

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Theresa's Hospital
Centre ID:	OSV-0000741
Centre address:	Clogheen, Tipperary.
Telephone number:	052 746 5205
Email address:	anne.hally@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Bridget Farrell
Lead inspector:	Gemma O'Flynn
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance 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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 01 November 2016 09:20 To: 01 November 2016 18:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of a one day unannounced inspection, the purpose of which, was to monitor ongoing compliance with the regulations. Actions that arose following the centre's previous inspection in September 2015 were also followed up. There were 28 actions in the last inspection, of those, 16 had been satisfactorily addressed and 12 had not been satisfactorily progressed. These are discussed throughout the report and related mainly to ongoing premises issues; care plan documentation; implementation of allied health recommendations and health and safety.

St. Theresa's is a community hospital that delivers respite, convalescence and palliative care. The average stay is approximately 2 -12 weeks. The centre can accommodate 18 residents at any one time. 15 beds are utilised for convalescence care, 1 bed for respite care and 2 for palliative care.

During the course of the inspection, the inspector met with residents, staff and the person in charge. Resident and staff views were elicited, practices were observed and documentation was reviewed. Overall, the inspector found that care was

delivered to a good standard and staff knew the residents' needs well. There was good interaction observed between residents and staff and all interactions were seen to be timely, respectful and friendly. Visitors were seen to be made welcome throughout the day. There were numerous cards, emails and newspaper cuttings displayed in the entrance foyer showing very positive feedback from previous residents and/or their family in regards the care they received during their stay at St. Theresa's.

Areas of non compliance were identified as set out in the table above. These are discussed throughout the report and in the associated action plan.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

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

Findings:

There were sufficient resources to ensure the effective delivery of care as described in the statement of purpose. There was a clearly defined management structure that identified who was in charge and accountable and what the reporting structure was.

Management systems were in place to monitor the care provided. A senior management meeting was held three monthly and agenda items included review of clinical risks, trends and frequency of incidents occurring in the centre, audit updates and health and safety issues. Minutes were reviewed for the last meeting that took place in September 2016. A clinical risk management group also met quarterly, the purpose of which was to review incidents occurring in the centre and its sister centres in the county.

An audit system was in place. In 2016, three audits had taken place: hygiene audit; documentation audit and a medication audit. The person in charge discussed the learnings and improvements that came about as a result of the audits and these were meaningful such as identifying improvements in medication practices and cleaning routines. However, the inspector found that the audit process was not comprehensive. For example, audits of the use of restraint were not carried out and this was an area of non compliance during this and the previous inspection. Resident rights and consultation was also not subject to audit and this was an area identified as requiring improvement as discussed below.

An annual review had been completed since the last inspection and considered the quality and safety of care. It also set out planned future improvements. This was filed on computer in the person in charge's office who said it was available to residents if they wished to view same.

The person in charge said that she met with residents on a daily basis. However, there

was no formal procedure for consulting residents about the running of the centre and eliciting feedback to improve the residents' experience. Whilst a survey had been issued in June 2016, that included topics such as environment, food, staff and privacy, despite a 100 per cent response rate, it had only been issued to five residents and the results had not been collated and analysed to identify issues and a plan for same. Given the high turnover of residents in the centre, the inspector found that a total five participants was insufficient to give comprehensive feedback. This was discussed with the person in charge.

Some feedback from residents who spoke with the inspector said that the day could be long and they may not have someone to talk to. Staff said that whether they had time to spend chatting or engaging in an activity with residents was dependent on the number of residents being admitted on a given day and the dependency levels of the residents in the centre, given the turnover of residents was high from week to week. The inspector did not observe any form of structured or planned activity taking place. This was discussed with the person in charge at the close of inspection.

Judgment:

Non Compliant - Moderate

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a person in charge of the designated centre and she was engaged in the governance of the centre on a regular and consistent basis. She had held the post of person in charge since March 2012. She was employed full time and had the experience as required by the regulations.

Residents and staff could identify her and said that she was an approachable and effective manager.

She demonstrated clinical and legislative knowledge during the course of the inspection.

It was evident via conversations with the person in charge and via meeting minutes reviewed that she was committed to improving the overall environment and experience for the residents in St. Theresa's community hospital.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
One aspect of this outcome was examined on this inspection.

Staff files were made available for inspection. Information required as per schedule 2 of the regulations was in place in most files reviewed, however, in some reviewed, there was no evidence of identity such as a driving licence or passport or evidence of qualifications. This was discussed with the person in charge.

A vetting disclosure was in place in the sample of all files reviewed. The person in charge gave a verbal assurance that all staff working in the centre had the required vetting.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:

There was a policy in place for safeguarding vulnerable adults in the centre. Staff were familiar with the policy and where to access further guidance if necessary. Staff could describe what abuse was and what they would do in the event of a concern arising in regards the safeguarding of residents.

The person in charge and staff who spoke with the inspector confirmed that there had been no allegations of abuse in the centre since the previous inspection.

Training records demonstrated that staff had been trained in safeguarding vulnerable adults from abuse. The person in charge was the designated officer and had attended training in that regard in March 2016. She was also delivered training to staff in the subject matter.

Resident who spoke with the inspector said that they felt very safe in the centre and that the staff were very good to them.

The person in charge confirmed that residents' finances were not managed or held in the centre due to the short stay duration of admissions.

There were policies in place for the management of residents with responsive behaviours and for the use of restraint. Overall, a restraint free environment was promoted, however, where restraint was used it was not in line national policy. The inspector found that where medication was used on an 'as required' basis to modify behaviour, the process for same required review. For example, there was no rationale documented for the medication's administration, no record of alternatives trialled before the use of chemical restraint and no record of the benefit of the medication. This issue was identified on the previous inspection. The inspector noted that documentary evidence for the use of chemical restraint indicated that its use was infrequent.

A risk assessment was completed for bed rail use, however, there was no alternative available in the centre so that bed rails would be a last resort such as grab rails, low low beds and crash mats, however, the person in charge stated that where bedrails were deemed to be inappropriate, additional resources would be made available, including extra staff if necessary. Therefore alternatives for same were not documented. There was no evidence of multidisciplinary involvement in the clinical decision to use the restraint.

Care plans were in place to guide staff in supporting residents with responsive behaviour. These were pre-populated documents that gave general, non person specific guidance to staff, however, it was evident that as information became available, staff updated the document with person specific information that gave good information and guided staff well. It was evident via conversations with staff that they were aware of interventions and these were seen to be implemented during the course of the inspection.

Training in responsive behaviour had been provided to the majority of staff via an external provider. Some staff had not attended this formal training, an inhouse training session delivered by nursing staff with experience in the area had been provided. The person in charge stated that it was her plan to have all staff trained to the same

standard, particularly as this was a resident need that was arising in the centre more frequently, however, there was no date in place or planned for this training.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The centre had policies and procedures relating to health and safety and the health and safety statement was displayed in the person in charge's office. A risk management policy was in place.

Procedures were in place for the prevention and control of healthcare associated infections. Staff with responsibility for the cleanliness of the centre demonstrated knowledge of their responsibilities in this regard and said that formal training in infection control was scheduled for November 2016. The centre was clean and free from odour on the day of inspection. However, as identified in the previous inspection, handwashing sinks in the centre's bedrooms were domestic in design and wash hand basins were not provided in close proximity to the sluicing facilities.

A risk register was available for review, however the review of risks and their associated controls had not taken place on an annual basis as was the centre's practice as confirmed by the person in charge. There was no formal process in place for identifying new or changing hazards prior to annual reviews taking place. Management meeting minutes demonstrated that the person in charge had identified that hazard identification sheets were required for this purpose but no frequency for the use of same had been identified.

A clinical risk management group had responsibility for reviewing incidents in the centre and meeting minutes evidenced that information that would contribute to the reduction of recurrences was considered, such as, the number of falls in a quarter and the time that they occurred. Medication incidents were also reviewed at these meetings and the root cause of the incident was recorded.

Incident forms were completed as required, however, as identified on the last inspection, there were gaps in the documentation of same. For example, the section for immediate action taken was not always completed.

Staff were training in safer techniques for moving and handling of people.

Suitable fire equipment was in place and service records for same were available for review and were seen to be up to date. Fire exits were unobstructed on the day of inspection. Staff were trained in fire safety, and whilst overall were clear on what was required of them in the event of the fire alarm sounding, some aspects of their responsibilities were not recounted clearly, such as who would give instruction to staff in the event of the alarm sounding.

Personal emergency evacuation plans were in place for residents in the sample of files reviewed. These included pictorial guides as to what assistance was required in the event of an evacuation. Manual handling plans were in place in the sample of resident files reviewed and these were seen consider situations relevant to the setting.

Documentation pertaining to risk assessments for residents who smoked in the centre was not completed for all residents. The person in charge undertook to complete same and sent a written assurance to the inspector the day after the inspection to ensure same had been completed.

Fire evacuation drills were taking place as part of a structured training day with an external instructor. Although carrying out drills under the supervision of an external fire safety contractor is considered good practice, additional independent drills carried out with staff are also required to determine if the fire procedures are fit for purpose and staff responses are adequate. Additional drills also identify training, staff and equipment needs.

In the absence of these additional drills, there was no evidence, documentary or otherwise, to demonstrate that the plans and practices in place were sufficient to ensure a timely evacuation if the need arose. There was no documentary evidence of what the drill (if any) had entailed, what had gone well and what required improvement. There were no details as to the length of time it would take to evacuate all residents from a specific zone if needed. This was discussed with the person in charge over the course of the inspection and was an issue identified on the previous inspection.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
There were written operation policies in place relating to medication management. The

non compliances identified in the previous inspection had been satisfactorily addressed.

The process in place for handling medicines, including controlled drugs, were safe and in accordance with current guidelines. A random check of controlled medicines tallied with records. Medication that had a reduced shelf life once opened had the date of opening recorded on them. The medication fridge was seen to be locked, daily temperatures were recorded and were within the required parameters.

The inspector observed a medication round and found that administration practices were in line with current guidance for nurses and the practice for disposal of unused medication was found to be safe.

Medication errors were recorded and were subject to review at the clinical risk management meeting.

The person in charge had identified that improvements were required in regards access to a pharmacist and stated that changes were planned and should be completed within an approximate three month time frame.

Judgment:
Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
A record of all incidents occurring in the centre was maintained and overall notifications were submitted as required by the regulations in a timely manner. However, there were gaps in the information submitted in the in the quarterly returns. For example, environmental restraint was not included on the notification despite it being utilised in the centre.

Judgment:
Substantially Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an

individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Residents' health care needs were met through timely access to medical treatment. A general practitioner (GP) visited the centre twice daily, Monday to Friday. An out of hours service was available at the weekend.

Although, the average duration of a resident's stay was approximately two weeks, residents had access to allied health such as a physiotherapist, whom visited twice weekly, as seen on inspection and confirmed by residents who spoke with the inspector. Referrals to other health professionals such as dieticians and speech and language therapists were arranged prior to discharge and the person in charge said that speech and language assessments often took place on site prior to discharge.

Residents had general health observations undertaken on admission such as vital signs, weight, urinalysis and blood profiles. General health promotion was seen via leaflets regarding flu vaccine, dementia, coping with fatigue being available in the foyer and health promotion notices were seen to be displayed on the notice board in the sitting area, such as tips for a healthy brain.

A comprehensive range of assessments were completed on admission, these included matters such as risk of developing pressure sores, risk of falls, malnutrition risk, manual handling and dependency level assessment. These were completed for all residents in the sample of files reviewed.

Associated care plans were in place for identified problems. The person in charge and clinical nurse manager said that these were under review. The inspector found that care plans were in place, and whilst they were initially completed with pre-populated, non resident specific guidance, it was evident that staff added person centred information as it became available. Efforts to elicit information were made via asking family to complete a document that gave detail background and personal information for residents who could not impart that information themselves and this information was reflected in the relevant care plan.

Wound care documentation was reviewed and whilst records demonstrated that consistent care was provided, a detailed care plan was not always in place to give guidance regarding frequency of dressing changes and materials to be used. Where recommendations by allied health professionals had been made, these were not included in the care plan and staff who discussed same with the inspector were not aware of

them, such as fluid intake recommendations.

The centre provided palliative care, care plans were reviewed for residents who had received end of life care. Whilst they gave guidance in regards to general care to be provided in the format of pre-populated data, the care plans were not seen to be person centred in their approach. For example, the person's wishes for their end of life care and after care were not recorded. General statements such as ' facilitate religious and cultural needs' and 'provide comfort measure' were documented but these lacked specific information pertaining to the resident. Given that the centre provided ongoing, dedicated palliative care services, the inspector found that this was an area of documentation that required improvement. However, written feedback regarding end of life care delivered to loved ones, was displayed in the foyer of the centre and the praise was very high for the care delivered and the staff who delivered it.

Kitchen staff who spoke with the inspector, demonstrated knowledge of residents' dietary needs and specific recommendations were seen to be displayed on a notice board in the kitchen.

Residents were observed to have the right to refuse treatment and same was documented by the relevant nurse. Discharges were discussed and planned for as evidenced in the sample of residents' discharge plans reviewed.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Non compliances relating to the premises in previous inspection had not been satisfactorily progressed and are restated in this outcome. It was noted however, that since the last inspection, the majority of recommendations made by an occupational therapist had been implemented, with the exception of recommendations made regarding the shower room.

The premises and grounds were visibly clean on the day of inspection and an attractive, secure garden had been added since the previous inspection. This was accessible from the sitting room area. There had been efforts made to make the communal areas homely and attractive and this had been achieved. Additional seating was available in the foyer and a small oratory was also available. Paintings and pictures was displayed throughout the centre.

As per the previous inspection, the occupancy in both wards had been reduced from eight to six with a modest space around each bed. However, storage was still an issue as six residents shared one wardrobe. Each had a small locker by the bedside but there was no lockable space for valuables. The person in charge stated that proposed plans included reducing the ward capacity further so that three residents would be accommodated on each ward.

Storage for equipment remained inadequate. For example, transfer hoists, commode chairs and walking aids were stored in an area off the main corridor, however, not all equipment was easily accessed without having to move all other equipment that was in storage.

A bath was available in each ward bathroom but the person in charge confirmed that these were not suited to residents with complex mobility issues.

As found in the previous inspection, the sluicing facilities were inappropriate in terms of their location. For example, a bedpan washer was provided beside an assisted shower room at a distance from the adjoining ward. A bedpan washer was not provided adjacent to the other ward (Our Lady's). The design of sluicing facilities was not adequate due to the domestic nature of the taps and absence of a splashback.

Some minor decorative upgrade was required in some areas, for example, a single room required painting as the walls were stained and marked.

The person in charge discussed the plans that were in place to progress the deficits in the centre's premises. To date, there was no definite funding in place except a sum that had been raised by community funding. Planning had not been applied for. Correspondence was shown to the inspector evidencing that talks were taking place regarding the premises, however, there had been no significant progress since the previous inspection.

Judgment:
Non Compliant - Major

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People)

Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):

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

Findings:

There was a planned roster in place and this was available for review. Staff who spoke with the inspector confirmed that there was sufficient staff on duty day to day and a recent addition in the evening shift to provide a carer for an additional three hours had proved beneficial. Staff meeting minutes evidenced good feedback regarding this additional cover. An additional clinical nurse manager had been recruited since the last inspection although this role hadn't been fully embedded due to planned extended leave. Due to multiple staff being on leave, there was a reliance on agency staff to fill shifts. The person in charge stated that these shifts were always filled and if a situation arose whereby a shift could not be covered, admissions would be restricted.

There was a registered nurse on duty at all times and up to date registration details were held in the centre. Staff confirmed that the person in charge was proactive in facilitating training for staff and details of upcoming training events were displayed on a notice board in the staff room.

Staff were up to date with mandatory training, as discussed and actioned in the safeguarding outcome, not all staff had received the same standard of training to support residents with responsive behaviours.

Staff appraisals were conducted in 2016 and evidence was seen for same. The person in charge said that three staff required a completed appraisal and these were planned prior to the year end. The appraisals gave an opportunity to discuss work performance, set objectives and identify future training needs. Staff interests in specific healthcare areas were also identified.

Staff meetings were held; support staff meetings took place in October, June and March of 2016 and nurses' meetings took place in August and March of 2016. Agenda items for both included feedback from residents/relatives; recruitment, premises issues, health and safety updates and audit learnings.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Gemma O'Flynn
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St Theresa's Hospital
Centre ID:	OSV-0000741
Date of inspection:	01/11/2016
Date of response:	22/11/2016

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The audit process was not comprehensive.

For example:

Audits of the use of restraint were not carried out and this was an area of non-compliance during this and the previous inspection. Resident rights and consultation was also not subject to audit and this was an area identified as requiring improvement as discussed below.

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

There was no formal procedure for consulting residents about the running of the centre and eliciting feedback to improve the residents' experience.

Activities required review to ensure that all residents needs, wishes and preferences were met.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

1. Carry out a Restraint audit- 31/12/2016
2. Commence weekly meetings with patients to elicit feedback- 30/11/2016
3. Structure the activities programme and display daily planned activities-31/12/2016
4. Arrange for Activity Coordinator's to attend a specific training programme in Jan/Feb 2017

Proposed Timescale: 28/02/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Information required as per schedule 2 of the regulations was in place in most files reviewed, however, some were incomplete. For example, there was no evidence of identity such as a driving licence or passport or evidence of qualifications in some files reviewed

2. Action Required:

Under Regulation 21(2) you are required to: Retain the records set out in Schedule 2 for a period of not less than 7 years after the staff member has ceased to be employed in the designated centre.

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

1. Personnel files will be checked to ensure information required as per schedule 2 is included

Proposed Timescale: 31/12/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Not all staff had received the same standard of training in supporting residents with responsive behaviours.

3. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

1. Organise responsive behaviour training for all staff. The training Coordinator has been contacted re schedule for 2017. Request for training logged with the National health & Safety helpdesk.

Proposed Timescale: 31/03/2017

Theme:

Safe care and support

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

The use of restraint was not always in line with national policy.

For example: where medication was used on an 'as required' basis to modify behaviour, the process for same required review. There was no rationale documented for the medication's administration, no record of alternatives trialled before the use of chemical restraint and no record of the benefit of the medication.

Where bedrails were in use alternatives for same were not documented. There was no evidence of multidisciplinary involvement in the clinical decision to use the restraint.

4. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

1. Education sessions arranged with the CNS Dementia Care for 15/11/2016 and 29/11/2016 to discuss use of restraint and alternatives to restraint. The CNS for Dementia Care will review documentation around restraint.
2. Restraint audit to be carried out to look at the restraint practices within St Theresa's
3. Nursing staff meeting on 29/11/2016 to include discussion on restraint assessment and implementation of the necessary care plans.

Proposed Timescale: 31/12/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The review of risks and their associated controls had not taken place on an annual basis as was the centre' practice as confirmed by the person in charge.

There was no formal process in place for identifying new or changing hazards prior to annual reviews taking place.

Incident forms were completed as required, however, as identified on the last inspection, there were gaps in the documentation of same. For example, the section for immediate action taken was not always completed.

5. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

1. Update of St Theresa's Health and Safety Statement as per national guidelines
2. Introduction of a daily hazard notification sheet to be completed by the person in charge
3. Discussion at next staff meeting on 29/11/2016 re completion of the NIMIS incident forms

Proposed Timescale: 28/02/2017

Theme:

Safe care and support

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

As identified in the previous inspection, handwashing sinks in the centre's bedrooms were domestic in design and wash hand basins were not provided in close proximity to the sluicing facilities.

6. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

Capital funding is required to make the necessary upgrades at St. Theresa's Hospital Clogheen. A phased capital development is planned. The first phase 1A will go to tender in the next 3 months with builders on site in 2017. Phase 1A's extension will incorporate a link corridor, a single ensuite and twin ensuite room. The number of beds on the male ward will reduce from 6 to 3 beds.

The case continues to be made for additional capital which will allow for the continuation of and expansion of existing services at St. Theresa's.

As Minor Capital will be partially required for phase 1A the replacement of domestic sinks will be incorporated in the Capital plan as funding becomes available.

Proposed Timescale: Phase 1A Dec 31 2017.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

Fire drills were not taking place outside of structured training sessions. There was no evidence to demonstrate that the plans and practices in place were sufficient to ensure a timely evacuation if the need arose.

7. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Evacuation drill report sheet to be completed for carrying out fire drills within St Theresa's hospital. Fire drills to be organised on a quarterly basis outside of scheduled training.

Proposed Timescale: 31/03/2017

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

There were gaps in the information submitted in the in the quarterly returns, for example, environmental restraint was not included on the notification despite it being utilised in the centre.

8. Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

The use of environmental restraint was discussed reviewed at our Quality Improvement Committee meeting on the 9/9/2015. A decision was made to continue the use of environmental restraint and to include it in our quarterly returns to HIQA.

Proposed Timescale: 31/01/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

A detailed care plan was not always in place to give guidance to staff to ensure safe and consistent practice. For example, wound care and end of life care.

It was not evident that allied health recommendations were always implemented.

9. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

The agenda for our next nursing staff meeting which is scheduled for 29/12/2016 will include discussion on improving our patient centred care plans. Discussion will also include sharing of our documentation audit findings carried out on the 26/10/2016.

Proposed Timescale: 31/12/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The premises required upgrade so as to promote residents' dignity, independence and wellbeing.

For example:

As per the previous inspection, the occupancy in both wards had been reduced to six with a modest space around each bed.

Storage was an issue as six residents shared one wardrobe. Each had a small locker by the bedside but there was no lockable space for valuables.

Storage for equipment remained inadequate. For example, transfer hoists, commode chairs and walking aids were stored in an area off the main corridor, however, not all equipment was easily accessed without having to move all other equipment that was in storage.

A bath was available in each ward bathroom but the person in charge confirmed that these were not suited to residents with complex mobility issues.

The sluicing facilities were inappropriate in regards their location. The design of sluicing facilities was not adequate due to the domestic nature of the taps and absence of a splash back.

Some minor decorative upgrade was required in some areas, for example, a single room required painting as the walls were stained and marked.

10. Action Required:

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

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

Capital funding is required to make the necessary upgrades at St. Theresa's Hospital Clogheen. A phased capital development is planned. The first phase 1A will go to tender in the next 3 months with builders on site in 2017. Phase 1A's extension will incorporate a link corridor, a single ensuite and twin ensuite room. The number of beds on the male ward will reduce from 6 to 3 beds.

The case continues to be made for additional capital which will allow for the continuation of and expansion of existing services at St. Theresa's.

Minor decorative changes will be completed

Proposed Timescale: Minor decorative changes 31 January 2017

Phase 1A 31 Dec 2017

Proposed Timescale: 31/12/2017

