

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Joseph's Hospital
Centre ID:	OSV-0000613
Centre address:	Lifford Road, Ennis, Clare.
Telephone number:	065 6840666
Email address:	meave.oconnor@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Mark Sparling
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	104
Number of vacancies on the date of inspection:	16

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 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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 August 2014 09:45	12 August 2014 19:00
13 August 2014 09:15	13 August 2014 17:30

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

Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 12: Safe and Suitable Premises
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition

Summary of findings from this inspection

This inspection was thematic in its approach but the inspector also followed up notifications received by the Authority from the provider and some of the actions that had emanated from the last inspection of the 30 and 31 October 2013. The centre is currently registered to accommodate a maximum of 120 residents. On the day of inspection there were 104 residents receiving care in the centre of both short and long term duration including four residents on temporary transfer to the acute services. Staff had assessed the needs of 80% of the residents as maximum dependency.

The centre provides accommodation to residents in four separate units including a 12 bed dementia care unit. The inspector completed a visual inspection of the dementia specific unit the Holly Unit, and undertook the inspection in the three larger continuing care units, the 42 bed Hazel unit, the 42 bed Alder unit and the 24 bed Ash unit.

Prior to this inspection the centre was requested to complete and submit to the Authority a self assessment questionnaire on the two core inspection outcomes of food and nutrition, and end of life care. The person in charge had assessed the centre as in minor non compliance with end of life care requirements and moderate non compliance with food and nutrition requirements; the inspector based on the evidence judged the centre to be in moderate non compliance with both outcomes. The provider was also requested to distribute questionnaires to relatives of deceased

residents for completion on a voluntary basis. Nine completed questionnaires were returned to the Authority, the feedback received was consistently positive in relation to the care received at end of life by their family member and the respect and dignity afforded by staff.

The inspector reviewed records including policies, medical and nursing records, audits, satisfaction surveys, medication records and records pertaining to fire safety procedures and precautions. The inspector spoke with staff including the person in charge and the business manager for services for older persons. The inspector observed care and practice and spoke with residents and relatives throughout the inspection process.

The feedback received from residents and relatives was consistently positive and while there was evidence of good care and practice and systems for reviewing the quality of care and services provided to residents significant deficits were identified by the inspection process.

The inspector was satisfied that staff supported residents to achieve a comfortable and dignified death, however the end of life care plans seen were somewhat ambiguous and reflected the lack of practical efforts made to afford all residents an opportunity to consider and communicate their end of life preferences and wishes.

While there was evidence of good practice, acknowledgement of the need for change and willingness to change, and the feedback received from residents was good, the available facilities and procedures did not facilitate a quality dining experience or ensure that all residents nutritional needs and requirements were at all times met.

In general the inspector found the premises to be visibly clean, in good repair and in fairly good decorative order, however as identified on all inspections undertaken to date the premises does not conform to all of 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. The design and layout of the centre did not promote the privacy, independence and quality of life of residents.

The inspector was very concerned that adequate precautions were not in place against the risk of fire or for reviewing and adequately acting on reports of deficits in fire safety precautions including systems for giving warning of fires, fire detection systems and directional signs to allow staff and any other person to readily identify and respond to the location of a fire. The inspector was not satisfied that adequate risk assessments were in place for residents who consumed tobacco and while there were care plans for smoking they were vague and did not outline core controls such as the resident's visibility and supervision required while smoking. The inspector based on the inspection findings was not satisfied that the provider had adequately acted on the recommendations of an internal investigation commissioned following a critical incident in March 2014. Given the risk identified the provider on the 14 August 2014 was issued with an immediate action plan to immediately address the completion of risk assessments, the provision and proper maintenance of fire fighting equipment and the provision of directional signage that accurately reflected the information displayed by the fire panel when activated. Given the level of risk

identified time frames for completion were set by the Authority. A satisfactory response was received within the required time frame.

Section 41(1)(c) of the Health Act 2007. 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.

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):

No actions were required from the previous inspection.

Findings:

The inspector was very concerned that adequate precautions were not in place against the risk of fire or for reviewing and adequately acting on reports of deficits in fire safety precautions including systems for giving warning of fires, fire detection systems and directional signage to allow staff and any other person to readily identify and respond to the location of a fire. The inspector was not satisfied that the provider had adequately acted on the recommendations of an internal investigation (the report of which was received by the provider on 24 June 2014) into a fire related serious incident in March 2014. The inspector was not satisfied that core recommended actions to address or reduce contributory factors and thereby reduce the risk of future harm including; risk assessments, clear and specific care plans, fire blankets, fire training for all staff, a full review of the fire detection system, the agreement and confirmation of one identifier per unit that concurred with the fire detection system had been adequately addressed and the consequent ongoing serious risk of harm and injury warranted the issuing of an immediate action plan to the provider.

There was a comprehensive policy on the consumption of tobacco products dated as approved on 25 July 2014 but it was not implemented in practice.

Three residents were identified by staff as consumers of tobacco products on the three units inspected. With the exception of one resident the provider had failed to adequately assess the risks of each resident who smoked and failed to identify, record and implement clear, specific, adequate and appropriate control measures related to the specific risks identified including the residents visibility and supervision while smoking. A risk assessment for a second resident was held centrally but there was no evidence of its communication to staff on the clinical unit. Staff spoken with including the person in charge confirmed that the risk assessments were not in place and while there were care plans for smoking the inspector saw that they were vague and did not outline core controls such as the resident's visibility and the supervision required while smoking. There was contradictory documentation of controls that had been identified as necessary such as restricted access to smoking materials and all staff spoken with were

not conversant with the controls in place. For example one care plan stated that a resident was not to have access to smoking materials yet a note seen in the nurses' station advised staff to remove smoking materials from the resident at night. Staff said that they "thought" night staff removed smoking materials from another resident but this was not specified in the care plan; staff reported that they did not have time to supervise residents while they smoked.

There was one designated external smoking shelter off the "long corridor"; resident smoking however was seen to be facilitated externally at each unit. The inspector saw that one such area was poorly maintained, was littered with strewn matches, and the receptacle for the disposal of smoking materials was a plastic bucket that also contained rubbish including tissue paper.

The provider had failed to provide at each area that was deemed and utilised as a smoking area an adult sized fire blanket that was readily accessible, clearly identifiable and properly maintained. The inspector saw that on one unit the fire blanket was in the kitchenette (an area restricted by coded access), it had become detached from the wall, was in a container on the sink and when lifted up by a staff member had water dripping from it.

On reviewing documentation including records of completed fire drills and correspondence from the person in charge the inspector noted that deficits in fire warning systems, the fire detection system and directional signs, that in an emergency "would have serious consequences", had been brought to the attention of the provider. It was noted that a number of fire alarm call points were recorded as having failed to operate on the 3 June 2014, that the information displayed on the fire alarm panel was "confusing" and that directional signs did not correspond to the information displayed on the fire alarm panel. Some staff spoken with confirmed this; new names had been allocated to each unit sometime back but staff continued to use the older historical numerical names in practice and on documentation seen by the inspector. The provider had failed to ensure that the information on directional signs for staff, residents and other persons conformed with and accurately reflected the information displayed by the fire detection system when activated despite this being a recommendation of the internal investigation in June 2014. On the second day of inspection the inspector requested that the fire alarm be activated and the inspector saw that there were no directional environmental cues on the main long corridor that accurately reflected the information displayed on the fire panel (signs referred to the numerical names) and this could result in staff or other persons being unable to readily identify the location of a fire or staff going to the wrong location in the event of a fire. Signage was not in place on the long corridor for all of the residential units. The inspector saw that signs on corridors, at the entrances to units and rooms, and the information on the fire panel had a combination of numerical, graphic, narrative English and Irish identifiers but no one agreed identifier.

Records seen confirmed that the provider was requested on the 23 June 2014 to conduct a full review of the fire detection system and to agree one identifier for each unit and ensure that this was the information that was relayed by the fire panel. There was evidence in the form of engineer's reports dated 30 May 2014 of "a test on the cause and effect of the fire alarm system" and the testing of the emergency lighting and

the quarterly service of the fire detection system on the 13 June 2014 and the 4 July 2014. However, the inspector was not satisfied that there was documentary evidence available to support that a full review has been undertaken by a suitable qualified person of all fire safety precautions including but not limited to the fire detection system, devices for giving warning of fires and directional signage and confirmation that the system was in full working order and that any and all identified issues and defects had been addressed.

Staff training records for fire safety training undertaken in April and November 2013 and to date in 2014 indicated that there was no record of attendance for at least nineteen staff.

The inspector saw that over the course of this two day inspection staff were receiving fire safety instruction on the procedures to be followed should the clothes of a resident or other person catch fire; staff spoken with demonstrated knowledge and learning.

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

Findings:

The inspector followed up on the actions from the last inspection and saw that audits of medication management practice were completed as outlined in the provider's response to the action plan. The audits included the monitoring of the signing and dating of discontinued medication by the relevant General Practitioner (GP). Based on a small random sample of medication prescription and administration records seen the inspector did not note any deficit in the management of discontinued medications but did see that;

- as previously identified at the time of the last inspection the handwritten prescriptions were not completed in block capitals as required by local instructions for the safety of the resident, were difficult to read and accurately understand and therefore increased the risk of a medication administration error. Staff spoken with concurred with this.
- there were regular and frequent instances of the absence of nurse signatures to indicate that all medicinal products were administered in accordance with the directions of the prescriber. While there was an agreed code available for identifying reasons for non administration of prescribed medication these were not seen to be utilised. In one instance a "tick" was used to indicate administration and this does not concur with

professional standards and regulatory guidance for nursing staff

- the maximum dosage of medications prescribed on a PRN basis (medication that is not scheduled or required on a regular basis) was not at all times stated.

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:

Person-centred care and support

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

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

Findings:

In general the inspector found the premises to be visibly clean, in good repair and in fairly good decorative order, however as identified on all inspections undertaken to date the premises does not comply with all of 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. The design and layout of the centre did not promote the privacy, independence and quality of life of residents. It was confirmed to the inspector that while the provider had explored different options and was committed to the long term future of the centre, there was no definitive, agreed explicit plan to address the identified non compliance.

Hazel unit and Alder unit both have capacity to accommodate 42 residents and are of similar design and layout. Neither unit offered adequate sitting, dining or recreational space; there was no dining space and communal space consisted of a small alcove off the main corridor with seating for approximately six residents. There were two single bedrooms on each unit that were not of a suitable size and layout for the needs of all residents and did not allow for the safe and effective use of assistive equipment by staff or access to both sides of the bed; staff spoken with confirmed this. The remaining accommodation for residents was provided for in multi-occupancy rooms of six. The inspector saw that the majority of residents spent their day in bed or at their bedsides, they had limited space for the storage of personal possessions with some seen to be stored on windowsills, on the floor or on top of their single wardrobe. All residents had not been provided with personal secure storage space and the centres policy on the management of resident personal possessions did not reflect the provider's responsibility to provide such a facility.

There were insufficient numbers of showers (no baths were in place) and this was compounded by the lack of adequate and suitable storage facilities. There were two assisted showers but one on each unit was used for the storage of wheelchairs, specialised seating and other items leaving one assisted shower on both units to 42 residents. There were 13 boxes of incontinence products stored in one toilet. One single bedroom at the time of inspection was also used as a storage facility. There was one shower available to 24 residents on the Ash unit.

The impact of the design and layout of the environment on the quality of the dining experience is discussed in Outcome 15. The inspector also saw that residents had no means of securing privacy other than closing their bed screen, of enjoying quiet time or having private conversations with staff or visitors unless assisted to leave the unit and access the communal space available on the main "long corridor" of the overall service. This room was not seen to be utilised at any stage during the inspection process. The facilities for exercising choice to access television was limited due to lack of communal space and the multi occupancy accommodation as visibility was dependent on the location of the residents bed. While some residents were seen to engage with each other from bed space to bed space the lack of adequate and readily accessible communal space was seen to impact greatly on residents' opportunities to engage with each other socially.

All units did have direct access to external grounds and there was evidence of upgrading works completed on some of these. Some however, were not suitable for or safe for use by all residents given the lack of hard surface and circulation areas.

Judgment:
Non Compliant - Major

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:
There were policies in place to guide end of life care and there was evidence that some staff had attended relevant education and training. Training records indicated that nursing staff had attended recent training in the management of syringe drivers, basic and advanced (a device to assist in pain and symptom management); palliative care education in 2011 including care specific to dementia; two staff nurses were currently undertaking post graduate palliative care education. However, while further training was planned based on the records seen the attendance of other grades of staff at end of life education was very low.

Based on the clinical records reviewed by the inspector the inspector was satisfied that staff supported residents to achieve a dignified and comfortable death; this finding was reflected in the positive feedback received from relatives of deceased residents. There was evidence that staff continuously monitored each resident's condition, were attuned to changes and sought the appropriate review and intervention from the GP. Treatments to provide symptomatic relief were prescribed and administered in a timely fashion and where appropriate, care was supported by the palliative care team. It was evident that staff endeavoured to keep family members informed, families were facilitated to be with the resident and facilities for their comfort were available.

There was a deficit of single room accommodation available but staff said that the option of a single room was always made available if possible and on the day of inspection a single room was available if necessary. Relatives surveyed said that the availability of a single room was very relevant to the privacy and dignity afforded at end of life, they understood the limitations of the physical environment and confirmed that staff endeavoured to and did provide a single room when at all possible. There was a mortuary on site that staff confirmed was in regular use; there was evidence of the appropriate equipment for the discreet and respectful removal of residents' remains from the clinical area to the mortuary. There was a spacious church that was used by the local community but to which residents had access with specific and sufficient space reserved for them. Some residents were seen to access the facility, mass was also broadcast on the radio to individual units and individual residents were seen to seek comfort in prayer at their bedside. Staff spoken with said that procedures were in place for the routine observance of sacraments including the sacrament of the anointing of the sick; however this was not always recorded.

Following death there was documentary evidence that staff followed procedures in relation to verification, confirmation and notification of deaths and a recent audit of practice in this area had been completed.

At the time of the last inspection a policy on allowing a natural death was in draft format. However, all staff spoken with were not aware that there was an explicit policy to support planning for, decision making and intervention in the event of a sudden or unexpected death. Training records indicated that approximately 25% of staff had updated and current basic life support training.

However, while it was evident that appropriate care was provided at end of life based on the records reviewed, and relatives surveyed said that staff had held discussions with them, there was very little evidence to support that staff ascertained and recorded residents end of life choices, preferences and wishes and staff spoken with confirmed this. There was some evidence that at times care was directed by an end of life care plan or by care plans that addressed interventions to meet specific end of life problems such as pain and fluid intake. The care plans seen however were somewhat ambiguous and reflected the lack of practical efforts made to afford all residents an opportunity to consider and communicate their end of life preferences and wishes.

Judgment:
Non Compliant - Moderate

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:

While there was evidence of good practice, acknowledgement of the need for change and willingness to change, and the feedback received from residents was good, the available facilities and procedures did not facilitate a quality dining experience or ensure that all residents nutritional needs and requirements were at all times met.

There was a policy in place and staff were facilitated to attend training on general issues pertaining to nutrition and specific problems such as swallowing difficulties; the most recent training was facilitated in May 2014. There was satisfactory attendance of staff at other relevant and related education and training such as wound prevention and management and the provision of enteral nutrition.

There was a large catering service on site from which residents meals were freshly prepared daily. There was documentary evidence that the catering service and the unit based kitchenettes were monitored by the relevant Environmental Health Officer (EHO) and the centres own food safety co-ordinator. The inspector saw adequate and varied stocks of dry, fresh, chilled and frozen food products including fresh fruit and dairy products such as cheese and yogurt. The menu operated on a three weekly cycle and offered choice at each main meal. The meals seen by the inspector appeared appetising, nutritionally balanced, reflected the menu of the day and also indicated that individual preferences were facilitated. A satisfaction survey had been undertaken with residents in April 2014, participation was sufficient to be meaningful, the results were generally positive but numerous suggestions had been made by residents to enhance the variety of available meal options; staff spoken with confirmed their commitment to advance these requests. However the menu was not clearly displayed on all units and staff spoken with confirmed that until recently residents meal choices were ascertained up to one week in advance. The centre had identified the need for change and at the time of inspection were trialling on two units the ascertaining of residents meal choices on a daily basis; the inspector confirmed to management and staff that this change was necessary and welcome. The inspector also recommended at verbal feedback that the trial requisition form would benefit from review and the inclusion of the available evening meal choice for residents requiring diet of a modified consistency.

The available physical facilities did not provide for pleasant dining surroundings, did not enhance the social dimension of meals and did not afford residents the opportunity to communicate, interact and engage with each other. With the exception of Ash Unit which had a dining room and a small number of residents who took their meals in the

limited communal space the majority of residents had their meals served to them on trays while in bed or while seated at their bedside; staff were seen to apportion meals on the main corridors. Family members were seen to be facilitated to assist at mealtimes and they confirmed that this was their choice but again the multi-occupancy rooms and absence of dining space meant that this arrangement did not provide for due regard for the privacy and dignity of all residents. Adequate staff assistance and supervision was in place but throughout the course of the two day inspection the majority of staff were seen to stand while assisting residents to eat and drink; at times but not always this was as a result of insufficient space between seated residents.

Over the two days of inspection the inspector saw that while meals were served at conventional times the timeframe between meals was not reasonable with residents seen to finish their main meal at approximately 12:45hrs and to receive their next and last substantive meal a little over three hours later at 16:00hrs. The inspector saw and staff spoken with confirmed that hot and cold drinks and snacks were not offered between main meals other than at 19:30hrs and again at 21:30hrs. Staff said that residents could have what they wished and the inspector saw that adequate stocks were available on each unit; however, given the dependency levels of the residents the inspector did not believe this arrangement of requesting rather than offering to be suitable to the residents needs. Given the timing of the last substantive meal and based on staff spoken with the snacks offered at 17:30hrs were not sufficiently prescribed for the inspector to be reassured that a substantive nutritious snack was routinely offered and available to each resident.

There were procedures in place for meeting specific nutritional needs and requirements. A nutrition and hydration assessment was completed on admission, a validated nutritional assessment tool was completed three monthly or more frequently if necessary, residents were weighed routinely three monthly. Residents had daily access to medical review, there was evidence of good access to speech and language therapy (SALT), of regular blood profiling, and action had been taken to address limited access to dietetic services with documentary evidence of recent dietetic review of residents. Residents with an identified nutritional risk had a specific nutritional care plan and the person in charge had undertaken a comprehensive audit of nutritional care planning in April 2014; the audit noted deviations but there was documentary evidence of feedback to each unit of the actions necessary. However, the inspector noted across units that there were ongoing inconsistencies in both planning for, implementing, reviewing and updating care to ensure that residents did not experience poor hydration and nutrition with significant deviations in care noted based on the clinical records and practice reviewed. In summary the inspector found:

- the last documented record for the administration of a prescribed supplement to a resident demonstrating recent significant weight loss was the 12 July 2014; staff confirmed this omission
- the systems for formally communicating and reviewing instructions for modified diet and fluids were not sufficiently robust across all units to ensure that residents were not at risk of aspiration and choking. One resident with a SALT plan for modified diet and fluids dated December 2013 was seen to be provided with normal diet and fluids and staff spoken with described generic interventions for modifying fluids rather than the specific graded requirements of each resident
- nutritional care plans were not updated and did not accurately reflect SALT review and

instructions

- residents demonstrating weight loss and assessed as requiring more frequent body weights in the plan of care were not weighed at the required frequency. For example one resident assessed as requiring to be weighed weekly had no recorded weight for the previous three weeks; staff confirmed that this was correct

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:

Mary Moore
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. Joseph's Hospital
Centre ID:	OSV-0000613
Date of inspection:	12/08/2014
Date of response:	05/09/2014

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 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:

Failing to assess the risks of each resident who smoked. Failing to Identify, record and implement adequate and appropriate control measures related to the specific risks identified including the residents visibility and supervision while smoking.

Failing to provide at each area that was deemed and utilised as a smoking area an adult sized fire blanket that was readily accessible, clearly identifiable and properly

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

maintained.

Failing to ensure that the information on directional signs for staff, residents and other persons conformed with and accurately reflected the information displayed by the fire detection system when activated.

Failing to ensure that adequate signage was in place on the long corridor for all locations.

Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Risk Assessments have been carried out on each resident who smokes.

Adequate and appropriate control measures are in place, including visibility and supervision of smoker while smoking (these control measures have been identified and recorded in writing as per the attached risk assessments)

Care plans which are informed by the relevant risk assessment are in place for each resident who smokes.

Appropriate Fire Fighting equipment is readily accessible, clearly identifiable and properly maintained in designated smoking areas.

Additional equipment including Fire blankets now in situ since 11am on Friday the 15th of August 2014.

Interim directional signs are now displayed which accurately correspond with the information on the Fire Detection System. This was in place by Thursday evening 14th August 2014.

Permanent signs will be displayed at the earliest opportunity but no later than Friday 17th October, 2014.

Proposed Timescale: 17/10/2014

Theme:

Safe care and support

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

Failing to ensure that a full review has been undertaken by a suitable qualified person of all fire safety precautions including but not limited to the fire detection system, devices for giving warning of fires and directional signage and that confirmation was in place that the system was in full working order and that any and all identified issues

and defects identified had been addressed.

Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

Documentary evidence in relation to a full review of all Fire Safety Precautions was undertaken by suitable qualified persons and details of same were provided to the Authority on the 20th August, 2014.

Arising from the Review of all Fire Safety Precautions mentioned above an Action Plan with Proposed Time frames concerning issues to be addressed was submitted to the Authority on the 21st August, 2014 and 22nd August, 2014.

- Remove the remaining hose reels completely and the capping off of same – Friday 19th September, 2014.
- Replace the Fire hose reels with appropriately sized and located fire extinguishers to INS 290 and IS 291 Standards – Friday 19th September, 2014.
- Corridors have been renamed. Interim signage erected. Permanent signage – work in progress – Friday 17th October, 2014.
- Signage has been provided since Thursday 28th August, 2014 beside each of the control panels showing the three lines and what each line means so that staff can be trained to identify the location of the fire without confusion. As of today the 5th September, 2014 a total of 85 staff have received this training. Training is ongoing and will be completed by 30th September, 2014.
- An appropriate zone map will be provided at the main panel indicating all the zones within the property. This map identifies the zone and zone names and their location with a smaller cut down map within each of the zones showing the specific locations within that zone so that the fire detection device can be found – Friday 19th September, 2014.
- Signage Policy completed by Friday 5th September, 2014.

The following documentation was also provided to the Authority on the 26th August, 2014.

- Fire Safety Checklist.
- Fire Safety Handbook for each individual Unit:
 - Alder Unit.
 - Ash Unit.
 - Cherry Unit.
 - Hazel Unit.
 - Heather Unit.
 - Holly Unit.
 - Kitchen Area.
 - Rowan Unit.
 - Spindle Unit.
 - Willow Unit.
- Administration Section.
- Fire Safety Policy and Procedure.

Proposed Timescale: 17/10/2014

Theme:

Safe care and support

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

Staff training records for fire safety in April and November 2013 and to date in 2014 indicated that there was no record of attendance for at least nineteen staff.

Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Staff training records were reviewed and it has been confirmed that a total of 13 nurses and 12 multitask attendants require further training. Further training has been arranged for these staff on the 23rd September and the 3rd October, 2014.

Proposed Timescale: 03/10/2014

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:

Handwritten prescriptions were not completed in block capitals as required by local instructions for the safety of the resident, were difficult to read and accurately understand.

There were regular and frequent instances of the absence of nurse signatures to indicate that all medicinal products were administered in accordance with the directions of the prescriber.

The maximum dosage of medications prescribed on a PRN basis (medication that is not scheduled or required on a regular basis) was not at all times stated.

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:

The Procedure for prescription writing has been re-issued to the relevant staff. The matter has also been highlighted again with the medical staff assigned to the Unit.

The recording of the administration of certain medicinal products (e.g. food supplements) which do not require to be documented on a medical prescription is currently being reviewed.

The maximum dosage of medications prescribed on a PRN basis needs to be recorded at all times. This issue has been highlighted with medical and nursing staff.

The issues of the absence of nurse signatures or the appropriate code has been addressed at a meeting with the Clinical Nurse Managers. The importance and the seriousness of this matter has been emphasised with the CNM's and with nursing staff.

In the context of Clinical Risk a learning notice has been issued to all nursing staff.

Monthly audits of the resident medication prescription and administration records are being undertaken with immediate effect.

Proposed Timescale: 17/09/2014

Outcome 12: Safe and Suitable Premises

Theme:

Person-centred care and support

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

The premises does not conform to all of 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. The design and layout of the centre did not promote the privacy, independence and quality of life of residents

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 Provider has reviewed the suitability of the premises with the Estates Management and the available professional technical advice indicates that there are significant limitations to develop the existing site to ensure full compliance with HIQA Environmental Standards while maintaining an existing public service. The Regulator will be aware of ongoing discussions at National level with the Social Care Division of the HSE.
- Further to the meeting with The Authority and the Provider on the 28th August, 2014 a further communication will issue to the Authority by the 19th September,

2014.

Proposed Timescale: 19/09/2014

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:

There was very little documentary evidence to support that practical efforts were made to afford all residents an opportunity to consider and communicate their end of life preferences and wishes; consequently the care plans seen were somewhat ambiguous.

All staff spoken were not aware that there was an explicit policy to support planning for, decision making and intervention in the event of a sudden or unexpected death.

The attendance of other grades of staff (other than nursing) at end of life education was very low.

Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

Review of Policy and current practices regarding End of Life Care in particular towards establishing and recording individual choices and preferences.

End of Life Policy will be updated to reflect changes in practice made following review of the current practices.

Updated Policy will be circulated to staff by Friday 3rd October, 2014.

Further training re: End of Life Care is planned for November, 2014 and January 2015. This training will incorporate all clinical staff.

Proposed Timescale: 31/01/2015

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

There were inconsistencies in both planning for, implementing, reviewing and updating nutritional care to ensure that residents did not experience poor hydration and nutrition with significant deviations in care noted based on the limited number of clinical records reviewed.

Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

The Person In Charge is undertaking a review of the Nutrition and Hydration Policy. The Provider has successfully recruited a Dietician / Nutrition Specialist to assist the Nutrition Hydration Audit which commenced in September, 2014 and in the case of all residents this professional review will be recorded, plans updated and monitored appropriately.

An Audit on the Nutritional Assessments and Care Plans will be undertaken by Wednesday 31st December, 2014.

Rosters are being reviewed with staff finish times being revised, the aim being to address the timing issue of the resident's main meals. (This will involve consultation with staff and their representatives and will be progressed as a priority.)

A checklist of snacks available has been compiled and a structured snack routine between main meals will be implemented by October 19th 2014.

Proposed Timescale: 31/12/2014

Theme:

Person-centred care and support

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

The timeframe between meals was not reasonable with residents seen to finish their main meal at approximately 12:45hrs and to receive their next and last substantive meal a little over three hours later at 16:00hrs.

This arrangement of residents requesting rather than being offering at structured intervals drinks and snacks was not suitable to the residents needs.

Action Required:

Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

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

There is a Daily Meal Requisition Form currently being trialled on Ash and Hazel Units. Form to be reviewed and rolled out to other units by Friday 19th September, 2014.

Review of the Nutrition and Hydration Policy will include reference to staff offering regular drinks and snacks to the residents.

A checklist of stock levels of appropriate and varied snacks available for evening snacks to be kept.

Rosters are being reviewed with staff finish times being revised, the aim being to address the timing issue of the resident's main meals. (This will involve consultation with staff and their representatives and will be progressed as a priority.)

A checklist of snacks available has been compiled and a structured snack routine between main meals will be implemented by October 19th 2014.

Proposed Timescale: 19/09/2014