Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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:	Louisa Power
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	10
Number of vacancies on the date of inspection:	8

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with 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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
14 September 2015 09:15	14 September 2015 19:15
15 September 2015 09:00	15 September 2015 15:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Major
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Substantially Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

The inspection was an announced registration inspection, took place over three days and was the seventh inspection of the centre by the Authority. As part of the inspection process, the inspector met with the provider nominee, assistant director of nursing, residents, relatives, visitors and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures, risk management documentation and staff records.

The documentation submitted as part of the application process was submitted in a timely and precise manner and was also reviewed prior to the inspection including questionnaires completed by residents; the feedback was positive and is referenced in the body of the report.

Since the last inspection, the Authority had received a concern in relation to a lack of person-centered care and inadequate hydration. An investigation was undertaken by the provider in relation to these concerns at the request of the Authority. These concerns were looked into throughout the inspection and the inspector's findings are outlined in the body of the report.

St Theresa's Hospital was a short stay unit managed by the Health Service Executive (HSE) that provided care for up to 18 residents requiring respite, rehabilitation, convalescence and palliative care. The targeted length of stay was 2-12 weeks and the centre did not aim to provide long term residential care. The single storey premises was located in the outskirts of Clogheen village and was originally built in the 1970s.

The inspector found that the person in charge and all staff were committed to the care and welfare of the residents. The inspector saw that the care and services to the residents was evidence based, person-centered and generally of a high standard. Residents looked well and cared for, engaged readily with the inspector and provided positive feedback on the staff, care and services provided. Staff interacted with residents in a respectful, warm and friendly manner and demonstrated a thorough knowledge of residents' needs, likes, dislikes and preferences.

Despite reconfiguration of the multi-occupancy bedrooms, the centre continued to pose challenges in meeting evidence based and safe infection prevention and control practices. An immediate action was issued during the inspection as the fire detection system was not extended to the laundry area located on the grounds of the centre. A number of additional improvements were required to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. The following is a summary of these required improvements:

• a review of the statement of purpose to include all of the required elements listed in Schedule 1 of the Regulations
• annual review of the quality and safety of care
• medication management practices
• a review of the residents' guide
• care plan development.

An action plan was submitted by the provider in response to this report. The Authority did not agree the timeframe outlined in the action plan with the provider in relation to the reconfiguration of the sluice facilities despite affording the provider two attempts to submit a satisfactory response.

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 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for residents. The statement of purpose was made available for residents, visitors and staff to read. The statement of purpose had been reviewed in August 2015. The ethos of care as described in the centre's statement of purpose was actively promoted by staff.

However, the statement of purpose did not detail all items listed in Schedule 1 of the Regulations including the arrangements for:
• management of the designated centre where the person in charge is absent from the centre
• respecting privacy and dignity of residents
• consultation with, and participation of, residents in the operation of the centre

Judgment:
Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:
There was evidence of a clearly defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. The person in charge was supported by a clinical nurse manager. A good and supportive working relationship between the person in charge and the clinical nurse manager. Staff with whom the inspector spoke were clear about the management structure and the reporting mechanisms. The inspector was satisfied that the management system in place ensured that service provided was safe, appropriate, consistent and effectively monitored. There were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

There was evidence of regular management meetings attended by the provider nominee and the person in charge. The minutes of the most recent meeting were made available and there was discussion in relation to staffing levels, rosters, budget, maintenance, health and safety, training and policy review. The person in charge confirmed that the provider nominee was accessible.

There was a system in place to review and monitor the quality and safety of care and the quality of life for residents. The results of recent audits were made available to the inspector. Audits were completed in a number of areas including documentation, hygiene and medicines management. Satisfaction surveys were completed with residents on a regular basis and there was a separate food survey. It was clear that improvements were brought about as a result of the learning from the monitoring review including changes to menu options.

A quality assessment and improvement committee had recently been formed comprising four persons in charge from designated centres in South Tipperary. The minutes of the first meeting in September 2015 were made available to the inspector and there was discussion in relation to clinical risk management, policy review, audits and training.

The provider nominee confirmed that an annual review of the quality and safety of care had not yet been completed.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:
A residents' guide was widely available which included details of the services and facilities provided, procedure respecting complaints and the arrangements for visits. However, the residents' guide did not outline the terms and conditions relating to residence in the centre.

A sample of residents' contracts of care was reviewed. The contract dealt with the care and welfare of the resident in the centre. Contracts were signed and dated by the resident or their representative at the time of admission. The contracts clearly set out the services to be provided and all the fees to be charged to the resident.

Judgment:
Substantially Compliant

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:
The centre was managed by a suitably qualified and experienced nurse with clear lines of authority, accountability and responsibility for the provision of service.

The person in charge had been in post since March 2012. The person in charge was employed full time and was a nurse with more than three years experience in the area of nursing of the older person within the previous six years. The person in charge had completed a post graduate qualification in gerontology in 2013. The person in charge had also completed a Masters in Business Administration (MBA) in 2010.

The person in charge provided evidence of ongoing professional development appropriate to the management of a residential care setting for older people, including short courses on clinical risk management, end of life, food and nutrition, health and safety, hand hygiene and CPR. The person in charge had also completed 'Train the Trainer' courses in elder abuse and hand hygiene. The training matrix confirmed that mandatory training was up to date for the person in charge.

While speaking with the inspector, the person in charge demonstrated comprehensive knowledge of residents, their care needs and a strong commitment to ongoing improvement of the quality of the services provided. She was seen and reported to be

visible, accessible and effective by staff, residents and relatives. Residents and relatives were observed to be relaxed and comfortable in her presence.

The person in charge demonstrated good knowledge of the relevant legislation and her statutory responsibilities. The person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis.

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):
No actions were required from the previous inspection.

Findings:
The records listed in Schedules 2, 3 and 4 of the Regulations were maintained in the centre. All of the key policies as listed in Schedule 5 of the Regulations were in place. Policies were made available to staff who confirmed they understood the policies. The inspector noted that policies were implemented. However, as outlined in Outcome 7: Safeguarding and Safety, the organisational policies in relation to the protection of vulnerable adults and response to allegations of abuse required review to incorporate the 'Safeguarding Vulnerable Adults from Abuse' national policy and procedures.

Records were kept securely, were accessible and were kept for the required period of time. Residents' records were kept in a secure place. The inspector found that the system in place for maintaining files and records was very well organised with clear systems in place.

The inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

Residents' records as required under Schedule 3 of the Regulations were maintained. The residents' directory was up-to-date and contained all matters referred to in article 19. Entries to the nursing records were maintained in line with relevant professional

guidelines. Daily records were completed.

Records listed in Schedule 4 to be kept in a designated centre were all made available to the inspector.

Records relating to inspections by other authorities were maintained in the centre and the inspector viewed documentation relating to food safety and fire safety.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the Regulations.

Judgment:
Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
There had been no periods where the person in charge was absent from the centre for 28 days or more since the last inspection and there had been no change to the person in charge. The provider was aware of the obligation to inform the Chief Inspector if there is any proposed absence of the person in charge and the arrangements to cover for the absence.

The inspector was satisfied that there were suitable arrangements made for the management of the centre the absence of the person in charge. The clinical nurse manager was identified as the person to act as the person in charge in her absence. The clinical nurse manager was a registered nurse with many years' experience in care of the older person. The clinical nurse manager demonstrated good, sound clinical knowledge and that she had a good understanding of her responsibilities when deputising for the person in charge.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
Systems were in place to protect residents from being harmed or suffering abuse. There were processes in place to provide residents with support that promoted a positive approach to behaviour that challenges. A restraint-free environment was promoted. However, some improvements were required in relation to the development of positive behaviour support plans and the provision of training for staff.

The person in charge and all the staff spoken with confirmed that there had been no incidents of alleged, suspected or reported abuse in the centre since the previous inspection.

There were organisational policies in place in relation to the protection of vulnerable adults and response to allegations of abuse. The policies were comprehensive and contained sufficient detail to effectively guide staff. However, the policies required review to incorporate the 'Safeguarding Vulnerable Adults from Abuse' national policy and procedures; this is covered in Outcome 5: Documentation.

Training records confirmed that training in relation to responding to incidents, suspicions or allegations of abuse had been facilitated. However, the records indicated that not all staff had attended training at the time of the inspection. Staff with whom the inspector spoke were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Residents with whom the inspector spoke confirmed that they felt safe in the centre and would raise any concerns with the person in charge or the staff.

The person in charge outlined that, due to the nature of admissions and the short duration of residents' stay in the centre, residents' finances were not managed by the centre.

A centre-specific policy in relation to the management of behaviour that is challenging was made available to the inspector. The policy was comprehensive and evidence based. Records confirmed that training had been provided to relevant staff in the response and management of behaviour that is challenging. However, the training matrix indicated and the person in charge confirmed that not all staff had completed this training at the time of inspection. The inspector noted that, where appropriate, personalised care plans had not been developed to guide staff in the proactive and reactive management of behaviour that challenges.

A policy in relation to restraint was made available to the inspector. The policy was comprehensive, evidence based and promoted a restraint-free environment. Where bedrails were in use, the inspector saw that the residents had clearly requested bedrails. The policy suitably detailed the ongoing monitoring and observation of a resident while a bedrail was in place and this was evidenced in practice. A risk-balance tool was completed for residents prior to the use of a bedrail and reviewed on each re-admission.

The inspector observed that chemical restraint was administered infrequently. However, an assessment was not completed prior to and during the use of chemical restraint in accordance with "Towards a Restraint Free Environment in Nursing Homes", a policy document published by the Department of Health.

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 health and safety policy and statement were made available to the inspector and had been last reviewed in July 2015. These documents were augmented by a risk register which included a range of centre-specific risks, an assessment of each risk and the controls identified as necessary to reduce each risk. The risks identified specifically in the Regulations were included in the risk register. There was evidence that the risk assessments were regularly reviewed and updated.

A comprehensive emergency plan was in place, dated October 2013, which covered events such as adverse weather conditions, water shortages and electrical power outage. The emergency plan was augmented by an evacuation policy, reviewed in May 2015, which outlined alternative accommodation should the centre be uninhabitable.

Incident forms from January-September 2015 were reviewed; a total of 7 falls were recorded and 1 accident was recorded. There were arrangements in place for investigating and learning from accidents. The actions to prevent recurrence were not consistently outlined in all incident forms.

Clinical risk management meetings took place on a quarterly basis and were attended by the local clinical risk manager and the person in charge. Incidents that have occurred in the previous quarter are discussed at these meetings and minutes indicated a proactive

approach to learning from incidents and accidents.

Suitable fire fighting equipment was observed to be provided throughout the centre. There was an adequate means of escape. Fire exits were unobstructed. Fire records were comprehensive, accurate and easily retrievable. The clear procedure for safe evacuation of residents and staff in event of fire was also displayed prominently in a number of areas throughout the centre. Staff completed a weekly visual check of fire equipment, exit routes, alarm system and fire notices.

The training matrix confirmed that fire training was up to date for all staff. Staff demonstrated good knowledge on the procedure to follow in event of a fire. Fire drills took place at least twice per year. However, documentation in relation to fire drills did not outline the following in order to provide an assurance that adequate provision is made in relation to safe evacuation of residents and staff from the centre:
• whether the drill simulated a day or night-time scenario
• time take to complete the drill
• any difficulties encountered during the drill.

The inspector noted that personal evacuation plans (PEEPs) had not been developed for residents. Therefore, there was no plan in place for the safe evacuation and placement of all residents in the centre from all locations, taking into account the number of staff required to evacuate the resident, the ideal means and route of evacuation and the location of the resident.

The fire panel was serviced on a quarterly basis, most recently in June 2015. However, the fire detection system did not cover the laundry building which was located in the grounds of the centre and was not interconnected to the centre. Fire safety equipment was serviced on an annual basis, most recently in September 2014. Emergency lighting had been serviced regularly, most recently in June 2015. The centre was a 'no smoking' area.

All staff were trained in the moving and handling of residents. Moving and handling equipment was serviced in line with the manufacturer's recommendations. Staff demonstrated a good understanding of the use of the hoist and contemporary moving equipment. Safe moving and handling practices were observed. Hand rails and grab rails were installed throughout the centre. A manual handling plan had been developed for each resident. However, the format and content of this plan was predominantly used in the acute setting. The plan outlined situations not routinely required for this setting such as moving from bed to trolley and did not adequately outline situations required for this setting such as transfer into vehicles and the use of an assisted bath.

The inspector observed that improvements were required to ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority, are implemented. The inspector saw and staff confirmed that there were adequate supplies of personal protective equipment (PPE) available. A colour coding cleaning system was in place to prevent cross contamination which was clearly implemented by staff. Alcohol hand get dispensers were provided throughout the centre and staff were supplied with personalised hand gels. Bed spacing was planned and managed in a way that minimised the risk of the spread of healthcare

associated infections (HCAIs). Supplies of alginate bags were provided for contaminated linen. Training in infection prevention and control had been facilitated for staff in 2014/15. Hand-washing facilities were provided in some areas throughout the centre. However, hand-washing facilities were not provided in close proximity to the centre. Hand-washing sinks in single bedrooms that could be used for isolation were domestic in design. The design and location of sluicing facilities was not adequate to minimise the risk of spread of HCAIs; this is further discussed in Outcome 12:Safe and Suitable Premises.

There was a contract in place for the disposal of clinical waste and records were maintained of removal and transport.

Judgment:
Non Compliant - Major

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:
Residents were protected by the designated centre's policies and procedures for medication management. However, improvements were required in documentation and storage practices.

The centre-specific policy on medication management and administration was made available to the inspector which had been reviewed in June 2015. The policy was comprehensive and covered the ordering, receipt, storage, prescribing, administration, return/disposal of medicines. Staff with whom the inspector spoke demonstrated adequate knowledge of this document.

Medicines were supplied by the pharmacy department in the local acute hospital and some residents brought their own medicines in from home. Robust measures were in place to ensure that medication reconciliation was completed at admission and discharge.

Medicines to be stored at room temperature were stored in a locked cupboard or medication trolley. The temperature of the refrigerator used to store medicines was noted to be within an acceptable range; the temperature was monitored and recorded daily. However, the refrigerator containing medicines was observed to be unlocked and was located in a clinical room which was accessed by non-nursing staff.

Medicines management training was facilitated regularly. The inspector observed that nursing staff demonstrated a person centred approach and adhered to professional guidance when administering medicines. Resources relating to medicines management were made available.

Staff reported and the inspector saw that it was not practice for staff to transcribe medication and no residents were self-administering medication at the time of inspection.

A sample of medication prescription sheets and administration records were examined. The medication prescription sheets examined were current. Prescription sheets examined did not always contain a date for each medication order. Therefore, these prescription orders are not complete authorisations to administer medications as per the Medicinal Products (Prescription and Control of Supply) Regulations.

Medication administration sheets examined identified the medications on the prescription sheet, contained the signature of the nurse administering the medication and allowed space to record comments on withholding or refusing medications. The times of administration matched the prescription sheet. The inspector noted a medication incident where medicines were not administered to a resident as prescribed; this was brought to the attention of the person in charge immediately.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. A record was kept of the medicines returned to ensure a verifiable audit trail. However, the date of opening was not recorded for medicines with a reduced shelf-life when opened. Therefore, staff could not identify when these medicines expired and require disposal.

Judgment:
Non Compliant - Major

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

Findings:
The inspector noted that a comprehensive record of all incidents was maintained. The action from the previous inspection had been satisfactorily implemented and notifications to the Authority had been made in line with the requirements of the Regulations.

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

Findings:
There was evidence that timely access to health care services was facilitated for all residents. A medical officer was appointed for the centre and visited the centre on three occasions over the 2 day inspection. An "out of hours" GP service was also available if required. In line with their needs, residents had access to allied healthcare professionals including physiotherapy, occupational therapy, speech and language and dietetics. The inspector spoke with the physiotherapist who visited the centre two mornings per week. She reported that timely referrals were made and she was facilitated to assess and treat residents on an individual basis. Residents were enabled to make healthy living choices such as smoking cessation.

A selection of care plans was reviewed. There was evidence of a pre-assessment undertaken prior to admission and each re-admission for residents. After admission, there was a documented assessment of all activities of daily living, including maintaining a safe environment, communication, breathing, eating and drinking, elimination, personal care, mobility, spirituality and dying. There was evidence of a range of evidence based assessment tools being used and ongoing monitoring of falls risk and nutritional need. Care plans were developed for residents in line with their assessed needs. Many care plans reviewed were personalised and contained sufficient information to guide staff in the care and support of residents. However, this was not consistent; some care plans were pre-printed and had not been adequately completed to reflect the needs of the individual resident. The inspector saw a care plan in relation to mobility that was generic in nature and did not reflect the residents' current and significant needs. A care plan in relation to diabetes did not contain adequate information in relation to the management of high or low blood sugars.

Each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances during each admission and was reviewed on each re-admission. However, consultation with the resident and their representatives was not

clear at each review

Wound management was in line with national best practice. Wound management charts were used to describe the cleansing routine, emollients, dressings used and frequency of dressings. The dimensions of the wound were documented and used to evaluate the wound on an ongoing basis.

There was a strategy in place to prevent falls whilst also promoting residents' independence. An evidence-based assessment tool was used to assess residents' risk of falls on admission and at each re-admission. Care plans were developed which outlined interventions to reduce falls. The inspector noted that the interventions outlined had been implemented.

The inspector noted that comprehensive information was provided on discharge and at transfer to and from hospital. A resident's right to refuse treatment, e.g. medicines or transfer to hospital, was respected and documented.

Judgment:
Non Compliant - Moderate

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:
The single storey premises was originally built in the 1970s with extensions added in 1993 and 1998 incorporating end of life facilities, a day room, oratory, office and additional bathrooms.

An occupational therapist had reviewed the centre in line with the needs of residents in 2014. The report of the review was made available to the inspector. The report outlined a number of improvements that were required to the centre to ensure that it met the needs of residents including installation of additional hand and grab rails in the sanitary facilities, provision of suitable and adjustable shower chairs and fitting of more suitable flooring in a number of areas. The person in charge confirmed that this had not been completed.

The premises and external grounds were visibly clean, well maintained, adequately heated, lighted and ventilated and generally in good decorative order. However, the inspector observed that the shower room beside St Joseph's Ward required attention due to peeling paint on the radiator and evidence of rust on the shower.

Accommodation for residents comprised three single bedrooms, one triple bedroom and two wards which each contained six beds each. Each bedroom had a wash-hand basin and one of the single rooms was en-suite. There were separate male/female toilets provided near the entrance to the premises, a shower room with a toilet and a bathroom with a toilet.

A large day room that incorporated dining facilities provided adequate communal space for the residents. A quiet room was located near the day room and residents were observed to use this room throughout the day. Residents have access to a safe and mature garden.

The inspector noted that great effort had been made to add homely touches to the premises. The furniture in the day room was domestic in nature and included an attractive side board. A small seating area was provided in the main reception area and residents stated that they enjoyed taking a brief rest on the seats or sitting there and 'watching the world go by'. Fresh floral arrangements were dotted around the centre. Photos, pictures and paintings of the local area were displayed in communal areas and bedrooms.

The person in charge outlined that the number of beds had been reduced from eight to six in each of the wards. This had resulted in a modest increase in the space around each bed and had a positive impact on ensuring residents' privacy and dignity.

The inspector noted that assistive equipment was stored in corridors and sanitary facilities. There were separate staff facilities for changing and storage but the inspector saw that the storage space for staff clothing was inadequate. The person in charge confirmed that lockable storage was not provided for residents.

Sluicing facilities were provided in two main areas. As outlined in Outcome 8: Health and Safety, the location was not appropriate. One bedpan washer was provided beside St Joseph's Ward but it was located in an assisted shower room at a distance from the sluicing facilities. A bedpan washer was not provided adjacent or near to Our Lady's Ward. The design of the sluicing facilities was not adequate due to the domestic nature of the taps. An action plan was submitted by the provider in response to this report. The Authority did not agree the timeframe outlined in the action plan with the provider in relation to the reconfiguration of the sluice facilities despite affording the provider two attempts to submit a satisfactory response.

The inspector saw a functioning call-bell system in place and that staff responded promptly.

The kitchen was visibly clean and organised and inspection reports issued by the relevant Environmental Health Officer (EHO) were made available to the inspector.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
The inspector noted that there was a centre-specific comprehensive complaints policy, last reviewed February 2014. The complaints policy identified the nominated complaints officer and also included an independent appeals process as required by legislation. A summary of the complaints procedure was displayed prominently at the main reception area along with a photograph of the complaints officer. The complaints procedure was also outlined in the statement of purpose and residents' guide. However, the person in charge confirmed that there was not a nominated person, independent from the complaints officer, to oversee the process and ensure that all complaints are managed and documented appropriately.

The inspector reviewed the complaints log detailing the investigation, responses, outcome of any complaints and whether the complainant was satisfied. Complaints were seen to be investigated promptly and there was evidence of learning from complaints.

Judgment:
Non Compliant - Moderate

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:

The centre-specific policy on end of life care was made available and had been reviewed in July 2015. The policy was comprehensive, evidence based and would effectively guide staff to provide personalised care to residents at the end of life in line with their needs and wishes.

A selection of records relating to deceased residents were reviewed and the inspector noted that residents had received appropriate care and their physical, emotional, social, physiological and spiritual needs had been met. Adequate supports were put in place to meet residents' needs. Family and friends were kept informed of the resident's condition. Sudden and unexpected deaths were managed in an appropriate and sensitive manner.

The 'Little Flower Suite' was used to accommodate residents approaching the end of life and comprised a bedroom, en-suite shower room and kitchenette with tea and coffee making facilities. The suite led out to a patio with a seating area. A recliner chair was provided to allow families to stay overnight and staff confirmed that families were always made feel comfortable. Meals and snacks were available at all times.

Religious and cultural practices were facilitated. Members of the local clergy visited residents on a regular basis. Staff confirmed that ministers from a range of religious denominations were facilitated to visit. Access to specialist palliative care services was available on a 24 hour basis from South Tipperary hospice home care team.

Improvements were required in capturing residents' wishes at the end of life. End of life care plans did not record the wishes of the resident, including place of death, spirituality and whether friends and family are to be informed of condition.

An automated external defibrillator (AED) was available on site and staff had the appropriate training in the use of this device and cardiopulmonary resuscitation (CPR). The inspector decisions not to attempt resuscitation were seen to be based on clear clinical rationale and discussions and decisions were clearly recorded and reviewed as appropriate.

Practices after death respected the remains of the deceased person and family members were consulted for removal of remains and funeral arrangements. The end of life policy stated that personal possessions were returned in a sensitive manner and staff demonstrated an empathetic understanding of the needs of resident and family at end of life.

Judgment:
Substantially Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
There were centre-specific policies in place in relation to meeting the nutritional and hydration needs of residents that had been reviewed in 2014.

The food served was sufficient in quantity, freshly prepared, nutritious and wholesome and was of a good standard. The inspector observed that there was a clear, documented system between nursing and catering staff regarding residents' meal choices and preferences. There was evidence that choice was available to residents for breakfast, lunch and evening tea with respect to menu options and dining location. The menu for the day was displayed prominently in the day room and the inspector observed staff informing residents of menu choices. The inspector observed a detailed description of each part of the meal was provided to residents with visual impairment. A meaningful choice was provided at each meal including a hot option for supper.

The inspector observed lunch to be unhurried and a social occasion. The majority of residents chose to dine in the dining area. Restful music played in the background; staff sat with residents and helped to make conversation. A choice of napkins or clothes protectors was offered to residents. Tables were attractively set with flowers. The inspector noted that sufficient portions were plated and attractively presented in an appetising manner. Additional portions were offered to residents at each course.

A choice of healthy snacks was available at all times. Night staff had access to the kitchen to make hot drinks and a light snack for residents.

The inspector saw that residents were provided with a range of hot and cold drinks; fresh water was available at all times at each bedside, in the day room and from a dispenser in reception area. Staff were observed to offer drinks to residents on a regular basis throughout the day. Nursing staff reported monitoring the fluid balance of residents with specific requirements.

Residents were encouraged to remain independent and assistance was offered in a discreet and respectful manner. Gentle encouragement was given to residents who were reluctant to eat. Residents with whom the inspector spoke were complimentary of the meals and snacks served.

It was observed that every effort was made to present modified diets in an attractive manner. Staff with whom the inspector spoke demonstrated adequate knowledge of residents' needs in relation to diet and fluids of modified consistency and this was evidenced in practice.

Residents' weights were monitored on a regular basis and the Malnutrition Universal Screening Tool (MUST) was also utilised in practice. The inspector saw that residents

looked well, weights were stable, residents were not experiencing weight loss and nursing staff understood the relevance of weight loss when computing the MUST.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
The inspector found the centre to be relaxed and person-centred. There was a good level of visitor activity noted by the inspector throughout the day and residents with whom the inspector spoke reported that there was no restriction on visitors. A quiet room/oratory was provided for residents to meet visitors in private. The person in charge confirmed that an independent advocacy service is available to residents when required.

Residents were consulted about how the centre was planned and run. A satisfaction survey had been completed with residents. A separate food survey was completed to ascertain residents' views in relation to menu options and food quality. Feedback sought during this meeting informed practice and suggestions, e.g. new menu options, were seen to be implemented.

Residents' capacity to exercise personal autonomy and choice was maximised. Staff were observed to provide residents with choice and control by facilitating residents' individual preferences in relation to their daily routine, meals and their choice of activities. Some residents like to go to day care centre located in the grounds during their stay and this was facilitated.

Residents are facilitated to exercise their civil, political and religious rights. Residents were very conversant in current affairs and the person in charge reported that residents were afforded the opportunity to vote if in the centre on polling day. Mass was celebrated in the centre on a regular basis. The person in charge confirmed that ministers from a range of religious denominations were facilitated to visit.

The inspector observed televisions and radios in the communal areas. Residents also

had access to televisions in their bedrooms and newspapers were delivered every day. Residents' personal communications were respected and residents had access to a private telephone. Information on local events was displayed in the day room.

The reduction of resident numbers in the wards from eight to six was observed to have a positive effect on ensuring the privacy and dignity of residents. Adequate screening curtains were used in shared bedrooms. Staff knocked and awaited permission before entering residents' bedrooms. Staff addressed residents by their preferred names. CCTV cameras were not in use in areas where residents would have a reasonable expectation of privacy.

Staff with whom the inspector spoke were aware of the different communication needs of the residents. Individual communication requirements were highlighted in care plans and reflected in practice.

Improvements had been made in the provision of activities. The roster reflected that a staff member was allocated to activity provision for one hour each day. Activities supplies were provided to assist staff such as materials for knitting, board games and target games. A library of books was provided in the day room. Residents can opt out of activities if they so wish.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
There was a centre-specific policy on residents' personal property and possessions which had been reviewed in September 2015.

Due to the short duration of stay in the centre, residents' clothing was not routinely laundered on-site and residents were informed of this on admission. The person in charge and laundry confirmed that exception was sometimes made and that clothing was laundered separately and personally returned to the resident to safeguard against loss.

Residents with whom the inspector spoke confirmed that they could retain control over

their personal possessions and clothing. However, the inspector noted that inadequate storage was provided for residents who were accommodated in multi-occupancy bedrooms. A small locker without lockable storage was located beside each bed. One double wardrobe and four drawers were provided as communal storage for six residents in each ward.

Judgment:
Non Compliant - Moderate

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

Findings:
There was a planned roster in place. Based on observations, a review of the roster and these inspection findings, the inspector was satisfied that the staff numbers and skill-mix were appropriate to meeting the assessed needs of the complement of residents accommodated.

There was a registered nurse on duty at all times and a record is maintained of current registration details of nursing staff. Staff were observed to competently deliver care and support to residents that reflects contemporary evidence based practice.

A sample of staff files was reviewed and contained all of the required elements. The inspector noted that effective recruitment procedures were in place including the verification of references. The inspector saw that there was a selection of healthcare reading materials and reference books stored in the nurses' office. The inspector noted that copies of both the Regulations and the Authority's Standards were available. Staff were also able to articulate adequate knowledge and understanding of the Regulations and the Authority's Standards.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies - the programme reflected the needs of residents. As previously outlined in Outcome 7: Safeguarding and

Safety and Outcome 8: Health and Safety, there were gaps in mandatory training. Further education and training completed by staff included palliative care, continence, wound management, hand hygiene and dementia.

The inspector noted that regular meetings took place for nursing, support and kitchen staff. Topics discussed include health and safety, training, person centredness, risk management, infection prevention and control, activity provision and documentation.

Staff were supervised appropriate to their role and a formal system of annual appraisal had been implemented but had not been rolled out to support staff. The inspector observed and staff confirmed that the person in charge was approachable, supportive and visible.

Records made available to the inspector confirmed that the person in charge had confirmed that the appropriate vetting and training had been completed and that professional registration was up to date for agency staff. The person in charge confirmed that volunteers were not attending the centre.

Judgment:
Non Compliant - Moderate

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:

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	St. Theresa's Hospital
Centre ID:	OSV-0000741
Date of inspection:	14/09/2015 & 15/09/2015
Date of response:	03/11/2015

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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not detail all items listed in Schedule 1 of the Regulations.

1. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

Please state the actions you have taken or are planning to take:
The Statement of purpose will be updated to include deputising arrangements for the Person in Charge, arrangements for consultation with the operation of centre (Contracts of Care) and elaborate on the arrangements for respect and dignity of patients.

Proposed Timescale: 20/10/2015

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:
An annual review of the quality and safety of care was yet to be completed.

2. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
A Quality Assessment and Improvement Committee was set up in July 2015 to ensure delivery of safe, quality services within Older Persons Residential services
Membership of the Committee includes the Director of Nursing St. Brigid's Hospital Carrick on Suir, the Director of Nursing St. Theresa's Hospital Clogheen, the Director of Nursing Cluain Arann and the Manager of Older Persons services.
Meetings take place on a bi monthly basis.
The next meeting is scheduled to take place on the 4th November 2015.
To date the Committee has undertaken peer audits in hygiene and documentation.
Recommendations from the hygiene audit have been implemented.
The outcome of the documentation audit will be discussed at the meeting of the 4th November.
It is part of the purpose and function of the Committee to continue to review the quality and safety of care in all three site locations.

Proposed Timescale: 02/09/2015 and 04/10/2015 and ongoing

Proposed Timescale: 04/10/2015

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The residents' guide did not outline the terms and conditions relating to residence in the centre.

3. Action Required:
Under Regulation 20(2)(b) you are required to: Prepare a guide in respect of the designated centre which includes the terms and conditions relating to residence in the centre.

Please state the actions you have taken or are planning to take:
The residents guide has been amended to include Terms and Conditions as outlined in the Contract of Care

Proposed Timescale: 20/10/2015

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:
The organisational policies in relation to the protection of vulnerable adults and response to allegations of abuse required review to incorporate the 'Safeguarding Vulnerable Adults from Abuse' national policy and procedures.

4. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
St. Theresa's policy in relation to the protection of vulnerable adults and response to allegations of abuse has incorporated the 'Safeguarding Vulnerable Adults from Abuse' national policy and procedures. St. Theresa's will cooperate fully with training provided in respect of Vulnerable Adults.

Proposed Timescale: 20/10/2015

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 training to support residents with behaviours that are challenging.

5. 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:
Arrangements are in place to update the 3 outstanding staff members with appropriate training to support patients with behaviours that are challenging.

Proposed Timescale: 09/12/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personalised care plans had not been developed to guide staff in the proactive and reactive management of behaviour that challenges.

6. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
1.Discussion occurred at the Nursing Staff Meetings on the 7/10/2015 and 8/10/15 regarding individualised care plans to guide staff in the proactive and reactive management of behaviour that challenges.
2.The development of an individualised care plan for behaviour that challenges has been initiated
3. Training Date set for Nov. 18th and Dec. 9th for two staff remaining to attend challenging behaviour training.

Proposed Timescale: 09/12/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An assessment was not completed prior to and during the use of chemical restraint in accordance with "Towards a Restraint Free Environment in Nursing Homes", a policy document published by the Department of Health.

7. 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:
Staff members in St. Theresa's Hospital will familiarise themselves with and be compliant with "Towards a Restraint Free Environment in Nursing Homes" policy

Proposed Timescale: 30/11/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records indicated that not all staff had received training in relation to responding to incidents, suspicions or allegations of abuse.

8. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
Arrangements are being put in place to ensure that all outstanding staff members who require training in relation to the protection of vulnerable adults and response to allegations of abuse will receive same.

Proposed Timescale: 30/11/2015

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 actions to prevent recurrence were not consistently outlined in all incident forms.

9. Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
Discussion took place at Nursing Staff Meeting on 8/10/2015 regarding the completion

of Clinical Risk Incident Reports and the importance of incorporating learning from adverse events involving residents. Staff members are now aware that the section on 'measures to prevent recurrence' needs to be completed by the person writing the incident report and checked by the individual submitting the incident report. .

Proposed Timescale: 08/10/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The format and content of manual handling plan was not suitable for this setting.

10. 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:
The Risk Management Policy will include hazard identification and assessment of Risks throughout the designated centre.

Proposed Timescale: 31/12/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The hand-washing sinks in the single rooms that could be used for isolation were domestic in design (criterion 3.1).

Hand-washing sinks were not provided in close proximity to the sluicing facilities (criterion 6.1)

11. 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:
Domestic sinks will be replaced with infection control sinks.

Capital funding is required to make the necessary upgrades to the Sluice facilities at St. Theresa's Hospital Clogheen. The Capital submission will also include a modification and expansion to existing bed numbers. An estimated €1m is required for this Capital

development. A case will be made for the cost benefit of a small capital allocation which will allow for the continuation of and expansion of existing services at St. Theresa's. The Capital submission will be submitted for consideration as part of 2016 capital allocations. In the short term, the current facilities will continue to be used.
Proposed Timescale: Replacement of Domestic Sinks- 22nd December 2015
Modifications to the sluice facilities- Dependant on when Capital funding becomes available.

Proposed Timescale: 22/12/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Documentation in relation to fire drills was not comprehensive to ensure that adequate provision is made in relation to safe evacuation of residents and staff from the centre.

12. 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:
Fire Drills/Fire Training will be undertaken to ensure that all persons working and residents within St. Theresa's are aware of the procedures to take in the case of a fire. Ongoing fire drills will be scheduled throughout the year and will form part of orientation to any new staff member commencing in post.

Proposed Timescale: 22/12/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal evacuation plans (PEEPs) had not been developed for residents.

13. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
Evacuation plans pertaining to specific types of patient presentations will be developed. It will be noted in the persons chart as to what patient type they are e.g.

mobile/wheelchair user

Proposed Timescale: 22/12/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire detection system was not installed in the laundry.

14. Action Required:
Under Regulation 28(2)(ii) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
A Fire detection system is in place in the main building of St. Theresa's Hospital Clogheen, to the required Fire Regulation standard. There is currently no Fire detection system in place in the Laundry (a outbuilding, a short distance from the main building complex). Following the issue of the "Immediate Action Plan , Horizon visited St. Theresa' site on Wednesday 16th September. A quotation for the installation of a Fire detection system in the Laundry was received on Thursday 17th September. The order for the Fire detection system will be placed today Friday 18th September. As there is a one week lead in time on parts from the UK, the system will be installed week commencing the 28th of September and will be fully commissioned and certified by Friday the 2nd October.

Proposed Timescale: 02/10/2015

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The refrigerator containing medicines was unlocked.

15. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
Nursing Staff members were advised at the meeting on 7/10/2015 regarding the importance of keeping the refrigerator locked. All Staff members are now aware of their responsibilities.

Proposed Timescale: 07/10/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A medication incident was noted where medicines were not administered to a resident as prescribed.

16. Action Required:
Under Regulation 29(5) you are required to: 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 pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
1.The Medication Incident was reported and investigated by the Person in Charge and has been documented in St. Theresa's Medication Incident Log Book.
2.The Medication Incident was discussed at the Nursing Staff Meeting on 7/10/2015 and the importance of accurate documentation was re-enforced.
3.The Person in Charge will organise regular briefing sessions to all Nursing Staff on St Theresa's Medication Management Policy
4.The Person in Charge will ensure Nursing Staff will complete Annual learning on Medication Management.
5.St Theresa's will continue to perform Medication Management Audits to prevent Medication Incidents.

Proposed Timescale: 20/10/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The date of opening was not recorded for medicines with a reduced shelf-life when opened

17. Action Required:
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose 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.

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

Discussion took place at the nursing staff meeting on 7/10/2015 regarding the importance of checking expiry dates of medicinal products and discarding medicinal products which have been opened and are no longer being used by a patient. These checks will be incorporate into the daily fridge temperature checks.

Proposed Timescale: 20/10/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Prescription sheets examined did not always contain a date for each medication order

18. Action Required:
Under Regulation 29(5) you are required to: 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 pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
Discussion took place with both Medical Officers who currently prescribe the medications for all patients regarding the importance of the date in which the medication order was prescribed. Both are agreeable to comply in accordance with policy and legislation. Continued weekly Medication Audits will ensure prevention and immediate corrective action.

Proposed Timescale: 20/10/2015

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:
Consultation with the resident and their representatives was not clear at each review of the care plan.

19. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
1.Discussion took place at the Nursing Staff Meeting on 7/10/15 regarding completion

of care plans and the importance of ensuring they are patient centred and patient/problem specific.
2.Care plans will be formally reviewed on an ongoing basis and revised as necessary, based on the clinical/social presentation of the patient.
3.The Documentation audit completed in respect of St. Theresa's as part of the peer audit undertaken by members of the Quality Assessment and Improvement Committee has informed practice and will lead to improvements in documentation going forward.

Proposed Timescale: 22/12/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some care plans reviewed did not reflect the resident's current needs and did not contain adequate information to guide staff in the care of the resident.

20. 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:
1.Discussion took place at the Nursing Staff Meeting on 7/10/15 regarding completion of care plans and the importance of ensuring they are patient centred and patient/problem specific. Staff members are aware that a care plan must be in place within 48 hours of the resident's admission to St. Theresa's Hospital.
2.The Documentation audit completed in respect of St. Theresa's as part of the peer audit undertaken by members of the Quality Assessment and Improvement Committee has informed practice and will lead to improvements in documentation going forward.

Proposed Timescale: 22/12/2015

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:
Sluicing facilities were not adequate.

An action plan was submitted by the provider in response to this report. The Authority did not agree the timeframe outlined in the action plan with the provider in relation to the reconfiguration of the sluice facilities despite affording the provider two attempts to submit a satisfactory response.

21. 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 to the Sluice facilities at St. Theresa's Hospital Clogheen. The Capital submission will also include a modification and expansion to existing bed numbers. An estimated €1m is required for this Capital development. A case will be made for the cost benefit of a small capital allocation which will allow for the continuation of and expansion of existing services at St. Theresa's. The Capital submission will be submitted for consideration as part of 2016 capital allocations. In the short term, the current facilities will continue to be used.

Proposed Timescale: Dependant on when Capital funding becomes available.

Proposed Timescale:

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required to meet the needs of residents, in line with the report from an occupational therapist.

22. Action Required:
Under Regulation 17(1) you are required to: 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.

Please state the actions you have taken or are planning to take:
The recommendations made by the Occupational Therapist will be implemented

Proposed Timescale: 29/01/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate storage for assistive equipment and staff belongings.

Lockable storage was not available for residents.

23. 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:
It is planned to replace all shared wardrobes with individual wardrobes to include a lockable drawer for personal belongings.

Proposed Timescale: 29/01/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The shower room beside St Joseph's Ward required attention due to peeling paint on the radiator and evidence of rust on the shower.

24. 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:
The radiator in the shower room will be painted and shower tray will be replaced

Proposed Timescale: 29/01/2016

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not a nominated person, independent from the complaints officer, to oversee the process and ensure that all complaints are managed and documented appropriately.

25. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
The CNM2 has been assigned the responsibility of ensuring that all complaints are

appropriately managed and documented appropriately.

Proposed Timescale: 20/10/2015

Outcome 14: End of Life Care

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans did not record the wishes of the resident.

26. Action Required:
Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

Please state the actions you have taken or are planning to take:
Individual preferences will be recorded as part of the Care Plan going forward.

Proposed Timescale: 20/10/2015

Outcome 17: Residents' clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inadequate storage space was provided for residents.

27. Action Required:
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:
It is planned to replace all shared wardrobes with individual wardrobes to include a lockable drawer for personal belongings.

Proposed Timescale: 29/01/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A formal system of appraisal had not been rolled out to support staff.

28. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Discussion at Support Staff Meeting on 8/10/2015 regarding a formal system of appraisal. This will be rolled out, commencing in November 2015 and will be supported by the appointment of a new Clinical Nurse Manager 2.

Proposed Timescale: 30/03/2016