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 Camillus Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Shelbourne Road, Limerick
Type of inspection:	Unannounced
Date of inspection:	12 February 2020
Centre ID:	OSV-0000640
Fieldwork ID:	MON-0027504

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. 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.

Number of residents on the date of inspection:	63

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
Wednesday 12 February 2020	09:30hrs to 17:30hrs	Ella Ferriter	Lead
Wednesday 12 February 2020	09:30hrs to 17:30hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

Residents who spoke with the inspector were very complimentary about the care and support provided by staff. Inspectors met residents in communal areas and in individual bedrooms. They stated they were happy living in St Camillus Community Hospital, they felt safe and were well cared for. The inspectors observed staff treating residents with respect and dignity at all times. Staff took time with residents and knew their personal preferences. Inspectors observed good social interaction on Shannon Ward, where residents had gathered in the living room and were playing basketball with staff. However, on the other two wards activities were not seen to be taking place. Residents monthly meetings requesting more activities supported this finding. Inspectors also met a few visitors, who expressed satisfaction with the care their family member was receiving.

Capacity and capability

This was a one day unannounced inspection, carried out to monitor ongoing compliance with the regulations. The findings on this inspection were that the Registered Provider, the Health Service Executive (HSE), had demonstrated a clear commitment to improving the quality of care to residents living in St Camillus Community Hospital. It was evident that that the Registered Provider had taken a proactive approach, to ensuring that the proposed improvements specified in response to the compliance plan, submitted following the most recent inspection of January 2019, had been progressed.

Following on from the previous inspection, the Chief Inspector had placed two restrictive conditions on the registration of this centre. These conditions were time bound, and a date for implementation had been mutually agreed. The first condition was in relation to fire safety, as it was found on the previous inspection that the Registered Provider had not been taking adequate precautions against the risk of fire. The second condition was in relation to bedroom accommodation and communal space on Thomand Ward. On the previous inspection, two bedrooms in particular were found to be overcrowded. This condition was to ensure that all existing and future residents are afforded appropriate dignity and privacy, through the provision of adequate personal space, and to ensure that the premises meets the needs of the residents. Findings on this inspection were that all works in relation to fire safety had been completed. On Thomand Ward as agreed, beds had been removed from two multi-occupancy bedrooms, and additional communal space was allocated. The reduction in bed capacity from 17 to 15 was noted to have a positive effect on the quality of life of residents on Thomand Ward.

Undoubtedly, the constraints of the premises remained a challenge for residents and

staff. The premises did not fully meet the needs of the residents, and afford them appropriate dignity and privacy through the provision of personal space. The design and layout of the centre was institutional in appearance, with the majority of accommodation provided in multi-occupancy rooms, of between three and four residents. This detracted from efforts to create a homely and personalised environment for residents living in St Camillus Community Hospital. The HSE had a development plan in motion for the centre, and had informed the Chief Inspector that a 75 bedded replacement facility was planned, and would be constructed by December 2021.

The centre was managed by an appropriately qualified person in charge, responsible for the direction of care. She was supported in her role by two Assistant Director of Nurses (ADON), three Clinical Nurse Managers (CNM), a nursing and health care team as well as administrative, catering and household staff. The person in charge reported to the Registered Provider Representative (RPR), who visited the centre frequently and was available for consultation daily by phone and email. Formal management meetings took place where incidents, accidents, risk, quality improvement and staffing was discussed. Meetings between the person in charge, ADONS and CNMs also took place weekly, and regular staff team meetings were held with all different disciplines at various times throughout the year. Minutes of all of these meetings were maintained and viewed by the inspectors.

The centre had appropriate policies on recruitment, training and vetting of new employees. Improvements were noted in recruitment practices, particularly in relation to obtaining An Garda Siochana (police vetting) disclosures for all staff, as required under Schedule 2 of the regulations. There was a comprehensive programme of training, and all staff had attended up-to-date training in mandatory areas, such as responsive behaviour, safeguarding and fire safety. There was an induction and supervision procedure in place for new staff. Volunteers had their roles and responsibilities set out in writing as required by the regulations.

The inspectors observed good communication between staff and residents, and staff were seen to be caring and responsive to residents needs. Staff meetings and shift handovers ensured information on residents' changing needs were communicated effectively. The centre actively engaged in a safety pause at two intervals during the day, where areas such as falls, safeguarding, infection, fire safety and diets were discussed.

Residents admitted for long term care had a written contract and statement of terms and conditions agreed with the registered provider of the centre. However, it was found that residents admitted for respite services did not have a contract of care. There were systems in place to manage critical incidents and risk in the centre. Accidents and incidents in the centre were well recorded, appropriate action was taken, and they were followed up on and reviewed. Good systems of information governance were in place and the records required by the regulations were maintained effectively. Records and documentation as required by Schedule 2, 3 and 4 of the regulations were securely controlled, maintained in good order and easily retrievable for monitoring purposes. Records such as a complaints log, records of

notifications, fire checks were also readily available and effectively maintained.

There were organised systems and processes in place to monitor the quality and safety of care received by residents. This was through regular audits, in areas such as medication management, restraint, falls and complaints. Findings of audits were discussed at staff meetings and used to inform and improve practice. Overall, the findings on this inspection were that the management team had demonstrated good leadership, and a commitment to on-going quality improvement.

Regulation 14: Persons in charge

The person in charge was new to the role since the previous inspection. She had the required experience in the area of nursing the older adult, and was knowledgeable regarding the regulations, HIQA's standards and her statutory responsibilities. She was articulate regarding governance and management of the service. She demonstrated a strong commitment to the development of initiatives and quality management systems to ensure the provision of a safe and effective service.

Judgment: Compliant

Regulation 15: Staffing

Residents spoke positively in relation to staff and reported they were kind and pleasant. The staff compliment and skill mix was adequate to meet the needs of the residents on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements were noted by the inspectors on staff training since the last inspection. There was a comprehensive programme of training, and staff were facilitated to attended training relevant to their role. All staff working in the centre had up-to date mandatory training.

Judgment: Compliant

Regulation 21: Records

Residents' records were reviewed by the inspectors, who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspectors. The management team ensured that safe and effective recruitment practices were in place for all staff employed at the centre. Files of recently recruited staff members were reviewed and found to contain all documents as required by the regulations including Garda Síochána vetting disclosures.

Judgment: Compliant

Regulation 23: Governance and management

Ongoing continued improvements were seen in governance and management of the centre. There was a clearly defined management structure with clear lines of authority and accountability. Management systems were in place to ensure that the centre delivered appropriate, safe and consistent care to residents. Deficits in governance and management identified in the previous inspection, in areas such as fire safety and a review of occupancy levels had been addressed and acted upon.

Judgment: Compliant

Regulation 24: Contract for the provision of services

Each long term care resident had a written contract of care that included all of the information specified in the regulations. However, as found on the previous inspection residents who were admitted for respite care, did not have a contract of care.

Judgment: Substantially compliant

Regulation 30: Volunteers

All volunteers working in the centre had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 in place. They also had a memorandum of understanding which outlined their roles and responsibilities.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents and allegations were well documented and reviewed by the inspectors. All incidents occurring at the centre in 2019, except for one had been reported in writing to the Chief Inspector as required under the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints log was reviewed and showed that formal complaints were recorded in line with the regulations. An accessible and effective complaints procedure was in place. Residents' complaints and concerns were listened to and acted upon in a timely, supportive and effective manner. There was evidence that residents and relatives were satisfied with measures put in place in response to issues raised.

Judgment: Compliant

Quality and safety

Overall, the findings of this inspection were that improvements had taken place to enhance the quality of life for residents living in St. Camillus Community Hospital since the previous inspection. The management team had demonstrated a commitment to on going improvements, by reducing the number of beds in communal rooms, allocating further communal space and addressing deficits in fire safety and infection control. Residents' quality of life could be further enhanced through increased access to activities, and additional space for personal possessions.

Management and staff recognised the impact of the current premises on the quality of life for residents. The majority of accommodation was in multi-occupancy rooms. Therefore, this posed a challenge in assuring residents had adequate personal space, were afforded dignity when receiving care and had adequate storage for personal belongings. The inspectors noted that wardrobes allocated were extremely small and were insufficient to meet the needs of long term care residents. Delivering end of life care in multi-occupancy rooms was also challenging, as privacy and dignity was compromised.

Pre-admission assessments were completed to ensure that the centre could adequately meet the needs of prospective residents. On admission, residents were comprehensively assessed, and these assessments formed the basis of care plans to guide care for each resident. A sample of care plans were reviewed by the inspectors. Some were found to be person-centred and individualised, however, improvements were required in some instances to ensure that assessments were completed in a timely manner, and care plans were in place for all residents. This was also in relation to the assessment of residents that presented with behaviors that challenge. The management team acknowledged during the inspection, that this was an area that required improvement. Residents had good access to nursing and medical care, and were referred as appropriate to allied health and specialist services.

Significant improvements had been made with regard to fire safety since the previous inspection. A full review of fire compartment doors had been undertaken. Replacement doors had been installed where necessary, to ensure they would be effective in containing fire and smoke in the event of a fire. There were adequate procedures in place to ensure that fire safety equipment was functioning appropriately, and that emergency exits were not obstructed. There were regular fire drills taking place, to prepare staff to evacuate all residents in a compartment in a timely manner. There were good policies and procedures in place in relation to infection control. All staff had received training in infection prevention and control and the area was regularly audited. Deficits in infection control recognised on the previous inspection had been addressed and rectified.

The centre had policies and procedures in place to protect residents from abuse. All staff members had attended safeguarding training, and they demonstrated an awareness of the procedures relating to the identification and response to allegations of abuse. All allegations of abuse had been investigated and reported as necessary. The centre had recently put more robust procedures in place to protect residents personal finances. There was a low use of restraints in the centre, and staff were working towards a reduction in bed rail usage. Staff had received training in leading on a restraint free environment and managing behaviors that challenge. Inspectors observed staff treating residents with dignity and respect at every opportunity.

From discussion with staff, review of minutes of residents meetings and from the observations of inspectors it was apparent that staff had been striving to change the dining culture. There was a now a focus on making the dining experience more of a social occasion, where residents could engage with each other. This was a noted improvement from the previous inspection, where daily practice involved residents being served lunch by their beds. Residents rights were observed to be respected and facilitated in the centre. Formal residents' meetings were facilitated on each ward monthly, and there was evidence that relevant issues were discussed. Staff were observed to ask the resident's consent when attending to their needs. Residents were observed to exercise choice throughout the day of inspection. The management team informed the inspectors that they had plans to increase social days out of the centre for residents, to places like the shopping centre, cinema and to the park. There was an activities programme in place, and an activities

coordinator working on the day of inspection. However, similar to findings on previous inspections, activities were found to be limited and varied from ward to ward. Overall, the activities programme required review, to ensure that all residents had opportunities for social engagement.

Regulation 11: Visits

There were open visiting arrangements, and visitors were seen to freely come and go throughout the day of inspection. There were now facilities in place for residents to meet with visitors in private on Thomand Ward.

Judgment: Compliant

Regulation 12: Personal possessions

There continued to be inadequate space for residents to store their clothes and personal possessions, and to have access and control of their personal possessions. Inspectors were informed that in some of the units this could not be rectified due to the lack of space in the bedrooms.

Judgment: Not compliant

Regulation 13: End of life

A good standard of care was provided to all residents at their end of life. Residents' care preferences for their end of life were discussed with them, and recorded in their care plan. Detailed information on physical, psychological, social, and spiritual preferences were recorded. Family and friends were supported to remain with residents as they approached end of life. There was access good to palliative care services. However, the majority of residents were accommodated in multi-occupancy rooms, and therefore did not have the option of a single room as they approached end of life, should they wish to have complete privacy. There was also no suitable facilities available for families to spend time alone with residents as they approached end of life.

Judgment: Not compliant

Regulation 17: Premises

Improvements were noted and acknowledged in relation to the premises, such as equipment storage facilities, reduction of beds in shared rooms, and additional communal space. However, the current 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. Examples of this included:

- multi-occupancy bedrooms did not support residents' privacy and dignity
- an insufficient number of showers having regard to the dependency levels of residents (one shower between 15 residents on Thomand Ward)
- there was inadequate storage space for residents personal property and possessions
- residents were not always afforded space to have a chair beside their beds
- access to outside communal space was inadequate

Judgment: Not compliant

Regulation 27: Infection control

Overall, improved practices were seen in infection control. Findings on two previous inspections, in relation to inappropriate storage of equipment, particularly on Thomand Ward had been addressed. Sluice facilities were also no longer co-located in the same area as toilet facilities. There had also been work done in addressing segregated staff roles which was ongoing. There was now a clearer distinction between the multi-task attendant and the healthcare attendant.

Judgment: Compliant

Regulation 28: Fire precautions

It was clearly evidenced that there was now a more positive focus on fire safety. Actions set out in the compliance plan and communicated to the Chief Inspector in relation to fire safety had been implemented. All works had been completed and signed off by the Fire Safety Consultant. All staff had undertaken training in fire safety, and staff spoken with were knowledgeable of what to do in the event of a fire. There were daily and weekly checks carried out to ensure that fire exits were not obstructed and that the fire alarm functioned appropriately. The inappropriate storage of oxygen had been addressed and there were frequent fire drills taking place, to provide assurance that an evacuation could take place in a timely manner.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Nursing and care staff spoken with were familiar with and knowledgeable regarding each person's up-to-date needs. 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 by inspectors. Although some care plans were informative and person centred, it was also found that some residents care plans were incomplete and did not have comprehensive assessments.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Staff continued to promote a restraint-free environment, guided by national policy. There were very few bed rails or chemical restraints in use at the time of inspection. Residents using bedrails had a full assessment undertaken, alternatives trialled and consent obtained. Observations of the inspectors gave assurance that residents who presented with responsive behaviours, (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were responded to in a very dignified and person-centred manner by staff. Staff working at the centre all received training in managing responsive behaviours. However, improvements were required in the assessment of residents who had responsive behaviours, to identify triggers and develop strategies to de-escalate and prevent further recurrences. This information would assist in planning care delivery.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors were satisfied with the measures in place to safeguard residents and protect them from abuse. The person in charge confirmed that all staff and volunteers had Garda Síochána vetting (police clearance) in place as a primary safeguarding measure. Safeguarding training was up to date for staff. Any safeguarding issues identified were reported, investigated and appropriate action taken to protect the resident. There were improvements noted, and new procedures implemented to protect residents personal finances.

Judgment: Compliant

Regulation 9: Residents' rights

Residents meetings took place monthly on each ward, and they were well attended. The inspectors observed kind, respectful care and interaction between residents and staff. A review of the activities programme was required, to enable change and improve outcomes for residents. While there was an activity coordinator present in the centre seven days per week, this person was at times limited to providing activities on one ward, therefore limiting the opportunity for residents on the remaining two wards to have access to activities. Resources available such as the "activate centre" was not being maximised to ensure the best possible access to activities for all residents. The inspectors reviewed the activities programme and found it did not reflect activities on that particular day. There was a requirement to review staff in the context of meeting the social care needs of residents, and ensure that social engagement was seen as the responsibility of all staff working in the centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: End of life	Not compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Camillus Community Hospital OSV-0000640

Inspection ID: MON-0027504

Date of inspection: 12/02/2020

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 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: Action completed: A respite care contract has been agreed for use and will be included in the process for admission of respite residents. This will commence by mid March and will be fully implemented by 31st March 2020 Proposed Timeframe : To be completed by 31st March 2020	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Actions completed: Notifications will be submitted for all incidents/events in line with the requirements. Where there is a query in relation to the requirement to submit a notification, clarification will be sought and the appropriate notification will be completed in a timely manner. Immediate implementation completed by 09/03/2020. Proposed Timeframe : Completed 9th March 2020	
Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: Actions completed: Every effort is made to ensure that the residents are offered sufficient personal space to have their personal belongings with them. However restrictions of the layout of the building can result in limited availability of space. Staff will endeavor to optimize the space available. To date since inspection we have secured extra furniture to allow for personal possessions where space allows. We encourage personalization of bed space through photos etc that can be wall mounted. Bed positions have been changed to allow maximum usage of available space. Actions to be completed: It is anticipated that the development of the new facility scheduled for December 2021 will address these facility issues in full. Proposed Timeframe : To be completed by 31st December 2021	
Regulation 13: End of life	Not Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: Actions completed: A review is ongoing in each Unit to optimise the available space to ensure that suitable facilities are offered to our residents at end of life. Every effort is taken to ensure that families are afforded the opportunity to spend time with their loved one in a supportive and appropriate environment. Actions to be completed: The development of the new facility with an anticipated completion date by end of December 2021 will fully address the issue around availability of single rooms for residents as they enter end of life. Proposed Timeframe : To be completed by 31st December 2021	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Actions completed: Extensive review and reorganization of the individual wards has resulted in improved facilities for our residents. Each Unit will continue to utilize the space available to ensure that every effort is made to make personal space for each resident and optimize their lived experience within St Camillus Hospital. Actions to be completed: The development of the new facility will fully address the issue	

around availability of single rooms for residents as they enter end of life.

Proposed Timeframe : To be completed by 31st December 2021

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Action completed: A process has been put in place for each Ward Manager to review care plans with the primary care nurse and address any deficits in a supportive and developmental manner. The nursing office will continue to monitor auditing and identify areas requiring development to ensure that supports are in place to assist staff in achieving compliance with care plan requirements. In house training will continue to be given to staff to improve knowledge and competencies in care plan development and review. A bespoke care planning training program has been requested from the CNME office. Care plans found to be non compliant during inspection have been reviewed and updated in conjunction with resident/family.

Actions to be completed: An audit will be undertaken in respect of the care plans for each resident Completed by end April 2020

Proposed Timeframe : To be completed by 30th April 2020

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Actions completed: The care processes in regards to management of behaviors that challenge have been discussed and reviewed by the nursing office and the CNM's in the Wards. Information and guidance on the development of care pathways and appropriate recording of residents' behaviors has been highlighted. Action to be completed: Staff training is planned on the 6th May and the 27th May specific to Dementia. This will incorporate ABC chart recording and increase knowledge and awareness of the importance of this and its importance in the overall development of an individualized care process that will optimize the wellbeing for our residents. This will be supplemented with in-house support and assistance for staff provided by current staff who have undertaken

the Masters program in Dementia Care. Proposed Timeframe: To be completed by 30th September 2020

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Actions completed: The activity programme for St Camillus Hospital has been reviewed with our activity coordinators since the unannounced inspection. Designated responsibilities for the development of Unit/Ward centered activities have been agreed in order to ensure that activity programmes' in each area optimize the inclusion of residents and provide for meaningful activity and engagement in each area. In the development of activities our team will be cognizant of the abilities of our residents and ensure that all residents have a meaningful activity plan. This will include activities suited for residents of all dependency's and abilities. This is a learning process for staff, residents and families as the process develops within the Wards. Staff engagement with the provision of an appropriate stimulating environment is being encouraged through staff meetings and discussion at Ward level. Provision of supplies for activities will continue to be supported through the activity centre. Residents meetings will be used to establish the requests of residents in respect of activity provision. Further review of the Activity Programme is underway and will be completed over a six month period. Proposed Timeframe: To be completed by 31st August 2020

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(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Yellow	31/12/2021
Regulation 13(1)(c)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the family and friends of the resident concerned are, with the resident's consent, informed of the resident's condition, and permitted to be	Not Compliant	Orange	31/12/2021

	with the resident and suitable facilities are provided for such persons.			
Regulation 13(1)(d)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that where the resident indicates a preference as to his or her location (for example a preference to return home or for a private room), such preference shall be facilitated in so far as is reasonably practicable.	Not Compliant	Orange	31/12/2021
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	31/12/2021
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	Substantially Compliant	Yellow	31/03/2020

	number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
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.	Substantially Compliant	Yellow	09/03/2020
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	09/03/2020
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/04/2020

Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/09/2020
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/08/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/08/2020