Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St Luke's Home
Name of provider:	St Luke's Home Cork Company Limited by Guarantee
Address of centre:	Castle Road, Mahon, Cork
Type of inspection:	Short Notice Announced
Date of inspection:	29 September 2020
Centre ID:	OSV-0000290
Fieldwork ID:	MON-0030305

About the designated centre

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

St Luke's Home is a purpose-built facility, in operation on the current site since 1994 and provides residential accommodation for up to 128 residents. Following a series of redevelopments and extensions accommodation is arranged throughout four nominated 'houses' or units. Three of these units provide accommodation for 30 residents, comprising 18 single, two twin, and two four-bedded bedrooms. The fourth unit is dedicated for residents with dementia or a cognitive impairment, and the design and layout of this unit is in keeping with its dementia-specific purpose. Accommodation on this unit is laid out in a north and south wing, comprising 30 single and four twin rooms and accommodates 38 residents in total. All bedrooms have en-suite facilities including toilet, shower and hand-wash basin and additional communal shower and toilet facilities are also available close to communal areas on each unit. Each of the units have their own dining and living rooms. There are numerous additional communal areas and facilities available in the central area of the centre which includes the main restaurant, a large oratory for religious services and a spacious conservatory/ activity area that was bright with natural lighting. There is an arts and craft room and a separate library. Residents also have access to a hairdressing facility in this area. All communal areas are furnished in a homely style with dressers and soft furnishings and the centre is decorated with pictures, paintings, familiar furniture and soft furnishings throughout. The centre provides residential care predominately to people over the age of 65. It offers care to residents with varying dependency levels ranging from low dependency to maximum dependency needs. It offers palliative care, care to long-term residents with general and dementia care needs and has two respite care beds for residents with dementia. The centre provides 24-hour nursing care with a minimum of nine nurses on duty during the day and four nurses at night time. The nurses are supported by the person in charge, nurse managers, care, catering, household and activity staff. Medical and allied healthcare professionals provide ongoing healthcare for residents. The centre employs the services of a physiotherapist five days per week, occupational therapy, chiropody, dietetics, dentistry, ophthalmology and speech and language therapy is also available in the centre. St Luke's Charity continues to invest considerable and ongoing resources to support the Home during the global COVID-19 pandemic.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	121

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 29 September 2020	09:00hrs to 18:00hrs	John Greaney	Lead
Wednesday 30 September 2020	09:00hrs to 18:30hrs	John Greaney	Lead
Tuesday 29 September 2020	09:00hrs to 18:00hrs	Breeda Desmond	Support
Wednesday 30 September 2020	09:00hrs to 18:30hrs	Breeda Desmond	Support

What residents told us and what inspectors observed

The inspectors spoke with many residents on the day of inspection. Feedback was positive in relation to residents' relationship with staff, and people were happy with the care and attention they received. They described staff as helpful, kind and respectful. Discussions with staff indicated that they knew individual residents well and were able to relate to the inspector the specific care needs, on an individual basis. Staff were knowledgeable about each resident's preferences for personal care and for their daily routines.

There was a relaxed and homely atmosphere in the service and inspectors observed respectful and friendly interactions and chat between staff and the residents. Inspectors observed that residents were treated with kindness and respect. It was evident that they were familiar and comfortable in each others' presence. Observations demonstrated that staff knew residents' preferences and routines and these were facilitated in a caring manner. Residents were well dressed and appeared comfortable and relaxed in their setting.

Visiting restrictions had been relaxed in accordance with national policy. Visitors were seen adhering to infection control measures put in place to safeguard people in the centre. There was a designated staff member overseeing visiting, confirming that visitors did not have COVID-19 symptoms, had not been in contact with anyone known to have the virus and checking temperatures.

While there was some general concern regarding the impact of the global COVID-19 pandemic and the restrictions in place in response to it, residents were in good spirits during the day. Some residents said they would prefer if COVID-19 restrictions were not in place, but they understood the necessity for the restrictions. Some residents told the inspector that they understood why some things needed to change with life in the home but that they weren't going to let it get them down. Residents had gotten used to staff wearing face masks.

There were dining facilities in each of the units but there was also a large cafeteria near the main entrance. Dining in the cafeteria had recommenced and some residents were observed enjoying their meals there, while other residents had their meals in the smaller dining rooms or in their bedrooms.

Residents spoke highly of the staff and told the inspector that they liked their home. Residents also commented that the food was quite good and that they had options if they wanted something other than what was on the menu. Staff provided residents with snacks during the day and provided assistance in a discrete manner.

Capacity and capability

This was a good service with a clearly defined management structure with clear lines of accountability and responsibility for the day to day operation of the service. There were adequate management systems in place to oversee the quality and safety of care delivered to residents, detailing the contingency arrangements for staffing should a number of staff be required to self-isolate.

Inspectors followed up on issues identified for improvement on the previous inspection, which was conducted in January 2019. On this inspection improvements were noted in the areas of complaints management, fire safety and in the use of bed rails. As found on the previous inspection, not all contracts of care contained details of the room to be occupied by each resident. While there were improvements in training records, further improvements were required.

The registered provider is St. Luke's Home, Cork, Ltd., which is a charitable organisation and is governed by a board of directors. There is a chief executive officer (CEO) that has overall responsibility for the day to day operation of the centre. There is an executive management team, comprising senior managers from nursing, administration, the education and research centre, finance and human resources. Clinical oversight is provided by a director of nursing (DON) reporting to the CEO and supported by a team of managers that include two assistant directors of nursing (ADON) and a number of clinical nurse managers (CNMs). There is a CNM 2 on duty each weekend and a CNM 1 on duty each night with responsibility for oversight of the centre with the support of either the DON or ADON that are on-call on a rotational basis.

There are regular management meetings that include board meetings, executive team meetings, clinical nurse manager meetings and health and safety meetings. The CEO also meets individually with each member of the executive team on a weekly basis.

A 'COVID-19' folder was in place which included up-to-date information from the Health Service Executive (HSE) and Health Protection and Surveillance Centre (HPSC). There were various guidance documents contained in the folder that were updated regularly to include the most recent guidance on the prevention and management of COVID-19. Policies were updated regularly and details of policies and procedures that were impacted by the pandemic were contained in the COVID folder.There was a contingency plan for COVID-19. The contingency plan identified the impact of reduced staff numbers on care provision but did not detail how to supplement staffing should a number of staff require to isolate. While management informed inspectors that they were aware of what additional capacity was available to them, this was not documented and therefore would not be available should a significant number of the management team be impacted by the virus.

Staffing levels were adequate to the size and layout of the centre and the number of residents accommodated at the time of inspection. Training records indicated that staff were facilitated to attend training, however, not all staff had attended up-to-date relevant training. Inspectors were informed that staff had access to an recently

developed application (app) on their telephones that provided online training on COVID related issues. Training records, however, viewed by inspectors identified gaps in training in areas such as hand hygiene, putting on and taking off personal protective equipment (PPE) and in safeguarding residents from abuse.

Staff were monitored for signs and symptoms of COVID-19 through temperature checks and the completion of a COVID-19 related health questionnaire. Staff hand-over meetings at change of shift provided a forum for staff to discuss HPSC guidance updates along with discussion on residents' care needs.

There were systems in place to manage critical incidents and risk in the centre and accidents and incidents in the centre were recorded, appropriate action was taken and they were followed up on and reviewed.

Regulation 15: Staffing

There were adequate numbers and skill mix of staff to meet the needs of residents living in the centre on the days of the inspection. Night time staffing comprised a nurse and one carer in each of Exham, Gregg and Wise houses and a nurse and three carers in Maguire house. There is also a HCA working from 15:00hrs to 23:00hrs in each of the houses and an additional nurse that works until 23:00hrs on Maguire house. As the centre had not experienced an outbreak, there were no staff shortages experienced to date, due to the COVID-19 pandemic.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were supported and facilitated to attend training. It was found on the previous inspection of this centre that it was difficult to establish if all staff had completed relevant training due to the system in place for recording attendance. Since that inspection the recording system had improved and was now more streamlined. However, it was not possible from a review of the spreadsheet to easily determine training completed by each staff member in a manner that would identify for management which staff were overdue attendance at training. Inspectors were informed that gaps in training on subjects such as hand hygiene, infection prevention and control, and donning and doffing PPE were as a result of gaps in records rather than gaps in training.

Judgment: Substantially compliant

Regulation 21: Records

Records were stored securely and easily retrievable. A review of a sample of personnel files indicated that there were good recruitment practices. All files contained recent Garda vetting disclosures, employment references, photographic identification, and full employment histories.

Judgment: Compliant

Regulation 23: Governance and management

There was a system in place for monitoring the quality and safety of care delivered to residents. There was an annual review completed for 2019 that identified activities for the previous year, achievements and also identified areas for improvement. There was a programme of audits that included reviews of medication management, care planning, infection prevention and control, and the management of restraint. The system for monitoring the quality and safety of care required review to ensure that it was comprehensive and addressed issues identified for improvement in a timely manner. For example, a number of areas for improvement were captured by inspectors on a tour of the centre that were not captured through the centre's own monitoring system. Additionally, while some issues identified through an infection prevention and control audit conducted on 30 August 2020 had been addressed some issues, such as the storage of hoist slings on coat hooks, had not been addressed.

There was an adequate system in place for the clinical oversight of the centre. There was a director of nursing and two assistant directors of nursing on duty each day Monday to Friday, with responsibility for all parts of the designated centre. Each unit also had a clinical nurse manager to supervise care delivery and provide guidance to nursing care staff. Management of the centre at weekends and at night was provided by CNMs that worked on a supernumerary basis.

There were systems in place for the prevention and early detection of COVID-19 in the centre. Residents were monitored for any change on their condition and staff had their temperature checked twice daily. There was serial testing of staff for COVID-19 and residents were tested when symptoms indicated that a test was required.

There was a contingency plan in place should there be an outbreak of COVID-19. The contingency plan for staffing required review as it did not identify what additional capacity was available to management within their own staffing complement should a number of staff be required to self-isolate. It also did not state where additional staff would be sourced should the centre's own staff complement be unable to meet the needs of residents.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Contracts of care were in place for residents. The contracts included details of the fees to be charged, including fees for additional services. From a sample of contracts reviewed, one contract did not contain details of the room to be occupied by the resident.

Judgment: Substantially compliant

Regulation 30: Volunteers

Prior to the COVID-19 pandemic there were a large number of volunteers that supported staff in the provision of activities and other services to residents. When restrictions were initially introduced, volunteers were not permitted to visit the centre. More recently a small number of volunteers have returned to the centre and there were adequate measures in place to ensure they complied with infection prevention and control practices. Personnel records were maintained for volunteers that contained their roles and responsibilities set out in writing and a vetting disclosure in accordance with the requirements of legislation.

Judgment: Compliant

Regulation 31: Notification of incidents

From a review of accident and incident records, notifications required to be submitted to the Chief Inspector were submitted within the relevant time frames. As will be discussed in more detail under Regulation 8 Protection, a small number of complaints should have been addressed under the safeguarding policy and should have been notified to the Chief Inspector.

Judgment: Substantially compliant

Regulation 32: Notification of absence

Notifications of periods when the person in charge was absent were submitted with details of the arrangements in place for the management of the centre during that

absence.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a policy and procedure for management of complaints that was kept under regular review. A summary of the complaints process was included in the statement of purpose and the procedure for making a complaint was clearly displayed at reception. The notice on display identified the complaints officer and the appeals process, should the complainant be dissatisfied with the outcome of the complaints process. A summary of the analysis of complaints was outlined in the annual quality review and available for reference.

A review of the complaints log indicated that complaints were recorded and investigated. The inspector reviewed records of closed complaints that indicated they were investigated and the satisfaction or otherwise of the complainant was recorded. There were also a number of ongoing complaints with evidence of communication with the complainants in an effort to address the complaint.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures in accordance with Schedule 5 of the regulations were available in the centre. A review of the policies indicated they were reviewed regularly and at a minimum of every three years. Amendments to policies in accordance with updated guidance relating to COVID-19 were detailed in a COVID-19 reference folder.

Judgment: Compliant

Quality and safety

Overall, residents were supported and encouraged to have a good quality of life which was respectful of their wishes and choices. Inspectors observed that residents appeared to be well cared and residents spoken with by inspectors gave positive feedback on life in the centre. Residents' needs were being met through good access to medical and nursing care, opportunities for social engagement within the limitations of COVID-19 related restrictions and an environment that offered

adequate private and communal space and good access to the outdoors. Improvements were required, predominantly in relation to infection prevention and control, fire safety and storage of equipment.

Residents had access to appropriate medical and allied health services. There was evidence of regular medical reviews and referrals to specialist services as required. The centre employed a physiotherapist providing a service to residents for approximately twenty eight hours each week. Residents also had access to an occupational therapist that visited the centre on a monthly basis. Other services available included, speech and language therapy, dietetics, dental, and ophthalmic.

Nursing documentation was found to be completed to a high standard. Nursing assessments, including pre-admission assessments, informed the development of care plans and these were found to be person-centred, individualised and clearly described the care to be delivered. Systems were in place to ensure that care plans were reviewed and updated on a regular basis.

The design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely way. Residents had access to a number of secure outdoor areas, which were accessible from various parts of the centre. Residents also had access to pathways around the centre and walks down by the waterfront. There is good access to communal space allowing residents to maintain social distancing while in the various sitting rooms. While the centre was generally in a good state of repair, some areas required painting as there were scuff marks on walls. There was also a need for a review of storage facilities and equipment was seen to be inappropriately stored in various locations throughout the premises, which at times partially obstructed emergency exits.

There was an enhanced cleaning protocol and the centre was generally clean throughout. Staff were observed to adhere to good infection prevention and control protocols that included good hand hygiene practices and the appropriate use of PPE. Some improvements, however, were required, particularly in relation to the use of colour coded waste bins. For example, some clinical waste bins were yellow in accordance with the recognised colour coding systems, while others were white. There was also a need to ensure that clinical waste bins were stored appropriately. Other areas that required review included the need to ensure that hoist slings were stored appropriately and a need to install a wash hand basin in a housekeeping room.

There was good evidence of consultation with residents and relatives. Minutes of residents meetings indicated that issues raised were addressed. There was an advocate employed by the centre that was a good resource to residents and staff. Residents also had access to independent advocacy services and posters with contact details were displayed throughout the centre. There was a good system in place for communicating with residents and relatives. Leaflets and emails were seen to be distributed to ensure that residents and their families were kept up to date with any developments. Television and radio was widely available and residents were also seen to use personal phones and devices for communication. There were

a number of electronic tablets available so the residents could have video calls with their family members. There were adequate facilities for visitors to meet with residents and visiting was scheduled in accordance with guidance and also took account of the prevailing COVID-19 status within the community.

While there were procedures in place for fire safety, some improvements were required. For example, emergency exits were seen on occasion to be partially obstructed with equipment. There was also a need for a review of doors leading from some sitting rooms to internal gardens in the context of their role in the system for evacuating residents from the centre. It was not clear when or if these doors formed part of an evacuation strategy. There was also the possibility of being unable to return to the premises from the enclosed courtyard as at times the doors could not be opened from the outside. While there was a positive focus on fire safety, with regular fire drills, the scenario simulated could be enhanced through ensuring that staff practiced the evacuation of an entire compartment rather than an individual bedroom.

There was a scheduled programme of activities and residents were observed to be enthusiastically participating in activities in small groups. Activity personnel also ensured that one-to-one activities for residents that did not participate in group activities.

Regulation 11: Visits

Visiting was facilitated in accordance with HPSC guidance. Visiting had been stopped for approximately two weeks based on an assessment by management that there was an increase in the incidence of COVID-19 in the community. Visiting had once again resumed with a requirement that visits were arranged in advance. There were adequate arrangements in place for visitors to safely visit residents while observing social distancing. There were also adequate arrangements for the relaxation of restrictions on compassionate grounds for residents that were ill or nearing end of life.

Judgment: Compliant

Regulation 12: Personal possessions

There were very good laundry facilities with a system for segregating clean and dirty linen. There were procedures in place for returning clothing to residents following laundering. There was also a process for identifying laundry that did not have a label to identify ownership.

Bedrooms were personalised with adequate space for residents to store their clothing and personal possessions. A review as required of the twin bedrooms as

due to the arrangement of the furniture in some bedrooms meant that residents could not access their bedside lockers while they were in bed.

Judgment: Substantially compliant

Regulation 13: End of life

A review of records indicated that a high standard of care was provided to residents as they approached end of life. Advanced care directives (ACD) were completed for residents indicating their preferences for medical interventions in the event of becoming unwell.

Judgment: Compliant

Regulation 17: Premises

The centre is designed and laid out to meet the needs of residents. The centre is divided into four sections named Gregg House, Wise House, Exham House and Maguire House. Gregg, Wise and Exham houses each accommodate 30 residents in 18 single, two twin and two four-bedded rooms. Maguire House is the designated dementia unit and accommodates 38 residents in 30 single and four twin bedrooms. All of the bedrooms have en-suite facilities. There was adequate space between the beds in the shared bedrooms to facilitate physical distancing.

Bedrooms were personalised and enjoyed natural light. Corridors had handrails and call bell facilities were available in each bedroom. Communal bathroom and toilets were available at convenient locations along circulating corridors and within close proximity to the communal sitting and dining rooms. There was safe enclosed outdoor spaces with pathways and appropriate seating for residents. There was a choice of communal spaces and quiet rooms for residents and their visitors and these spaces mostly enjoyed lots of natural light.

While the centre was decorated to a high standard that included comfortable seating for residents, some areas of the centre required painting. Inspectors were informed that this was in the process of being addressed but works were delayed due to risks associated with external contractors entering the centre during the COVID-19 pandemic. There was also a need to review storage facilities as equipment was stored at various locations throughout the centre and at times posed a fire safety and infection control risk.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' nutritional status and dietary preferences were reviewed on admission to the centre, and where a specific diet was required the information was passed to the kitchen and staff. Staff who spoke with inspectors were familiar with resident's specific dietary needs and this information was shared at handover to support residents' safety.

Each resident was monitored for the risk of malnutrition during their stay and, where issues were identified, food intake was monitored and appropriate referrals were made, for example to a dietitian or speech and language therapist.

Residents reported that they enjoyed the food in the centre and that it was provided in sufficient quantities. They mentioned that if they did not like the choices available they were provided with suitable alternatives. Food was attractively presented and residents requiring assistance were assisted in a respectful and dignified manner.

Discussions with the chef indicated that catering staff were familiar with residents' dietary preferences and requirements. The chef also identified a plan for food preparation should the catering staff be impacted by the Covid-19 virus.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

A review of a sample of records of residents that were transferred to hospital indicated that there was good detail shared with the admitting facility, so that they could adequately care for the resident. A copy of the transfer letter was maintained in the residents' files.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy was updated to reflect the COVID-19 pandemic. The risk register had COVID-19 related risks identified with hazards and controls detailed to mitigate the risk to residents, staff and visitors. However, while COVID related risks were identified, the potential for staff shortages was not adequately addressed should a number of staff test positive for the virus. Additionally, the risk related to the spread of infection and the need to cohort a number of residents in a designated area should they test positive for the virus was not adequately addressed

under risk management.

Other risks identified during the inspection included:

- clinical waste bins were not adequate secured from unauthorised access
- the door to a clinical room was found unlocked on one occasion

Judgment: Substantially compliant

Regulation 27: Infection control

Inspectors acknowledged the effective infection control procedures adopted by staff which had resulted in the centre remaining clear of COVID-19 to date.

Staff had access to personal protective equipment and there was up to date guidance on the use of this available. All staff were observed to be wearing surgical face masks in accordance with the current health protection surveillance (HPSC) guidance. Hand hygiene notices were displayed and staff and residents had information and training on proper infection prevention and control practices.

Staff on duty confirmed that they had adequate supplies of PPE and were confident that they had appropriate knowledge to ensure they used them appropriately. Temperature checks were completed for staff each day. Staff had also been advised of the COVID-19 symptoms to be aware of, including the more unusual symptoms that sometimes presented in older people.

Inspectors identified the following areas that required improvement to ensure good infection prevention and control standards:

- colour coding of waste bins did not adhere to recognised colour coding. For example, some clinical waste bins were yellow while others were white but had a clinical waste sign attached to them
- some clinical waste bins were inappropriately stored, such as in an internal courtyard and were not always lockable
- a housekeeping room did not have a wash hand basin
- a sluicing sink in the laundry had hand wash gel and a paper towel dispenser that may inappropriately indicate it was for hand washing purposes
- a bedroom that was identified as being ready for an admission required further cleaning
- hoist slings were inappropriately stored on hooks on walls and on the handle of hoists and were not identified for individual use
- linen trolleys were stored on corridors and at times were obstructing fire doors.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Measures were in place to protect residents and staff against the risk of fire. Suitable fire fighting equipment was available and was serviced annually. The fire alarm was tested weekly and had preventive maintenance completely every three months. Emergency lighting was tested regularly by maintenance personnel employed by the centre. Personal Emergency Evacuation Plans (PEEPS) were in place for all residents.

Staff spoken with were knowledgeable of what to do in the event of a fire. Fire drills were conducted on a regular basis, and included drills involving night staff. However, the scenario simulated was predictable and usually involved the simulated evacuation of one resident from a bedroom. The provider was requested to review fire drills to ensure that staff were adequately prepared for evacuating residents from various locations to include the simulated evacuation of an entire compartment.

Other improvements required in relation to fire safety included:

- fire doors were seen to be frequently obstructed throughout the two days of the inspection by various pieces of equipment, including linen trolleys, trolleys containing PPE, and chairs. Inspectors requested that this be addressed immediately during the inspection
- daily checks of means of escape did not identify emergency exits that were partially obstructed
- doors in some sitting rooms were identified as emergency exits leading to enclosed courtyards. Management or staff could not identify for inspectors the role these exits played in the evacuation of residents in the event of an emergency
- should a resident of staff member use the emergency exit to the internal courtyards, there was not always a way to return to the centre as other doors were locked and could not be opened from the outside.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were written operational policies and procedures in place on the management of medications in the centre. Medications requiring special control measures were stored appropriately and counted at the end of each shift by two registered nurses. A sample of prescription and administration records viewed by the inspector which contained appropriate identifying information. Medications requiring refrigeration were stored in a fridge and the temperature was monitored and

recorded daily.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Each resident had a comprehensive pre-admission assessment conducted prior to admission. Information collected about each resident on admission, and throughout the residents' stay in the centre was used to develop a person-centred care plan. There was evidence of a multidisciplinary approach to care delivery. Documentation used was comprehensive and based on scientific tools to assess care. A sample of care plan documentation was reviewed inspectors. Care plans were very informative and and provided good guidance on care to be delivered to each resident on an individual basis.

Judgment: Compliant

Regulation 6: Health care

The health needs of residents were reviewed and overall they had access to a range of healthcare services. All residents had access to general practitioner (GP) services and records indicated that they were reviewed on a regular basis. There was an out-of-hours GP service available if a resident required review at night time or during the weekend.

There was access to allied healthcare professionals including physiotherapy, occupational therapy, dietetics and speech and language therapy.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There were policies in place about meeting the needs of residents with responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice.

Inspectors reviewed residents' records and noted that a comprehensive assessment had been undertaken. Possible triggers had been identified and staff spoken with were very familiar with appropriate interventions to use. Support and advice were

available from the psychiatric services.

The inspector reviewed the use of restraint and found that improvements had been made since the last inspection resulting in a significant reduction in the use of bedrails. Risk assessments were conducted prior to the use of bedrails and there was evidence of the exploration of alternatives to bedrails.

Judgment: Compliant

Regulation 8: Protection

The inspector found that measures were in place to protect residents from being harmed or abused.

All residents spoken with said they felt safe and secure in the centre, and stated that staff were supportive. Staff were knowledgeable of what action to take if they witnessed, suspected or had abuse disclosed to them. A review of complaints records indicated that some issues recorded in the complaints log and investigated under the complaints procedure should more appropriately have been investigated under the safeguarding policy.

Records reviewed confirmed that staff were facilitated to attend training on safeguarding residents from abuse.

The provider was pension agent for a number of residents and there were adequate banking arrangements in place for the management of residents' finances.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspectors saw that staff were respectful and courteous towards residents. There were good positive interactions between staff and residents observed during the inspection. Residents were observed to have freedom to use telephones and to conduct their business affairs at times that suited them. Staff were observed to undertake moving and handling manoeuvres in a gentle and competent manner that ensured residents' comfort and they explained the varied procedures they were undertaking at each step.

Residents told the inspector that they received good care and support from all staff. There were regular residents meetings, which provide a forum for residents to have a say in the day to day operation of the centre.Records indicated that issues raised were addressed.

The activities schedule was discussed with the activities coordinator and it was evident that considerable effort had been made by the activities coordinator, and indeed by all staff, to support residents in recreation and occupation in the absence of visiting activity personnel.

The centre had a number of electronic tablets that were in constant use. Residents in the centre regularly used the tablets to video call their relatives. The activities coordinator created a schedule so that time was set aside for each resident to have access to the tablets. Some residents were now in more frequent contact with relatives than prior to the NPHE.

A member of staff acted as advocate for residents and was a good resource for residents that required assistance. There was also access to external advocacy services.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 32: Notification of absence	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St Luke's Home OSV-0000290

Inspection ID: MON-0030305

Date of inspection: 30/09/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Currently due to the Covid-19 pandemic, we are incorporating a blended approach model in terms of our mandatory training. St. Luke's as part of our quality improvement plan is currently reviewing our options surrounding a web-based workforce management information system. This system will incorporate our HR training systems. We will audit all mandatory training on a quarterly basis.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A quality improvement plan is currently in progress. St. Luke's will establish an Audit Committee, incorporating all the multidisciplinary team players. The audit committee will identify key areas of continuing improvement required for the Home. It aims to build on an already established culture of quality improvement. Audit is also a standing item on our weekly team meetings. Our contingency plan provides all key operational details in the event of a Covid-19 outbreak. These details include a designated area of isolation for residents, staff lists setting out availability for extra shifts and links with external agencies for staffing purposes in the event of a Covid-19 outbreak.	

Regulation 24: Contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services: All contracts of care include allocation numbers for rooms. All changes in room allocation will be communicated to the resident and next of kin and documented accordingly. These contracts will be audited as part of our quality improvement plan.	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: St Luke' s has established a safeguarding committee and safeguarding will be audited as part of our quality improvement plan.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: Further education regarding person-centered care will be provided to staff on the importance of residents having access to their personal possessions.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Our Capital Expenditure Plan will be enacted along with an immediate risk assessed recommencement of our routine facility maintenance programme.	

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Our contingency plan provides all key operational details in the event of a Covid-19 outbreak. These details include a designated area of isolation for residents, staff lists setting out availability for extra shifts and links with external agencies for staffing purposes in the event of a Covid-19 outbreak.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
St Luke's is currently implementing the action plans of our Infection Prevention and Control audit issued on the 21st September 2020. Infection Prevention and Control will continue to be part of our audit schedule. We will also enhance, promote, and support our own internal infection control resource. We will also support the education of our healthcare workers around infection, prevention, and control.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
We will follow guidance from our Fire Safety and Training experts. We will deliver the required and agreed building changes and engage further with our fire training providers to modify our training program in line with your noted suggestions.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

Our blended training model has been enhanced to include safeguarding discussions. Notification of safeguarding concerns is highlighted in management meetings.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	30/01/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/03/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out	Substantially Compliant	Yellow	01/07/2022

	in Schedule 6.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/01/2021
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/12/2020
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	28/02/2021
Regulation 27	The registered provider shall ensure that	Substantially Compliant	Yellow	30/01/2021

	procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/01/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/01/2021
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	30/01/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within	Substantially Compliant	Yellow	30/11/2020

	3 working days of its occurrence.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	30/11/2020