



Report of an inspection of a Designated Centre for Older People

Name of designated centre:	St Camillus Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Shelbourne Road, Limerick
Type of inspection:	Announced
Date of inspection:	05 March 2018
Centre ID:	OSV-0000640
Fieldwork ID:	MON-0020756

About the designated centre

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

The designated centre of St Camillus' Community Hospital is located on the main campus of the hospital in Limerick city. The centre is operated by the Health Service Executive (HSE) and is registered to accommodate a maximum of 82 residents. At the time of inspection there were 65 residents registered at the centre. Information provided in the statement of purpose for the centre describes care for people over 18 years of age across the range of abilities from low to maximum needs in relation to advanced age, vascular and neuro-injury, dementia and physical or psychiatric chronic illness. Care planning processes are in accordance with assessments using an appropriate range of validated assessment tools and in consultation with residents. Arrangements are in place to provide residents with access to activities and there is a variety of communal day spaces provided including a large activity area on the first floor. Visiting arrangements are in place and residents are provided with information about health and safety, how to make a complaint and access to advocacy services.

The following information outlines some additional data on this centre.

Current registration end date:	10/06/2018
Number of residents on the date of inspection:	65

How we inspect

To prepare for this inspection the inspector or 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
05 March 2018	11:00hrs to 18:30hrs	Mairead Harrington	Lead
06 March 2018	09:00hrs to 17:00hrs	Mairead Harrington	Lead
05 March 2018	11:00hrs to 17:45hrs	Maria Scally	Support

Views of people who use the service

The inspectors met and spoke with residents throughout the inspection in various locations of the centre, including on the wards, in communal areas and in individual rooms. Inspectors received feedback from several residents on each of the wards and also met with some of their visitors and relatives. Residents were generally very positive in their feedback about the care they received. The inspectors spoke again with residents who had been met on the previous inspection and who commented that they were pleased with the increased access they now had to the main activity centre on the first floor, and both they and their relatives remarked on the benefits of being able to use this facility every day. Residents said that they were encouraged and enabled to attend family and community events, such as weddings and birthday celebrations. Residents commented that staff were nice and helpful and that they worked hard and the place was well kept. Residents spoken with indicated they did not have any specific complaints though some expressed preferences for more space to be able to store their belongings.

The inspectors noted that feedback from residents who were in single and lower occupancy rooms indicated that they felt they had good choice around their daily routine, such as when they got up and went to bed, or when and where they received visitors, for example. Feedback was also positive from residents and their visitors in some of the higher occupancy wards, though some residents in these wards indicated they did not have much control over their environment and commented on noise around their beds that woke them up in the morning, for example. Residents did acknowledge that staff made efforts to limit the impact of these circumstances and positive feedback was given on a colourful privacy screen that had been introduced in one ward since the previous inspection.

Inspectors also reviewed questionnaires that had been completed by residents and their relatives, as well as satisfaction surveys that had been undertaken by management in relation to areas of care such as the provision of healthcare, catering, respect and activities. Feedback included some examples of dissatisfaction in relation to available space for personal belongings, a preference for improved activities and better access to outdoor space. The feedback otherwise was positive and echoed the information that residents had shared with inspectors during conversation. The views expressed were mainly positive in relation to the standard of care provided.

Capacity and capability

Overall, the centre provided a very good standard of care in keeping with the needs of the resident profile. The registered provider had effective management systems that demonstrated a clear governance framework. This included a defined line management structure with clearly allocated roles and responsibilities, including appropriate reporting mechanisms to ensure functions were effectively delegated. Senior management and staff were appropriately qualified for their role and demonstrated their competence and capability in the course of the inspection. Governance arrangements for the service were as set out in the statement of purpose and there were systems in place to collate and review quality data to identify and assess areas for improvement.

Management articulated a commitment to regulatory compliance and a culture of improvement. Measures to improve the service had been implemented since the previous inspection and residents now had regular access to the communal recreation area. The deployment of resources had also been reviewed to support the provision of a suitable activity programme. The centre had two nominated staff members with responsibility for implementing an activation programme for residents that was available each day, including weekends, until 7.30pm. However, not all areas for improvement had been fully addressed. The continued use of multi-occupancy rooms for up to five residents impacted adversely on the daily quality of life and residents' privacy and dignity in this accommodation. These circumstances were acknowledged by both staff and management.

Management ensured a safe service was provided through the implementation of an ongoing quality management system that included the collation and review of information on incidents and accidents, as well as regular audits in key areas of care such as infection control, medication management, clinical care documentation, falls, use of restraint and the management of wound care. Appropriate arrangements were in place to protect residents from accidents that included an effective risk management policy and procedures for recording, investigating and reviewing incidents.

Communication systems included regular staff and management meetings, with regular regional meetings for senior management. Management were generally responsive in providing information required under the regulations, though there had been instances since the previous inspection where a substantial number of notifications had not been submitted within the required time frames. These omissions had since been satisfactorily addressed and management had implemented a revised protocol to ensure that all relevant information was notified in keeping with requirements.

The service provided good supervision for staff and there was a clinical nurse manager or senior staff nurse with responsibility for each ward. Management confirmed that there had been learning in relation to safeguarding incidents

reported since the previous inspection, and that the supervision of agency staff in particular had been improved through increased daily safety pauses and the provision of more detailed information around residents' needs at handover meetings. Management confirmed that these measures were kept under review as part of the active risk register. Resource planning strategies included the use of agency staff and recruitment initiatives. The centre also operated below registered capacity to ensure staffing levels were in keeping with the level of occupancy. Management explained that revised induction processes for all staff were being introduced to further develop a positive care culture and focus on resident preferences. Staffing levels were also supplemented by agency resources as part of contingency measures to manage unplanned absences and staffing was under continual review. These arrangements were satisfactory to ensure the wellbeing of residents.

Recruitment processes included the verification of references and police vetting for staff, though vetting documentation was not available as per the regulations. There had been several appointments of both nursing and care staff since the previous inspection. Inspectors spoke with members of staff in all areas of the service who generally commented positively on effective teamwork and management support. Feedback in some instances referenced the challenges of supervising continuity of care and effective communication with a changing staff profile. As identified on the previous inspection, the roles of multi-task attendants were not clearly defined and there were gaps in training and education relevant to the provision of care to residents.

Measures were in place to consult with residents and relatives in the management of the centre. Many residents and visitors spoken with were aware of planning proposals to address accommodation issues. Residents' meetings took place regularly and satisfaction surveys had been undertaken. An annual quality review reflected standards of care and provided a plan on progressing quality improvement initiatives. These features demonstrated that the service engaged with residents for their views. Management had also provided residents and relatives with an opportunity for input by circulating a copy of the completed annual review and inviting comments and feedback at a scheduled consultation meeting. Appropriate systems were in place to ensure that, overall, records and information required by the regulations were available, accurate, safe and accessible.

Regulation 14: Persons in charge

The person in charge was qualified in keeping with statutory requirements and actively engaged in the governance, operational management and administration of the service. The person in charge and management team demonstrated a

commitment to the development of initiatives and quality management systems that ensured the provision of a safe and effective service.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were in keeping with the assessed needs of residents having regard to the size and layout of the service. Contingency arrangements were kept under review in relation to managing staff absences. Appropriate systems of supervision were in place with a registered nurse on duty at all times.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained.

Judgment: Compliant

Regulation 24: Contract for the provision of services

Contracts of care did not fully reference the terms relating to bedroom accommodation or occupancy levels for residents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A written statement of purpose was available that was kept under regular review. It contained all the necessary information as set out in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 30: Volunteers

An action required from the previous inspection in relation to vetting procedures for volunteers had been addressed.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge demonstrated an appropriate awareness of the statutory requirements in relation to returning notifications of safeguarding incidents. However, since the previous inspection a substantial number of notifications had not been returned within the required timeframes.

Judgment: Not compliant

Regulation 34: Complaints procedure

Procedures for receiving and responding to complaints were in keeping with the requirements of the regulations. A complaints policy was in place and a summary of the procedure was on display in communal and access areas of the centre. The policy cited relevant legislation and identified both the complaints and appeals officer. The procedure summarised an internal appeal process and provided contact information for the office of the Ombudsman.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures as required by Schedule 5 of the regulations were in place and kept under review as appropriate.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider ensured governance arrangements were in place that reflected the size and complexity of the centre and included the necessary quality assurance processes. The centre was appropriately resourced to provide an effective service in keeping with the needs of the resident profile. However, systems of communication and oversight required review to ensure that statutory notifications were submitted in keeping with requirements.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Management had not fully addressed the areas for improvement previously identified in relation to segregated staff roles and related training. Some members of staff continued in a multi-task role undertaking duties in relation to household and cleaning, as well as having responsibility for providing personal care to residents. While all staff had received mandatory training, many multi-task attendants had not received training relevant to their role in providing resident care around dementia, end of life and managing responsive behaviours, for example.

Judgment: Not compliant

Regulation 21: Records

Records checked, in respect of documents to be held in relation to members of staff, were generally in keeping with requirements. Confirmation of police vetting documentation for the sample of files reviewed was provided as per Schedule 2 of the Care and Welfare Regulations 2013. However, the required disclosure form was not maintained on-site for a member of staff who had been employed since April 2016. Current professional registration was in place for all members of nursing staff. Documentation as required by the regulations was in place for all volunteers.

Judgment: Not compliant

Quality and safety

Overall, the service provided good healthcare outcomes for residents whose wellbeing was supported by effective care planning processes and access to relevant services. However, issues in relation to the premises and environment remained and the use of multi-occupancy rooms to accommodate up to five residents continued to impact on residents' quality of life, personal communication and activities. A number of areas for improvement relating to the environment and the layout of accommodation had not been adequately addressed and, as a result, the service did not fully meet the needs of all residents in relation to privacy and dignity.

Observations of care and a review of documentation and systems indicated that there were suitable arrangements in place to meet the health and nursing needs of residents. The care and support provided for residents was of a very good standard. The safety of residents was well managed with evidence of appropriate risk management protocols in place and relevant training for staff. A very good standard of evidence-based care was evident, as per previous inspections. Documentation was in place to demonstrate that timely and comprehensive assessments were carried out and appropriate care plans were developed in line with residents' changing needs. Consent forms were in place and residents and their families were consulted about care. There was evidence that residents were consulted in relation to their care and could exercise personal choice when agreeing to care arrangements. Mobility care plans provided guidance on the use of assistive equipment where necessary. Wound care was regularly monitored and residents were assessed for pain and reviewed. Members of staff had a clear understanding of residents' needs and could reference relevant information on care plans as necessary. Residents' nutrition and hydration needs were well catered for in relation to food choice and quality.

Significant action had been taken since the last inspection to improve availability of resources and increase access to recreation and activation for residents. Access to the central recreation area had been increased from just two days per week and was now available for use by residents every day, including at weekends. Residents were seen to regularly use this area for both collective activities and individual recreation, such as reading or watching DVDs. There was also a kitchen area for baking preparation and a sensory room for quiet time and therapies. An inspector reviewed the activity programme with the responsible staff members who were able to demonstrate a creative range of activities tailored to meet the needs of all residents, and inspectors saw these taking place during the inspection. Staff explained that records of attendance and participation were maintained and these were available for reference. Residents who could were supported to participate in community events and local day centre services. Links to the community were strong and local initiatives had contributed a specialised transport vehicle to the service.

At the time of inspection, the available accommodation, for up to 52 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. Personal items were often hung around bed-frames, on wardrobe doors or on window sills due to the lack of appropriate storage. These wards were institutional in

appearance. Residents and relatives described how they had been consulted with in relation to improvements around the environment, such as the provision of additional personal storage space and privacy screens. Management and staff acknowledged the impact of premises issues on residents' quality of life. An audit of personal storage space had taken place and some residents had been provided with new or larger wardrobes. The extent to which residents in multi-occupancy rooms could personalise their immediate living space was limited. Some residents and visitors also commented on the lack of personal storage space and this feedback was further echoed in some of the HIQA questionnaires completed. Additional screens had been provided to afford some visual privacy. Otherwise, limited action had been taken to address the premises issues that continued to impact on the experience of privacy and dignity for residents in multi-occupancy rooms.

Sarsfield and Shannon wards provided accommodation for up to 34 and 28 residents respectively. Residents on these wards had access to communal sitting and dining areas. Bedrooms 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, 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.

Thomond ward provided accommodation for up to 20 male residents. Accommodation included one three-bedded, one five-bedded and two four-bedded rooms, all equipped with wash-hand basins. Storage facilities on this ward were inadequate and wheelchairs, hoists and other equipment were stored variously in corridors and communal areas. Residents on this unit could only access bathroom facilities through an adjacent four bedded-area. This could disrupt other residents and did not support privacy. Private visiting facilities on this ward did not fully meet the needs of residents, particularly for those in multi-occupancy rooms who might not be well enough to move in order to receive visitors. There were three communal dining and seating areas though these were quite small and, depending on residents' seating needs, could only accommodate four to six residents at a time. Space for seating and personal storage around residents' beds in the multi-occupancy rooms was also very limited.

There had been no change to the provision of access to outdoor recreational space since the previous inspection. A secure outside area was accessible from the ground floor, though residents on upper floors had limited access. Outside access had also been identified as an area for improvement in some of the resident feedback questionnaires.

Overall, the centre was bright with natural light and a good standard of cleanliness was evidenced throughout. The inspector saw that measures were in place to protect residents from the risks presented by hygiene and healthcare-related infections. These included relevant training for all staff and effective cleaning routines and practices. Residents provided feedback in person, as well as in questionnaires, that indicated the centre was kept clean. 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.

An effective risk management policy was seen to be followed in practice. Management demonstrated that appropriate measures were in place to manage risk and ensure that residents were protected from environmental hazards or accidents. These measures included appropriate fire safety training and procedures around emergency planning and evacuation. Individualised emergency evacuation plans were in place for each resident that highlighted key information around mobility needs and the level of assistance required. Certification was in place to confirm that equipment, such as fire-extinguishers and emergency lighting, was regularly serviced and maintained in effective working order. Regular management meetings took place when these measures and arrangements could be reviewed.

Residents' rights were appropriately safeguarded through the implementation of relevant protocols around managing finances and independent advocacy access. The inspector saw that there were systems for recording, reporting and managing allegations of abuse. The person in charge demonstrated how these procedures were implemented to screen and investigate circumstances, and outlined the measures to safeguard residents that could be put in place where necessary. Where there had been instances that had not been notified appropriately in keeping with requirements, appropriate responsive action had taken place and the person in charge demonstrated a recording process that now included a check mechanism to verify returns took place in a timely manner. Staff had received relevant and current training in relation to the safeguarding of residents. Residents spoken with were familiar with staff and management and said they felt safe and well minded in the centre.

Regulation 11: Visits

Arrangements to receive visitors in private did not always meet the needs of all residents. Residents in a multi-occupancy room who might not be well enough to go to a private visiting area had to receive visitors next to their beds on the ward.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Personal storage facilities were not adequate for many residents in multi-occupancy rooms.

Judgment: Not compliant

Regulation 17: Premises

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 and did not fully meet the needs of residents as set out in the statement of purpose.

- Equipment storage facilities on Thomond unit were inadequate.
- Communal dining and seating facilities on Thomond were inadequate.
- Access to outside recreational space was inadequate.
- The space between beds in some multi-occupancy rooms did not provide enough room for a chair or access with assistive equipment.
- Suitable personal storage space was not available for all residents.

Judgment: Not compliant

Regulation 26: Risk management

A comprehensive risk management policy was in place that appropriately referenced the measures and controls in place to address risks to residents including abuse, the unexplained absence of any resident, accidental injury to residents, visitors and staff, aggression and violence and the risk of self-harm. An active risk register was in place that was regularly monitored and reviewed.

Judgment: Compliant

Regulation 27: Infection control

A centre-specific infection prevention and control programme was implemented. A nominated member of staff had responsibility for infection prevention and control in keeping with the related standards. Regular hand-hygiene audits took place and the results were clearly displayed on each ward.

Judgment: Compliant

Regulation 28: Fire precautions

Adequate precautions against the risk of fire were in place that included appropriate training, regularly maintained equipment and fire evacuation procedures and drills.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Pharmacy resources were available on-site and provided support in relation to training and education. Residents' medicine prescriptions were reviewed at least every three months. Practise in relation to the crushing of medicines had been revised since the previous inspection. However, in some instances where a medicine was to be crushed on administration, the instruction was not always signed off by the prescriber. Also, the dates of opening on some medicines had not been recorded as required.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Processes were in place to ensure residents were appropriately assessed on admission and that care plans were developed in keeping with relevant assessments and reviewed on a regular basis, at least every four months, or as changing needs might require. In one instance a care plan had not been revised to record the possible risk impact of a resident preference in refusing recommended care.

Judgment: Substantially compliant

Regulation 6: Health care

Care planning arrangements were in keeping with a very good standard of evidence-based nursing care and information on care plans indicated that residents were referred for specialist care as necessary according to their assessed needs. The centre provided effective access to healthcare services including a medical officer, pharmacist, speech and language therapist, dietitian and physiotherapist. Relevant

correspondence about transfers and referrals were maintained on files for reference.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There were relevant policies provided guidance to staff 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). Members of staff spoken with by the inspector had been trained and were able to demonstrate the knowledge and skills necessary to understand and respond appropriately to such behaviours. Where restraints such as bed-rails were in use, appropriate risk assessments had been undertaken, and documentation on care plans included relevant consent forms. Records on the assessment of risk in relation to the use of bed-rails were in place and a register of monitoring was seen to be routinely completed.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to ensure residents were protected from abuse and were safe in the centre. Training was provided for staff who understood their responsibilities in relation to ensuring residents were safe and protected.

Judgment: Compliant

Regulation 9: Residents' rights

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 provided visual protection but did not adequately protect the privacy of residents in relation to the conduct of personal activities and communication. These screens provided little or no protection from the noise and odours that a resident might experience in multi-occupancy accommodation. Circumstances remained whereby residents in a three-bedded room had to travel through the length of an adjacent four bedded-area to use the shower or toilet.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Camillus Community Hospital OSV-0000640

Inspection ID: MON-0020756

Date of inspection: 05/03/2018 and 06/03/2018

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 24: Contract for the provision of services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:</p> <p>Contract of Care:</p> <p>A review of the Contract of Care has been completed. Additional information added to the Contract of Care includes that the Centre is a Smoke –Free Campus and specific details on bed number / multi –occupancy room/ room number is set out for the resident to read and agree to.</p> <p>Time frame: June 30, 2018.</p>	
Regulation 31: Notification of incidents	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 31: Notification of incidents:</p> <p>The following process has been implemented with effect in order to ensure compliance with Regulation 31:</p> <ul style="list-style-type: none"> • Notification of any incident must be made within the specified timeframe i.e. three working days for notification. • The person in charge is aware that notification must take place and of the specified time frame. When the Director of Nursing (DON) is not on duty it is the responsibility of the ADON/PIC on duty to make the notification. • Weekly review of HIQA notification folder by the DON or person acting in position: Initial entry when HIQA notification is agreed and Reference Number is generated, this number is referenced in Night Report/Quality and Patient Management Report- during day time. Entry is completed in HIQA N.F.O. folder when same has been submitted to HIQA, this folder is audited on a weekly basis and signed off. 	

- Outcome now is the implementation of three (3) check systems that can be audited to comply with Notification time lines. Closure of notification is signed off and dated.
- **Time frame:** Immediate (May 2018).
- At Unit level, Quality and Safety Management Reports are completed twice daily.
- Notification issues are captured and reported i.e. safeguarding/ absent without leave/death/serious illness/falls.
- HIQA notification folder is in situ for nursing office staff to reference to ensure correct notification is carried out
- All notifications are printed and filed and recorded on index.
- There is a notice on the Safeguarding folder to immediately send NF 06 in case of safeguarding issues.
- Weekly correlation of Quality, Patient Safety and Risk (QPSR) are sent to all wards to monitor trends in quality care.
- Action Plan Hospital Management Meeting template/CNM Meeting template reviewed to reflect all notifications to HIQA and learning outcomes.
- **Time frame:** Immediate (May 2018).

Regulation 23: Governance and management

Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

A multi-disciplinary Project Team has been convened in the Centre to carry out a review of processes and oversight to ensure statutory notifications are submitted in keeping with requirements. Outcome of the initial meeting (14th May 2018):

Continuation of current practises to prevent safeguarding issues:

- Safety Pause highlighting resource allocation for personal care of residents requiring assistance of 2 staff.
- Prioritisation of resource management in scheduling of personal care at start of shift.
- Current communications at Ward level via CNM meeting, group email, communication diary on desk, white board / flash communication- safety pause.
- **Time frame:** Immediate (May 2018).

Additional practises to prevent safeguarding issues:

- Action plans/Evidence folder from another hospital/unit to be shared with the Centre.
- Introduce additional safety check /walk around at lunchtime.
- Introduce safety pause at 3-4 p.m.: observe what has changed.
- A designated officer has been identified and will attend training through National Safeguarding Office when available.
- Current Practise Development Officer will dedicate two weeks in May 2018 working with staff on current practises before new officer is appointed. This will include standardising of walkabouts, hot spots and issues and maintain a Unit based evidence folder of issues and actions implemented in liaison with Unit

CNMs.

- Risk advisor will provide training on incident management to heighten awareness of the occurrence, recognition and reporting of incidents amongst staff.
- Director of Nursing has developed a zero tolerance policy document, which is being circulated to all staff, which they are signing off stating that they have read and accepted it.
- CNM2 has sent a letter to residents' families reminding them that they have access to a designated nurse advocate.
- **Time frame:** 6 months (30th November 2018).

Promoting a safeguarding culture:

- Introduction of a zero tolerance policy document to non-compliance with safeguarding policy and communicated to staff.
- **Time frame:** Immediate

- Transfer learning and actions implemented, to be communicated to all Units in the Centre.
- World Elder Abuse Awareness Day will be celebrated on the **week of** 11th June 2018 in the Hospital
- **Time frame:** Promoting Safeguarding Culture 12 months (May 2019)

Arrangements to ensure effective supervision of staff:

- Staff supervision: Buddy up with experienced staff member at induction and / or new agency staff member/daily.
- Input of Practise Development Officer with staff on the Unit.
- **Time frame:** Immediate (May 2018).

Monitoring mechanisms in place to protect residents during personal care:

- Nursing Management to implement and monitor the actions to prevent safeguarding issues.
- Safeguarding Project Team to monitor progress.
- **Time frame:** To progress cultural change: 12 months (May 2019)

Regulation 16: Training and staff development	Not Compliant
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Segregated staff roles :

- Review of roster is underway which will support the specific role of all grades including Nursing, Health Care Assistants, Housekeeping, Catering.
- **Time frame:** Negotiations with Unions are ongoing despite experiencing various interruptions.

Regulation 16: Training and staff development	Not Compliant
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<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p>	
<p>Training for Multi-task attendants relevant to role:</p> <ul style="list-style-type: none"> • Policy on Staff Education and Training identifies the roles and responsibilities, the procedure audit and evaluation of staff training. • Bespoke training programmers have been developed to include Dementia, Managing Responsive Behaviors. Participation of all staff will be facilitated and is subject to staff engagement. • Responsive behaviours: A senior Staff Nurse who commenced training for instructor's position on Challenging Behaviours / MAPA training in May 2018 will provide onsite training to meet the needs of staff for responsive behaviour training. • Time frame: 12 months (May 2019). • End of Life training, "What Matters to Me" training: • Time frame: 31st May, 2019. 	
Regulation 21: Records	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p>	
<p>Record in relation to members of staff, the required disclosure form was not held on site.</p> <ul style="list-style-type: none"> • Disclosure forms are held centrally in a designated centre. It is the responsibility of the Data Controller to secure and manage the disclosure forms and have available for inspection by HIQA Chief Inspector. • Time frame: Immediate (May 2018). 	
Regulation 11: Visits	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 11: Visits:</p>	
<p>New Build:</p> <ul style="list-style-type: none"> • A Controlled Development Plan for the Centre is at an advanced stage, 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 has been appointed and they have completing a stakeholder's consultation process and the 1st stage of build is due to commence shortly. This building will be operational by end of 2021 and will meet requirements for privacy and dignity and availability of single rooms. As Thomond Ward is identified as the initial replacement block, residents should begin to transfer and commence occupancy in the new build by end 2019, but in any event, transfer will be in line with compliance by 2021. • Time frame: 31st December 2019. • All efforts will continue to meet resident's preference regarding choice of room. • A second mobile screen for Thomond ward will be provided to allow for privacy. • Time frame: July 2018. 	

- A detailed review has been undertaken with HSE Estates engineer and the fire officer to consider if partitioning is an option in this multi occupancy room (Thomond Ward). There is a plan to reconfigure a storage room in Thomond ward as a private sitting room however, this is pending relocation of a Unit which is proximal to Thomond; this is pending relocation of other services.
- **Time frame:** December 2018.
- Staff continue to discuss with residents and family members on areas for improvement and invite suggestions from all service users.
- **Time frame:** Immediate (May 2018).
- Each resident in the Centre who is not mobile, has the opportunity to be sit in a mobility arm chair and be moved to a private sitting room if desired, which can be arranged by Ward staff. There is also the availability to be taken to the Activity Centre for extra individual space if required.
- **Time frame:** Immediate (May 2018).

Regulation 12: Personal possessions

Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

At Unit level :

- Each resident in the Centre has a private locker with a locked compartment upon request.
- Areas outside of bedrooms have been identified for a number of residents and if requested by the resident, personal clothing will be stored externally but in addition to their bedroom.
- **Time frame:** Immediate (May 2018)

New Build:

- A Controlled Development Plan for the Centre is at an advanced stage, funding allocated under the Capital Development Programme, which includes a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6. A design team has been appointed and they have completing a stakeholder's consultation process and the 1st stage of build is due to commence shortly. This building will be operational by end of 2021 and will meet requirements for privacy and dignity and availability of single rooms. As Thomond ward is identified as the initial replacement block, residents should begin to transfer and commence occupancy in the new build by end 2019, but in any event, transfer will be in line with compliance by 2021.
- **Time frame:** 31st December, 2019.

Regulation 17: Premises

Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

New Build:

- A Controlled Development Plan for the Centre is at an advanced stage, funding allocated under the Capital Development Programme, which includes a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6. A design team has been appointed and they have completing a stakeholder's consultation process and the 1st. stage of build is due to commence shortly. This building will be operational by end of 2021 and will meet requirements for privacy and dignity and availability of single rooms. As Thomond Ward is identified as the initial replacement block, residents should begin to transfer and commence occupancy in the new build by end 2019, but in any event, transfer will be in line with compliance by 2021.
- **Time frame:** 31st December 2019.
- A small private area has been identified off the corridor on Thomond Ward and chairs available to sit and talk to friends and family.
- **Time frame:** Immediate (May 2018).
- Access to outside recreational space is available in the hospital garden. Families are encouraged to use the space for private time with their relative. Staff will facilitate the resident's access to outdoor space, weather permitting.
- **Time frame:** Immediate (May 2018).

Noise disturbances:

- Residents in higher occupancy rooms have experienced nearby noise when other residents are being attended to. All Staff have been instructed to give due consideration to all residents.
- **Time frame:** Immediate (May 2018).

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- Medication management training ongoing training by scheduled from CNMA 2018.
- Work stream appointed within CHO3 to review policy and practice on Medication Management.
- **Time frame:** October 2018.
- A Medication Audit is undertaken two monthly. All medication errors are investigated and closed out. QIP are completed by relevant staff member/ unit manager. Quality improvement plans are actioned as required. Learning outcomes communicated to all nursing staff and incidents closed following completion of action plan.
- **Time frame:** Immediate (May 2018).
- Results and key learning from audits are displayed on Quality Boards.
- **Time frame:** Immediate (May 2018).
- Medical Officer was consulted following this finding and agreed to review his

<p>practice regarding prescription of medications.</p> <ul style="list-style-type: none"> • Time frame: Immediate (May 2018). • New initiative: Chief Community Pharmacist is undertaking Medication Management audits. • Time frame: Commenced April 2018. • New initiative: Pharmacist is undertaking a drug round competency assessment on all wards. • Time frame: June 2018. 	
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Regulation 5: Individual assessment and care plan	Substantially Compliant
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<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <ul style="list-style-type: none"> • Care Plan documentation is audited quarterly as part of a quality improvement process, this ensures care plans continue to reflect individual resident needs. Audit findings are disseminated to Registered Nurses by communication from Auditor locally, Senior Nursing Management and Clinical Nurse Managers with deficits highlighted and areas for improvement recognized and time-framed. The Centre ensures the resident is at the center of the care planning process by ensuring a named Nurse specifically works with the resident and their family in identifying the resident's needs on an ongoing basis and ensuring these needs are met; a three monthly review process takes place. • To ensure compliance with this outcome, Senior Nursing Management will ensure written communication is disseminated through the Clinical Nurse Manager Forum to all Registered Nursing staff. This is to ensure all Registered Nursing Staff continue to understand their role in ensuring care plans identify risk and appropriate nursing actions are taken. • Time frame: Immediate (May 2018). 	
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Regulation 9: Residents' rights	Not Compliant
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<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <p>New Build:</p> <ul style="list-style-type: none"> • A Controlled Development Plan for the Centre is at an advanced stage, funding allocated under the Capital Development Programme, which includes a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6. A design team has been appointed and they have completing a stakeholder's consultation process and the 1st stage of build is due to commence shortly. This building will be operational by end of 2021 and will meet requirements for privacy and dignity and availability of single rooms. As Thomond ward is identified as the initial replacement block, residents should begin to transfer and commence occupancy in the new build by end 2019, but in any event, transfer will be in line with compliance by 2021. 	
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- Initial elevations for information with architect meeting with 3 D representation to be developed
- **Time frame:** end of May 2018.

- Public and resident consultation will be facilitated on the new design and build
- **Time frame:** July 2018.

- Interim measure: second privacy screen to be provided to facilitate privacy in multi occupancy room in Thomond Ward.
- **Time frame:** June 2018.

- Interim measure: Provision of headphones to accommodate noise reduction on a Unit.
- **Time frame:** Immediate (May 2018).

- Interim measure :Pursuit of toileting options to reduce olfactory offensiveness
- **Time frame:** Immediate (May 2018)

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	Interim measures described : 31 st July 2018 Final measure: Completion of new build 31 st December 2021
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and	Not Compliant	Orange	Interim measures described : 1 st May 2018 Final measure: Completion of new build: 31 st December 2021

	finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31 st May 2019
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	Interim measures described: 31 st July 2018 Final measure: Completion of new build 31 st December 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 in Schedule 6.	Not Compliant	Orange	Interim measures described : 31 st July 2018 Final measure: Completion of new build 31 st December 2021
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by	Not Compliant	Red	1 st May 2018

	the Chief Inspector.			
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	Immediate measures: 14 th May 2018 Promoting cultural change: 31 st May 2019
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 th June 2018
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's	Substantially Compliant	Yellow	21 st May 2018.

	pharmacist regarding the appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Substantially Compliant	Yellow	Action through regular medication audit - two monthly. Audit May- Chief Pharmacist Next audit August 2018. Notification to all wards on correct management of medication 21/5/18
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 3 working days of its occurrence.	Not Compliant	Red	30th April 2018
Regulation 9(3)(a)	A registered provider shall, in so far as is	Not Compliant	Orange	Interim measures described :

	reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			30thJune 2018 Final measure: Completion of new build 31 st December 2021
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	Interim measures described : 30th June 2018 Final measure: Completion of new build 31 st December 2021