Person in charge:	Majella Cussen
Lead inspector:	Geraldine Ryan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	70
Number of vacancies on the date of inspection:	4

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 07 November 2013 08:10 To: 07 November 2013 15:30

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

Outcome 08: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 17: Residents clothing and personal property and possessions

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on two specific outcomes, End of Life Care and Food and Nutrition. In preparation for this thematic inspection providers attended an information seminar, received evidenced-based guidance and undertook a self-assessment in relation to both outcomes. The inspector reviewed policies and analysed surveys which relatives submitted to the Authority prior to the inspection. The inspector met residents and staff and observed practice on inspection. Documents were also reviewed such as training records, care plans, medication management charts, complaints log, menus, minutes of residents' meetings and records pertaining to deceased residents. The inspector found moderate non compliance in the area of food and nutrition and a minor non compliance in the area of end of life care with the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and National Quality Standards for Residential Care Settings for Older People in Ireland.

While the thematic inspection focused on two outcomes as described above, there was a requirement for the inspector to review other outcomes in so far as they related to end of life care and food and nutrition. Some minor and moderate non compliances were identified and these are discussed in the body of the report.

Staff, spoken to by the inspector, were knowledgeable about the residents and their care requirements. Recent refurbishments include the provision of an overnight/kitchenette facility for families, dining rooms, storage and large bathrooms with walk in shower facilities. The overall bed complement had been reduced in

order to facilitate the programme of refurbishment.

However, improvements were required to meet regulatory requirements and these included:

- medication management practices
- residents' care planning process
- audit/evaluation of practices in relation to food and nutrition or on end of life care, as per the centre's policies
- records of residents' personal belongings.

Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 08: Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Safe Care and Support

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

A sample of medication management documentation reviewed indicated the following:

- nutritional supplements administered by nursing staff to some residents, were not always prescribed by the attending medical officer
- nutritional supplements were not always administered as prescribed; for example, a nutritional supplement prescribed administration four times a day (QDS), was over a nine day period, administered:
 - a) once a day for six days
 - b) twice daily for two days
 - c) three times daily for two days and no reason documented for the non administration
- the maximum dosage of medications administered as required (PRN) was not documented
- no dose charted for some laxatives
- some laxatives were not administered as prescribed.

There was evidence, on a number of charts reviewed, that some other medications were not administered as prescribed to residents and no reason documented for the non administration.

Nutritional supplements were stored in designated fridges.

A sample of medication charts reviewed indicated that some residents were prescribed laxatives on a regular basis and up to five laxatives on an as required basis. This is discussed under outcome 11.

Outcome 11: Health and Social Care Needs

Each residents wellbeing and welfare is maintained by a high standard of evidence-

based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective Care and Support

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector reviewed a sample of care plans in each of the three units. The care planning process required review as:

- residents' care plans were not up-to-date and reviewed three monthly
- several residents' care plans pertinent to weight loss/gain were not updated and a number of residents who had experienced weight loss/gain did not have a care plan
- some residents with a diagnosis of diabetes did not have a corresponding plan of care
- a number of residents' clinical risk assessments were not regularly updated
- some residents with oral care issues did not have an updated plan of care and an up to date oral assessment
- it was unclear on residents' files if the mini nutritional assessment (MNA) tool, was carried out three monthly or when required
- there was no care plan in place for residents who were prescribed a number of laxatives. While staff were knowledgeable as to what laxative suited a particular resident, there was no written protocol to guide and inform staff on the first line laxative to use
- a number of residents' care plans were not reviewed in consultation with the resident. Staff confirmed this observation.

Staff were knowledgeable with regard to the care of residents with a percutaneous endoscopic gastrostomy (PEG) tube.

Daily nursing notes were updated with current information.

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector reviewed the provider's self-assessment questionnaire. While the questionnaire captured information regarding to informal practices and management of end of life care, such information was not included in the guidance policy. The policy on end of life care required updating to include:

- the availability of overnight/kitchenette facilities for the family
- notification to the acute hospital (to ensure that no further correspondence to the home of family)
- arrangements to facilitate staff training
- details of a remembrance event
- how to inform other residents of the death of a resident
- support for other residents at this time
- staff support
- audit and evaluation.

The inspector saw evidence that an end of life resource folder was being developed in each unit.

Residents voiced positive experiences of their care. Some residents expressed to the inspector that in the event of becoming unwell, they would prefer to go to the acute services while other residents stated that they would choose to stay in the centre. However, this information was not recorded in residents' care plans.

The person in charge's overall self-assessment identified a number of specific actions to ensure compliance with regulation 14. These included commencing an audit of current compliance; carrying out a full review of policies relating to end of life care; identifying gaps in end of life care plans; staff training; produce and implement a leaflet on bereavement; create a pathway to inform acute hospitals of the death of a resident and the establishment of a group on end of life care. There was evidence that these specific actions were either completed or in progress.

A remembrance event was planned for November 2013. A bereavement leaflet for relatives 'When you experience a bereavement' had been developed. The leaflet offered practical information on what to do following a death, information on how to access bereavement/counselling services and how to register a death.

Questionnaires, asking relatives' opinions regarding end of life care, were sent to the relatives of deceased residents. The response rate was 40%. While most responses reflected satisfaction with the care received, other responses included references to the lack of availability of a single room and staff/family communication.

Staff training records indicated that in 2013:

- thirteen attended training in the Irish Hospice Foundation (IHF) programme 'What matters to me' in October 2013 and further training was planned for staff in November 2013
- two staff nurses had attended IHF end of life care in 2010
- one staff nurse had attended post graduate training on interdisciplinary palliative care in 2007
- one staff nurse had attended training on caring for patients with pain and on the use of a syringe driver (a mechanical pump used to administer medications) in 2009
- two staff nurses had attended training on end of life care for older people; pain management in 2008 and 2013.

Staff voiced how beneficial they found the training on end of life care and were knowledgeable in how to physically care for a resident at end of life.

Religious and cultural practices were facilitated. Residents had the opportunity to attend religious services held in the centre and ministers from a range of religious denominations visited. Members of a pastoral care team visited the centre. However, the policy did not include guidance to staff with regard to facilitating and engaging in cultural practices at end of life.

Family and friends were facilitated to be with the resident at end of life. An overnight /kitchenette facility for families, located on one of the units, was near completion. Residents and staff were involved in the choice of furnishings and decor. The person in charge was waiting on the delivery of some outstanding furnishings. Families had access to canteen services during the day and tea/coffee and snacks were provided and available at all times from the kitchenettes located on each unit.

The inspector reviewed care plans of deceased residents and noted that the residents had timely access to the attending medical officer and the out-of-hours service. The person in charge confirmed that residents had access to specialist palliative care, when required, and records reviewed evidenced this. There was evidence that residents received care at the end of his/her life which met his/her physical, emotional, social and spiritual needs. Documentation indicated that, within the last two years, 91% of deceased residents had their end of life care needs addressed without the need for transfer to an acute hospital.

The policy included that the resident's wishes and choices concerning end-of-life care were discussed and recorded, implemented and reviewed on a regular basis with the resident. However, the inspector noted that the majority of residents did not have an end of life plan of care. The person in charge stated that the implementation of end of life care plans for residents had just commenced and the inspector saw evidence of this.

There was evidence that medication management was regularly reviewed and closely monitored by the attending medical officer. This is discussed in further detail under outcome 8.

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector reviewed the person in charge's self-assessment questionnaire and the overall self assessment of compliance with Regulation 20: Food and Nutrition and Standard 19: Meals and Mealtimes. The person in charge had assessed the centre as having a moderate non compliance. Based on the findings on the day of inspection, the inspector concurred with this assessment.

The centre had up-to-date policies on food and nutrition. A record of staff training submitted to the Authority indicated that:

- 41 staff nurses, 46 care staff and 15 catering staff had attended training in consistency descriptors facilitated by the speech and language therapist (SALT) in August 2011
- 5 chefs had attended training, facilitated by an external company on modified consistency and natural fortification, in May 2013
- an acting catering officer completed further education and training awards council (FETAC) level 5 training in food management and hygiene in 2013
- 5 catering staff completed training in management of food hygiene in 2008
- 20 catering staff attended refresher training in food hygiene in 2008

The in-house speech and language therapy service (SALT) provided ongoing training to staff in food and nutrition, food consistency and dysphagia.

The inspector reviewed records of resident meetings and no issues were noted pertaining to food and nutrition.

The inspector met with the chef and assistant chef, who confirmed that a formal meeting of a menu group was convened on a monthly basis. Menus, food choices and preferences, residents experiencing weight loss/gain and meal times were discussed. Positive planned initiatives arising from the menu group included serving evening tea at 16:30 hrs, with a plan to extend this time to 17:15 hrs. While soup was served three days of the week, it was now planned to offer homemade soup daily. It was evident that the catering staff had up to date communication with regard to residents' likes/dislikes and in particularly residents who were admitted to the centre. A two weekly menu was in operation. However, the catering department currently have no input from a dietician to ensure the nutritional value of resident's meals. Residents confirmed that a staff member came around daily informing them what was on the menu and confirmed that

they had a choice in the menu.

Documentation submitted to the Authority indicated that:

17 residents (23%) were on a diabetic diet
1 residents (1%) was on a coeliac diet
1 resident (1%) was on a weight reducing diet
1 resident (1%) was on a renal diet
2 residents (2%) were on a high protein/high energy diet
5 residents (7%) were on enteral nutrition
31 residents (47%) were on modified consistency diet
31 residents (47%) were on a nutritional supplement.

It was evident that the majority of residents had specific dietary requirements and would benefit from an up-to-date nutritional review. The person in charge stated that the residents used to have access to dietetic services (14 hours). However, residents had no access or input from the services of a dietician since July 2013. There was evidence that some residents were weighed regularly. However, some residents who had experienced a loss of weight had not been weighed monthly as documented on their notes. In the sample of residents' care plans reviewed, weight monitoring indicated that residents had a weight loss varying between one kg and 10 kg. In the absence of dietetic services, staff were initiating efforts to address the residents who had experienced a weight loss/gain and who had particular dietary requirements. This management included administering nutritional supplements that were not prescribed. Staff voiced their concern at the lack of availability of dietetic advice. Based on the findings on the day of inspection, the inspector was of the view that current practices posed a risk to residents. Subsequent to the inspection the person in charge:

- initiated an audit of the current status of all residents' nutritional requirement using a mini nutritional assessment (MNA)
- engaged the services of a dietician from an external company.

Residents had access to occupational therapy and dental services and there was evidence of this in residents' care plans.

A sample of medication administration charts pertinent to nutritional supplements, prescribed by the attending medical officer, were reviewed. This was discussed under outcome 8.

The inspector observed mealtimes including breakfast, mid morning refreshments and lunch. Breakfast was served to residents between the hours of 08:30 hrs to 09:30 hrs. There was evidence that choice was available to residents for breakfast, lunch and evening tea. Residents had a choice for breakfast; hot/cold cereals, breads, beverages, eggs cooked to their preference. All had the option of having their breakfast served in bed, in the dining rooms or at their bedside and at a time of their choosing.

Hot trolleys containing lunch were transported from the main kitchen to the kitchenettes on each of the three units. Lunch was served from 12:20 hrs onwards. The inspector noted that lunch, in sufficient portions, was plated and attractively presented in an appetising manner. Gravies/sauces were served separately if required. Liquidised food

was served in separate moulded portions with the moulds resembling the original food form. Staff informed the inspector that residents could choose to have their meal in the dining room or in their room. On the day of the inspection, residents dined in the dining rooms or in their bedrooms. Residents were very complementary of the lunch. Evening tea was served from 16:30 hrs onwards.

Staff were observed assisting residents, particularly residents with a cognitive impairment, in a sensitive manner. While most staff were observed using the mealtimes as an opportunity to communicate and interact with residents, some staff did not engage with the residents. The inspector also noted staff putting plastic aprons on residents, without consulting or engaging with the resident. This practice did not promote residents' dignity.

Snacks and hot and cold drinks including fresh drinking water were readily available throughout the day. The inspector noted that staff levels were adequate to meet the needs of the residents during mealtimes. Residents received their meal in a timely manner.

Assistive cutlery or crockery required for a resident with reduced dexterity was provided when required.

The person in charge was asked to review the table settings in all units, so as to ensure that the dining tables were set in an attractive manner for the residents. Subsequent to the inspection the person in charge informed the inspector that table cloths, serviettes and delph had been procured.

The centre's complaints log was reviewed and there was no evidence of any issues pertinent to food and nutrition.

The centre was undergoing a programme of refurbishment which resulted in one unit (Sarfield unit) being temporarily located to another area. 21 residents were accommodated in this unit. It was evident that staff pursued all efforts in order to ensure that the temporary move did not impact in a negative manner on the residents' dining experience. The inspector noted that lunch was sociable, relaxed and unhurried. The Shannon unit, accommodating 28 residents, had recently been refurbished resulting in the provision of new dining rooms/unit kitchen and a family overnight room incorporating a kitchenette.

The Thomand unit accommodated 21 residents. Some residents chose to have their meal in the dining rooms or at their bedside. The residents' dining experience in this unit required review to ensure that it was more homely and that dining tables were set in an attractive manner.

Outcome 17: Residents clothing and personal property and possessions

Adequate space is provided for residents personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

There was a protocol for the return of personal possessions. However, on review it was evident that not all residents had an updated inventory of their personal belongings, signed by the resident where possible.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Geraldine Ryan
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 report¹

Centre name:	St. Camillus Community Hospital
Centre ID:	ORG-0000640
Date of inspection:	07/11/2013
Date of response:	06/12/2013

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 08: Medication Management

Theme: Safe Care and Support

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

The provider did not have in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Action Required:

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

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

There is a written operational policy in place relating to the ordering, prescribing, storing and administration of medicines in St Camillus Hospital. Policies on provision of nutritional supplements and bowel management will be reviewed and updated. A project in the catering department including meals; portion sizes and consistency appropriate to residents needs should result in a substantial reduction in the requirement for food/nutritional supplements. This work is ongoing and audits will form part of the implementation going forward.

All Nursing Staff will be asked to submit an up to date certificate of confirmation of completion of the ABA Medication management module in January 2014.

Proposed Timescale: 01/03/2014

Outcome 11: Health and Social Care Needs

Theme: Effective Care and Support

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

Not ensuring that a high standard of evidence-based nursing practice was provided.

Action Required:

Under Regulation 6 (3) (b) you are required to: Provide a high standard of evidence based nursing practice.

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

The DML nursing tool is evidenced based supported by "Care RAPs". These are complex tools and ongoing training will be sought through the NMPDU to provide the nurses with the learning opportunities required.

All policies are evidenced based and available in all departments.

Proposed Timescale: 10/12/2013

Theme: Effective Care and Support

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

Not setting out each resident's needs in an individual care plan developed and agreed with the resident.

Action Required:

Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

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

The DML Care Plan tool was introduced in 2012/2013 supported by training. A user

friendly guideline on how best to use this tool is being developed. This will allow staff to maximise the value of the tool and subsequently reflect care plan based needs assessment.

A letter will be sent to each resident or their care representative informing them of their named nurse and explaining the care planning process and inviting them to become involved in the creation/review of their care plan. On completion/ review the care plan will be signed by both parties. If signing is not possible this will be recorded.

A number of residents do not have close relatives visiting frequently or living in Ireland.

Proposed Timescale: 01/03/2014

Theme: Effective Care and Support

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

Not keeping each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

Action Required:

Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

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

CNM's will be instructed to supervise the completion/review of the care plans by named nurse in conjunction with residents keeping each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

The CNM's will be instructed to send a weekly report of the care plans reviewed each week to the DON for 3 months then monthly thereafter.

The issue of the three monthly reviews of the care plans have been brought to the attention of the CNMs. Each CNM is to undertake a review to identify the number of care plans that remain to be reviewed.

It is planned that an audit of the three monthly reviews will be incorporated into the Quality Improvement metrics.

Proposed Timescale: 10/12/2013

Theme: Effective Care and Support

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

Not revising each residents care plan, after consultation with him/her.

Action Required:

Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

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

Emphasis will be placed on this to ensure that the residents are actively involved in their care plan.

A letter will be sent to each resident or their care representative informing them of their named nurse and explaining the care planning process and inviting them to become involved in the creation/review of their care plan. On completion/ review the care plan will be signed by both parties. If signing is not possible this will be recorded.

Proposed Timescale: 10/12/2013

Theme: Effective Care and Support

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

Not notifying each resident of any review of his/her care plan.

Action Required:

Under Regulation 8 (2) (d) you are required to: Notify each resident of any review of his/her care plan.

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

A letter will be sent to each resident or their care representative informing them of their named nurse and explaining the care planning process and inviting them to become involved in the creation/review of their care plan. On completion/ review the care plan will be signed by both parties. If signing is not possible this will be recorded.

Proposed Timescale: 10/12/2013

Theme: Effective Care and Support

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

Not facilitating all appropriate health care and support to each resident on an individual basis to achieve and enjoy the best possible health.

Action Required:

Under Regulation 9 (1) you are required to: Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

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

Therapists including activation, physiotherapy, S&L therapy and OT, chiropody, hairdressing etc. are available to all residents. In addition to Medical and Psychiatry of Old Age and in-house X Ray services.

Proposed Timescale: 10/12/2013

Theme: Effective Care and Support

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

Not facilitating each residents access to physiotherapy, chiropody, occupational therapy, or any other services as required by each resident.

Action Required:

Under Regulation 9 (2) (b) you are required to: Facilitate each residents access to physiotherapy, chiropody, occupational therapy, or any other services as required by each resident.

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

Chiropodist services are provided to all residents of St. Camillus Hospital.

Physiotherapy and Occupational Therapy assessments and associated recommendations are available to the residents of St Camillus Hospital.

Speech and language therapy is available to the residents as well as ward based residents, relatives and staff training sessions.

On site dental services are available if required. Residents are facilitated to attend a dentist of their choice if requested.

A hospital wide nutritional needs assessment commenced on Monday 2nd December 2013 conducted by the community dietician.

Business Case is being progressed by the SOM with regard to the provision of a dietician.

Training on aspects on nutrition were provided to staff and some residents have been assessed since the inspection.

Proposed Timescale: 10/12/2013

Outcome 14: End of Life Care

Theme: Person-centred care and support

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

Not all residents had an end of life care plan capturing the resident's preferences with regard to care at this time.

Action Required:

Under Regulation 14 (1) you are required to: Put in place written operational policies and protocols for end of life care.

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

An action plan was completed as part of the pre inspection self assessment document on End of life Care The inspection report states "There was evidence that these specific actions were either completed or in progress."

Capturing the resident's end of life care preferences is one of the most challenging areas for staff to discuss with residents. Staff are continuing to work with the residents and their families with regard to creating end of life care plans

Twenty staff have been trained on "What matters to me" training conducted by the Hospital Friendly Hospice programme. Such training will be on-going.

A new Family Room is near completion.

Newly agreed protocols will be included in an updating of the "End of Life care" policies to inform practice e.g. Family Room availability.

Proposed Timescale: 10/12/2013

Outcome 15: Food and Nutrition

Theme: Person-centred care and support

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

Some staff assisting residents with their meal, did not communicate or engage with the residents. The inspector also noted staff putting plastic aprons on residents, without consulting or engaging with the residents. This practice did not promote residents' dignity.

Action Required:

Under Regulation 20 (4) you are required to: Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.

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

CNM's have will conduct teaching sessions on communication and dignity especially in relation to meal times with staff on their wards.

DoN & ADON along with the CNM's will monitor communication, engagement and experience of the resident at meal times to constantly improve the residents dining

experience.

A new improved coloured napkin/serviette is in use.

Proposed Timescale: 01/02/2014

Theme: Person-centred care and support

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

Not providing each resident with food and drink that takes account of any special dietary requirements and is consistent with each residents' individual need.

Action Required:

Under Regulation 20 (2) part 6 you are required to: Provide each resident with food and drink that takes account of any special dietary requirements and is consistent with each residents individual needs.

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

As described in the pre inspection self assessment document "A LEANing on Excellence " project is currently being implemented in the catering Department.

As part of this project on Monday 18th of November training commenced by an external chief on a three week cycle menu, which encompasses nutritional requirement, appropriate consistency, choice and variety of meal choice for all residents.

The resident's assessment document includes a nutritional and hydration assessment tool from which an individual care plan if required is devised. The implementation of this will be included in the review undertaken by each CNM.

Proposed Timescale: 10/12/2013

Outcome 17: Residents clothing and personal property and possessions

Theme: Person-centred care and support

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

Not maintaining an up-to-date record of each resident's personal property, signed by the resident.

Action Required:

Under Regulation 7 (2) you are required to: Maintain an up to date record of each residents personal property that is signed by the resident.

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

On admission a record is created of all personal property that each resident has in the

hospital.

A system will be put in place whereby the property record will be updated as part of the three monthly reviews in conjunction with the resident. If the resident is capable and willing to they may sign the property list or their relative/carer.

Proposed Timescale: 10/12/2013