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## **St Camillus' Hospital registration inspection report, 30 May 2011, 31 May 2011 and 1 June 2011**

Item Type	Report
Authors	Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI)
Publisher	Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI)
Download date	2026-05-21 06:08:58
Link to Item	<a href="https://hdl.handle.net/10147/143565">https://hdl.handle.net/10147/143565</a>

Health Information and Quality Authority  
Social Services Inspectorate

Registration Inspection report  
Designated Centres under Health Act 2007



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<b>Type of centre:</b>	<input type="checkbox"/> Private <input type="checkbox"/> Voluntary <input checked="" type="checkbox"/> Public
<b>Registered provider:</b>	Health Service Executive (HSE)
<b>Person authorised to act on behalf of the provider:</b>	Maria Bridgeman, Senior Operations Manager
<b>Person in charge:</b>	Majella Cussen
<b>Date of inspection:</b>	30 May 2011, 31 May 2011 and 1 June 2011
<b>Time inspection took place:</b>	<b>Day-1 Start:</b> 10:30hrs <b>Completion:</b> 19:00hrs <b>Day-2 Start:</b> 09:00hrs <b>Completion:</b> 19:00hrs <b>Day-3 Start:</b> 12:00hrs <b>Completion:</b> 17:30hrs
<b>Lead inspector:</b>	Margaret O'Regan
<b>Support inspector(s):</b>	Caroline Connelly and Breeda Desmond
<b>Type of inspection:</b>	<input checked="" type="checkbox"/> <b>Registration</b> <input checked="" type="checkbox"/> <b>Announced</b> <input type="checkbox"/> <b>Unannounced</b>

## About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

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.

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.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centers and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on [www.hiqa.ie](http://www.hiqa.ie) in keeping with the Authority's values of openness and transparency.

## About the centre

### Location of centre and description of services and premises

St Camillus' hospital site extends to 12 acres and many of the buildings date from the 1840's. There is a diverse range of services offered in St Camillus' including day hospital services, clinic services and residential care services. The range of residential services offered includes;

- rehabilitation, including stroke rehabilitation
- respite services
- long-term residential care
- services registered with the mental health commission.

The hospital has 20 beds allocated for short-term stay which are described as "discharge to home beds" and "assessment beds". These beds are occupied by residents who need to recuperate from an acute illness and make plans for their return home. Alternatively, during this period, residents may have their long-term placement needs assessed and arrangements put in place accordingly. Within the hospital complex there is a department of old age psychiatry which is approved under the Mental Health Act and can accommodate 28 residents for assessment and respite.

A day hospital, which is located on the site, has x-ray facilities, DEXA scan facilities (testing for osteoporosis), 24-hour blood pressure and ECG monitoring facilities, tilt table testing for investigation of low blood pressure, diagnostic ultrasound testing for arteriosclerosis and facilities to undertake blood testing for screening and monitoring purposes. Residents in the long-term care units have access to the day hospital services by referral, including referral to a consultant gerontologist and psychiatrist of old age. In addition, long-term residents have access to other amenities/therapies on site which include physiotherapy, occupational therapy, speech and language therapy, podiatry services, dietetic services and dental services.

Also on campus and complimenting the care provided in the residential units are; a church, a pharmacy, a shop, a hairdresser, a minibus, an administration department, a maintenance department, a kitchen facility, a HSE central laundry facility and an activity centre.

The provider applied to register the centre for 109 long-term care beds. These beds are in three different units. The Sarsfield Ward is located on the ground floor and provides 49 beds for male and female residents. The rooms comprise of six twin rooms, five treble rooms, two five-bedded rooms and two six-bedded rooms. The Thomand Ward is located on the first floor and provides 28 beds for male residents. The rooms comprise of one six-bedded ward, one four-bedded, a 12-bedded ward, two twin rooms and two single rooms. The Shannon Ward is located on the first floor and provides 32 beds for female residents. It comprises of eight four-bedded rooms. The service occasionally caters for younger residents whose needs are assessed prior to admission and a decision made whether the service can meet the individual's needs.

<b>Date centre was first established:</b>			1842	
<b>Number of residents on the date of inspection:</b>			85	
<b>Number of vacancies on the date of inspection:</b>			24	
<b>Dependency level of current residents:</b>	<b>Max</b>	<b>High</b>	<b>Medium</b>	<b>Low</b>
<b>Number of residents</b>	52	10	12	11
<b>Gender of residents</b>			<b>Male (✓)</b>	<b>Female (✓)</b>
			34	51

### Management structure

The Registered Provider is the Health Service Executive (HSE) West, represented by the Senior Operations Manager, Maria Bridgeman. The Person in Charge is Majella Cussen and she reports to the Senior Operations Manager. The Person in Charge is supported in her role by two Assistant Directors of Nursing and two Clinical Nurse Managers 3 (CNM3) who are assigned to night duty. There are three Clinical Nurse Managers 2 (CNM2) and three Clinical Nurse Managers 1 (CNM1) and a team of nursing staff, healthcare assistants, and multi-task attendants. There is a hospital administration department who has responsibility for overseeing the budget, residents' finances and general administrative duties.

**Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.**

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007.

Inspectors met with residents, relatives, visiting personnel and staff members over the three days of inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate Fit Person interviews were carried out with the provider and the person in charge. The Fit Person self-assessment document was completed through a collaborate series of multidisciplinary meetings in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

This inspection was announced and was carried out over a three-day period. Inspectors found that there was a good team spirit amongst staff and good leadership shown by the person in charge. There was awareness amongst staff of the need to change from a medical approach to care to a more social care approach. The centre catered for many different types of care such as respite, long-term, rehabilitation and discharge to home. As a result there was an unclear delineation as to which beds were used for the purposes of long-term care and which were used for rehabilitation and short-term care. Inspectors were informed by senior management that a plan was being progressed to streamline the different functions within St Camillus'. Inspectors concluded that management and staff had made considerable efforts to overcome the limitations of the hospital structure and were providing a good standard of care to highly dependent residents. There were some limitations identified, relating in particular to the premises, which are outlined in the Action Plan at the end of this report.

## Section 50 (1) (b) of the Health Act 2007

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.**

### **1. Statement of purpose and quality management**

#### **Outcome 1**

*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.*

#### **References:**

Regulation 5: Statement of Purpose  
Standard 28: Purpose and Function

### **Inspection findings**

A comprehensive and well set out written statement of purpose was available. As stated in this statement of purpose, the primary aim of St Camillus' Hospital is twofold;

- to provide a friendly and comfortable home
- to ensure residents and their families/carers will receive quality care in a safe and friendly environment.

It was noted by inspectors that the atmosphere in the wards between staff and residents was friendly. Residents and staff were seen to share jokes and staff had good insights into residents' backgrounds and circumstances and vice versa. Equally there was a convivial atmosphere amongst staff and the management team. However, some residents, relatives and staff stated that this level of familiarity was compromised when agency staff were employed to fill gaps in the duty roster. To minimise this problem the senior management team had taken initiatives to secure the services of regular agency staff and where possible assign these staff members to the unit they had previously worked in. The management team had also facilitated training for agency staff.

The second aim of the centre, the provision of quality and safe care, was to a large extent achieved. Practices observed were safe. Many residents and relatives confirmed to inspectors their satisfaction with the care provided. One of the main impediments to the provision of quality care was the inadequacy of the physical environment. This is further discussed in Outcome 15. Other issues in relation to care which required to be addressed are discussed in Outcome 2.

While the statement of purpose was detailed and easy to follow and it described the service and facilities provided, it did not meet all of the requirements of Schedule 1, (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The room sizes were not included nor were the exclusion criteria for admission. The detail with regards to the type of nursing care provided was limited. In addition the organisation chart contained in the statement of purpose needed to be updated to reflect recent changes to the management structure.

**Outcome 2**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis.*

**References:**

Regulation 35: Review of Quality and Safety of Care and Quality of Life  
Standard 30: Quality Assurance and Continuous Improvement

**Inspection findings**

Quality improvement activity was evident in many aspects of life and care in the centre. There was a system in place to gather and audit information related to clinical and non-clinical areas of care including falls, infection control, medication management, service provision, amongst others. Improvements had taken place following such audits; for example, a staff member was assigned to the residents activity programme, an area was designated for activities to take place, care plans had been updated and more emphasis was being placed on the social aspects of care. However, there was scope for further learning and changes to be made to practices from the results of audits. For example, a medication audit took place but there was no clear data as to changes that had occurred in practices or if the dosage of psychotropic and hypnotic drugs had decreased, increased or stayed the same.

The system of review that was in place included consultation with residents and their representatives. There were suggestion boxes throughout and resident forum meetings had commenced in all three units. Minutes were seen of these meetings. The CNM2 met with residents daily and inspectors saw nursing notes of discussions which took place with families. There was room to improve this consultation process. For example, residents or their representatives should be included in the meals and mealtimes committee, actions should be decided upon at meetings such as the residents' forum meetings and changes implemented accordingly, a record of the outcomes from these actions should be maintained, residents should be provided with information about actions taken as a result of audits or changes being implemented which affected their life in the centre.

Inspectors recognised that considerable work had already been made by staff and management in embracing the cultural change of involving residents and their representatives in a greater way in the day-to-day running of the service. Staff demonstrated their commitment to this change process, by the manner in which they acknowledged suggestions made by inspectors and the enthusiasm they showed for the changes that had already begun to take place.

**Outcome 3**

*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.*

**References:**

Regulation 39: Complaints Procedures  
Standard 6: Complaints

**Inspection findings**

The complaints policy was comprehensive. A synopsis of the policy was available both in the statement of purpose and the residents' guide. Guidance was displayed throughout as to how residents or relatives could make a complaint.

Residents and relatives outlined to inspectors that they had easy access to the CNM2 and other staff, to discuss any issues they had. The person in charge stated that most complaints/concerns were dealt with as they arose. A record of complaints, actions taken and outcomes were maintained by the CNM2 on each unit and a copy kept by the person in charge. They were kept under review to facilitate analysis and inform improvements. For example, one relative, whose family member was on respite care, had an issue with her family member's accommodation. This was brought to the attention of the CNM2 and rectified on the resident's following admission. There were several other instances recorded where corrective action had been taken to resolve the issues raised.

In discussions with relatives, the inspector was informed of a concern one visitor had and which she had brought to the attention of the staff. It was noted in the complaints log that this concern had not been recorded. Staff were aware of the concern and had discussed the matter with the residents' family.

**2. Safeguarding and safety****Outcome 4**

*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.*

**References:**

Regulation 6: General Welfare and Protection  
Standard 8: Protection  
Standard 9: The Resident's Finances

**Inspection findings**

Measures were in place to protect residents from being harmed or suffering abuse. The staff, which inspectors spoke with, were aware of what to do if they had any concerns in this matter. However, not all had received the mandatory training in this

area. A plan was in place to facilitate further training for staff. A centre-specific policy on elder abuse was available and staff were aware of the policy contents. Contact details of the local designated elder abuse officer were available as part of the policy. Residents spoken with confirmed to inspectors that they felt safe in the centre and relatives concurred with this. They attributed this to the kindness and respectfulness of staff.

The CNM2 spoke with residents and relatives on a daily basis. She reviewed practices and supervised staff as part of ensuring the safety of residents. Staff, residents and relatives concurred, in general, that there was an 'open door' policy to speak with the ward management staff in the event of them having a concern.

Residents' finances were maintained in accordance with best practice. Signed and detailed records were maintained of withdrawals and lodgements. This was managed by the administrative staff.

#### **Outcome 5**

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

#### **References:**

Regulation 30: Health and Safety  
Regulation 31: Risk Management Procedures  
Regulation 32: Fire Precautions and Records  
Standard 26: Health and Safety  
Standard 29: Management Systems

### **Inspection findings**

There were up-to-date, centre-specific policies and procedures relating to health and safety. The practices observed by inspectors promoted the protection of residents, relatives and staff. For example, hoists were used by staff when lifting; sanitising hand gel dispensers, which were available throughout, were seen to be used by staff and visitors; the potential for slips and trips were minimised; staff had attended training in fire safety and fire marshals were on duty at all times; 24-hour security was provided by the hospital porters and augmented by an outside security firm; a clear and rehearsed evacuation plan was in place.

The environment was clean and there was an ongoing maintenance programme in place. Inspectors spoke with staff from different departments including kitchen, laundry, maintenance, housekeeping, nursing and care staff with regards to infection control practices in operation. These included hand hygiene, management of infected laundry, disposal of infected waste, management of residents with methicillin resistant staphylococcus aureus or clostridium difficile. Staff were aware of the protocols in place and were able to explain, in a satisfactory manner, what the practices were. Staff had access to protective clothing and alcohol hand gels were available. Notices with regard to the importance of hand hygiene were displayed throughout and staff informed inspectors they had received training in this. Audits had also been conducted on hand hygiene practices in April 2011. A repeat audit was

to take place in June 2011 to ensure that practices were improving and best practice protocols were being adhered to. Laundry staff discussed best practice with the inspector including the segregation of infected laundry, the use of special bags for this type of laundry and the appropriate wash temperatures used.

Waste management practices were seen to be satisfactory. Contracts were in place for the disposal of clinical waste and appropriate segregation of waste took place. The incidence of needle stick injury was low and attributed to the use of special gloves to prevent such injuries. The environmental health officer reports were reviewed and the kitchen was seen to be clean, tidy, well organised and well stocked.

Arrangements were in place to respond to emergencies and this was evidenced in their fire policy and risk management policy. Fire records showed that fire safety equipment including fire alarms and emergency lighting was serviced appropriately. Fire exits were unobstructed and records were available to indicate they were checked daily. Floor plans for emergency evacuation were displayed throughout. Fire safety training, including fire drills took place and staff had completed their mandatory fire training. There were clear guidelines in place on what to do if the centre had to be evacuated including arrangements for residents, if it was not possible to return to the centre. An independent assessment was recently conducted by a fire consultant. A report had been issued which identified a number of areas needing immediate attention. These included the erection of fire safety doors in bedrooms and compartmentalising some units. These works have been given priority by the provider and need to be completed before a fire safety certificate will be issued.

Residents were assessed on admission regarding falls risk. Other risk assessments undertaken with residents included moving and handling requirements, skin integrity, nutritional status, cognition and oral hygiene. The accident rates in the centre were low as noted by the notifications submitted to the Authority and the records in the accident books. Hand rails were in place on the corridors and grab rails in the toilet areas to assist residents with their independence. However, the layout and design of the premises was such that residents' independence, in terms of being able to mobilise, was curtailed. Nonetheless, one resident was seen to be able to use his electric wheelchair and others were seen using their walking frames. Storage space for equipment was limited and equipment was seen to be stored in vacant bedrooms. All staff interviewed stated they had completed their mandatory training in manual handling and lifting.

**Outcome 6**

*Each resident is protected by the designated centres' policies and procedures for medication management.*

**References:**

Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines  
Standard 14: Medication Management

## Inspection findings

There was a medication management policy for prescribing, administering, recording and storing of medicines. There were appropriate procedures for the handling and disposal of unused and out-of-date medicines. The processes in place were in accordance with current professional guidelines and legislation and inspectors observed nurses adhering to these guidelines when administering medication. Controlled drugs were maintained in accordance with the rules. Self-medication was outlined in the medication management policy and at the time of inspection no resident was responsible for their own medication.

Review and monitoring of medication management practice occurred in consultation with the medical officers and the pharmacist; all of whom met with the inspectors and outlined the process of medication reviews. They described cases where they worked together to find the best combination of medication and/or therapy to control residents' symptoms. The pharmacist deals with all returned medication and conducts education sessions for staff.

Medication errors and near misses were recorded and audited. HSE incident report forms were used and reports entered on the STARS database, a system for reviewing all incidents and near misses on a national level and allowing hospitals to benchmark themselves with other hospitals.

### **3. Health and social care needs**

#### **Outcome 7**

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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.*

#### **References:**

Regulation 6: General Welfare and Protection  
Regulation 8: Assessment and Care Plan  
Regulation 9: Health Care  
Regulation 29: Temporary Absence and Discharge of Residents  
Standard 3: Consent  
Standard 10: Assessment  
Standard 11: The Resident's Care Plan  
Standard 12: Health Promotion  
Standard 13: Healthcare  
Standard 15: Medication Monitoring and Review  
Standard 17: Autonomy and Independence  
Standard 21: Responding to Behaviour that is Challenging

## Inspection findings

There were many practices which showed evidence of good nursing practice. Inspectors found a low incidence of medication errors, pressure sores and falls. Pressure relieving equipment (mattresses and cushions) were used appropriately; observations of the residents medical conditions were made and acted upon; relatives were consulted with and kept informed of their relative's condition; risk assessments were carried out for residents using bedrails; low-low beds were provided for and used when needed; alarmed cushioned were used on chairs and on beds to alert staff to the risk of a resident falling and at the same time minimising the use of restraint; staff had well established links with hospital services and palliative care services with whom they sought support from as needed; care plans were in place, albeit limited in their detail with regards to social care needs.

Inspectors met with residents who had complicated care needs addressed in an expert fashion. Overall there was good medical nursing care provided. However, a greater emphasis needed to be placed on the social aspects of care and creating a more homely environment. Some of the nursing practices needed to move from a medically orientated model of care to a more social model. There was recognition amongst many of the staff of the need for this and initiatives had commenced in the provision of activities for residents.

A member of the nursing staff was assigned, on a part-time basis, to coordinating activities. Inspectors saw this staff member facilitating art and craft sessions, card games, gardening and a magic show. Inspectors observed a relaxed and good humoured atmosphere during activities which took place in an area separate from the wards.

Staff at the centre had taken part in a study organised by the National University of Ireland, Galway (NUIG) in relation to reminiscence therapy and dementia care (DARES). The programme involved creating residents' life story books. At the time of inspection a number of residents had such books completed or partly completed. Further training is to be provided by the University and it is envisaged the learning from participation in this study will be implemented throughout. However, it was unclear from staff when the introduction of life story books for more residents would take place. The books which were completed were stored in the office, when a more appropriate place might be beside the resident as they were the resident's property. The person in charge and other staff had attended training in person centred care. The person in charge envisaged that this training together with the experience gained from the study with NUIG would enhance person-centred care.

Weekly activities were listed on ward notice boards and included bingo, flower arranging, art and crafts, pet therapy and relaxation therapy. Inspectors viewed some of these activities in progress such as flower arranging and art and crafts. The opportunities to engage in activities which might be considered to be risky but nevertheless fulfilling were limited. However, occasional outings were arranged and some activity was organised for each weekday. Residents were encouraged to participate insofar as possible. This was borne out to inspectors in conversation with residents and many of their relatives, some of whom were happy with the level of activity and others who saw the need for improvement in this area. Residents spoke

of their trips in the organisation's mini bus. These included outings to the shopping centre, the Hunt museum and the newly opened tunnel. One resident availed of outings with the Irish Wheelchair Association each Friday. There was scope to increase the frequency of such excursions, as the ones which did take place were much appreciated by residents. Residents also remarked to inspectors they would like to get out more.

Residents and relatives highlighted to inspectors the need for a secure garden area. Plans were underway to develop such an area. Inspectors met with the therapy dog and his owner on their weekly visit to the centre. SONAS, a relaxation and reminiscence type programme, was carried out on a weekly basis. Orientation boards were in place at several locations; however, they were not always accurate and other orientation aids such as clocks, were not set at the correct time. Overall, there were some very nice and interesting activities available, especially for those less dependent but there was little activity provided for those with a cognitive impairment or those who spent considerable periods of time in bed.

There was concern expressed by relatives and noted by inspectors, in relation to the frequency or lack of frequency in which residents received showers or baths. In some wards residents only received this type of personal care every three weeks and relatives were particularly concerned that their relative's hair was unwashed. A bed bath was given to residents daily. Many residents were seen to spend all day or most of the day in bed. Even though these residents were provided with good quality mattresses and as mentioned already, the incidence of pressure sores was low, being in bed for extended periods of time comprised their opportunities for communication and other psychosocial involvement. It was also observed that the residents in bed had little personal clothing in their wardrobes. Communal clothing was seen in the linen room. Several of the residents had insufficient space beside their bed for a chair and in some units the dining and communal space was insufficient to accommodate all the residents. There was a limited call-bell system in place. There was limited space for residents to walk around. All this impacted on the quality of life for many residents, in particular those who were of maximum dependency.

Residents had access to a range of health services, including physiotherapy and occupational therapy, both of which were on site. There was a gym on site which was primarily used for residents in the rehabilitation unit. Dietician services were available on site as were dental, x-ray, phlebotomy, podiatry and speech and language therapy. These services did not incur an additional fee. Referral for allied health therapies was usually via a medical referral. Referral appeared to be made in instances where rehabilitation was needed; for example, following a hip replacement. There was limited health promoting interventions devised and reviewed by allied health professionals for residents with chronic conditions.

Recognised assessment tools were used in assessing residents. Inspectors found that significant work had been done with developing a revised care plan for residents. Staff had received training and were aware of the importance of planning care around the residents' social needs as well as their medical needs. However, the care plans examined were incomplete in some details. For example, care plans were not signed or dated, care plans had not been reviewed on a three-monthly basis, social

need were not assessed, the activities care plan was not completed, residents and/or relatives signatures were not recorded on care plans.

Consent forms were present; however, in some instances, this consent was seen to have been obtained from relatives, in particular consent for restraint. While relatives should be involved in discussing their relative's care, the decision when to use or not to use restraint is a nursing or multidisciplinary decision. A restraint policy was available as was a bedrail assessment tool. The bedrail assessment tool was a risk assessment to be conducted when a decision had been made to use bedrails. It did not detail how a decision was made in the first instance to use bedrails. Similarly there was no clear assessment conducted where lap belts and other forms of physical restraint was used. The overall incidence of the use of restraint had been reduced and was low but proper assessment had not been conducted for these residents who continued to use restraint. In theory there was a system in place of releasing restraint such as lap belts on a two hourly basis. However, there was no record available for this.

The centre had the services of two medical officers. Both of these doctors visited the centre each weekday and two out of three weekends. A local GP cooperative provided medical cover one weekend in three. Residents' medical notes were examined by inspectors and they were seen to contain details of regular reviews, referrals to specialist services, transfer letters and laboratory results.

#### **Outcome 8**

*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.*

#### **References:**

Regulation 14: End of Life Care  
Standard 16: End of Life Care

### **Inspection findings**

The spiritual and pastoral care services in St Camillus' were provided by a Roman Catholic priest who visited daily and a religious sister who was experienced in the provision of pastoral care. Inspectors met and spoke with both these people who talked highly of the respect they observed being given to residents by staff. Religious leaders from other denominations visited as required. Mass was said in the chapel each Sunday and was relayed throughout by an intercom system. Rosary was said daily in the Sarsfield ward and was normally organised by the residents.

Arrangements were in place for a resident to have a single room when end of life is approaching. These single room facilities were adequate and provided privacy for residents and their families. A bed was available on the corridor adjacent to Shannon ward, with a surrounding screen, for a family member to use if they wished to stay overnight. Palliative care services were accessed through Milford Hospice community home care team which is located nearby.

**Outcome 9**

*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.*

**References:**

Regulation 20: Food and Nutrition  
Standard 19: Meals and Mealtimes

**Inspection findings**

A policy regarding nutrition was available that incorporated a recognised nutritional assessment tool which identified those at risk of under nourishment. Residents' weights were checked monthly and more frequently if necessary. A dietician was available on site to take referrals.

All the wards were serviced by a central kitchen from which meals were delivered for distribution. There was a good choice available on menus and this was confirmed by relatives who spoke highly of the quality of the food and the facility to have an alternative meal if a resident did not care for the one being served. Menus were displayed in each ward. In addition, inspectors noted that pantries on the wards were stocked with supplies such as yoghurts and snacks, so that staff could make, for example, tea and toast for a resident outside of regular mealtimes. Staff assessed the type of meal presentation required for residents and relayed this to the kitchen, for example, liquidised, semi solid and/or presented in food moulds. It was noted by inspectors that there was a good variety of food moulds available in the kitchen to assist in presenting food in an attractive and appealing manner. However, these moulds were not routinely used and modified consistency dinners were seen to be served with all the foods liquidised together and served in a bowl.

There was inadequate dining space available for residents; there was limited dining space in the Shannon and Thomand wards and the Sarsfield ward, which accommodated up to 49 residents, had a nice dining area for approximately 20 residents. Many residents were seen to have their meals served on a bed table placed in front of the chair they sat in during the day or served to them whilst in bed. Tea time started at 16:00hrs and further snacks were served around 20:00hrs. However, some relatives felt that that supper was served too early and that there was a delay in serving this meal. This delay sometimes resulted in the food being cold and some relatives choose to give assistance to their family members at this time. Inspectors observed this assistance being offered. Seventy five percent of the residents were of high or maximum dependency and most needed assistance with their meals, in part due to the lack of adequate dining space and the resulting lack of facilities to promote residents' potential independence at mealtimes. In summary, mealtimes for the majority of residents, needed to be improved upon to become a sociable, relaxed and pleasurable part of the day.

## **4. Respecting and involving residents**

### **Outcome 10**

*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.*

#### **References:**

Regulation 28: Contract for the Provision of Services  
Standard 1: Information  
Standard 7: Contract/Statement of Terms and Conditions

### **Inspection findings**

Contracts of care were issued to all residents and a record was maintained of this. The majority of contracts had been returned and where there was a delay a note was made in the residents file accordingly. The contracts set out the overall care and services provided to the residents and the fees to be charged. A copy of the contract of care was included in the resident's guide.

### **Outcome 11**

*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.*

#### **References:**

Regulation 10: Residents' Rights, Dignity and Consultation  
Regulation 11: Communication  
Regulation 12: Visits  
Standard 2: Consultation and Participation  
Standard 4: Privacy and Dignity  
Standard 5: Civil, Political, Religious Rights  
Standard 17: Autonomy and Independence  
Standard 18: Routines and Expectations  
Standard 20: Social Contacts

### **Inspection findings**

Training had been given to some staff in providing person-centred care to residents. Management personnel confirmed that this had precipitated a shift from task-oriented to more individual care. Staff were aware that this process had only begun and much more was needed to develop this desired model of care. Inspectors noted that residents were being encouraged to participate in the life of the centre and this was borne out by the recent formation of residents' forums on each ward. Minutes of these meetings were seen by inspectors. However, greater emphases needed to be placed on recording the actions to be taken from matters arising and recording the

outcomes of these actions. Also residents needed to be kept informed of the actions and outcomes from these meetings.

Comment boxes were available on each ward but little feedback had come through via this route. Given the informal visiting policy of the centre, there were opportunities for relatives to feedback to staff on a regular basis and relatives confirmed that they felt reassured and comfortable in doing this. Each resident who required an advocate was assigned a nurse who acted on their behalf. A record was maintained of who was advocate for whom. The person in charge was liaising with an independent advocacy person with a view to securing her services.

Opportunities for residents to exercise autonomy and choice were somewhat limited by their degree of physical dependency, cognitive impairment and the premises not designed to cater for their needs. Nevertheless, the centre promoted a culture of inclusion and consent; for example, residents were asked to give permission to have their photograph taken for identification purposes on medication charts, wound charts and care plans. Family and social relationships were encouraged through the open visiting policy. Relatives who spoke with inspectors had a well rounded view of how the centre operated at different times of the day, as they were free to call at any time.

Residents were facilitated to vote and a voters' register was retained on site. Appropriate official supervision was available at voting time or alternatively residents were taken by their families to the polling station. Inspectors noted the efforts made by staff to promote privacy and dignity within the limitations of the ward structure. Screens were used around beds and inspectors noted that regular staff had a good understanding of the idiosyncrasies of individual residents, particularly those with cognitive impairment. A voluntary group called the League of Friends of St Camillus' undertook fundraising campaigns. The next project to be undertaken from funds raised is to create a secure garden area. The Lions Club, transition year students and the Irish Wheelchair Association were involved in voluntary works within the centre.

The religious beliefs of residents were met by the attendance of ministers of different denominations and by the facilitation of religious ceremonies both on the wards and in the campus chapel. This was confirmed in conversation with a priest in attendance on the inspection days. In addition, relatives confirmed that a Catholic voluntary organisation attends regularly to visit residents and pray with them if they wish. In addition pastoral support is provided by a religious sister with whom the inspectors also met with.

Newspapers were available daily and were part of the provisions supplied through the mobile shop. Inspectors met with the shopkeeper who had worked in the centre for many years. She explained to inspectors her routine of visiting the wards daily with her trolley and facilitating residents to purchase sundry items including newspapers, chocolate and toiletries. It was clear she had a close affiliation with the residents and enjoyed her work.

**Outcome 12**

*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.*

**References:**

Regulation 7: Residents' Personal Property and Possessions

Regulation 13: Clothing

Standard 4: Privacy and Dignity

Standard 17: Autonomy and Independence

**Inspection findings**

The centre had written operational policies and procedures relating to residents' personal property and possessions. Inspectors saw that a record was kept of property and was signed by the resident. However, due to the confined space available to residents, there was inadequate space provided for a reasonable number of personal possessions. In addition many of the residents did not have lockable storage space compromising their ability to retain control over their possessions and the storage space provided for their own clothes was also limited.

The laundry provision on site provided a service to all HSE facilities in the Mid-West including centres for care of the elderly in the region. It was apparent to inspectors that a very good service was provided for the laundering of linen. Issues were highlighted by relatives of problems arising with regards to personal laundry; namely, clothes going missing or being damaged. Notices had been placed in the wards advising residents and relatives that the centre was not responsible for personal laundry; however, this is not in line with regulations which require the provider to make adequate arrangements for residents' personal laundry. In instances where relatives were taking their family member's clothes home, discreet signs were placed on the resident's wardrobe or locker indicating this. A clothes labelling system was in place and staff told inspectors that when laundry is missing efforts were made to find the missing item. Overall however, greater care needed to be taken in the laundry of personal items.

**5. Suitable staffing****Outcome 13**

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

**References:**

Regulation 15: Person in Charge

Standard 27: Operational Management

## Inspection findings

The post of the person in charge was full time and held by a registered nurse with the required experience of nursing dependant people. She demonstrated clinical knowledge to ensure suitable and safe care both during inspection and during the fit person interview. Clear management and accountability structures were in place. The person in charge was engaged in governance, operational management and administration associated with her role and responsibilities regarding the centre. She attended regular meeting for CNMs, staff nurses, multi-task attendants, medical management, multidisciplinary team and senior management. Minutes from these meetings were viewed by inspectors.

A diverse range of clinical audits were ongoing to inform practice and improve quality of service and safety of residents. The person in charge along with support staff demonstrated a commitment to delivering quality care to residents and striving for continuous improvement.

### **Outcome 14**

*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.*

#### **References:**

Regulation 16: Staffing  
Regulation 17: Training and Staff Development  
Regulation 18: Recruitment  
Regulation 34: Volunteers  
Standard 22: Recruitment  
Standard 23: Staffing Levels and Qualifications  
Standard 24: Training and Supervision

## Inspection findings

From examination of the duty roster and from conversations with staff, the inspector established the average staff to resident ratio was 1:4 during the daytime. This reduced from 16:00hrs and from 17:30hrs to 08:00hrs the ratio was approximately 1:8. It was noted on the roster that several shifts were covered by regular agency staff. It would appear many residents went to bed early when the greater numbers of staff were on duty. Tea was served early at 16:00hrs and according to a number of relatives it was sometimes cold because residents were waiting too long for assistance.

There was a recruitment policy in place. However, on examination of staff files it was noted not all the required documents were present, such as photographic identification, medical certification of fitness, and three references. Many of the references supplied were from work colleagues, which is not best practice.

Previously it was identified that not all staff had completed mandatory training, in particular training in relation to elder abuse prevention and detection. Since that previous inspection the number of staff who received this training had increased, however, some staff were still awaiting this tuition. Other staff training undertaken in the past six months included infection prevention and control, hand hygiene, resuscitation, medication management, wound care, fire training, and moving and handling.

Staff were supervised in their roles by their line manager but formal staff appraisals did not take place. New staff receive induction and opportunities for training.

**6. Safe and suitable premises**

**Outcome 15**  
*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. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**References:**  
Regulation 19: Premises  
Standard 25: Physical Environment

**Inspection findings**

The application for registration pertained to three units, referred to as wards. These were the Sarsfield ward, located on the ground floor and providing 49 beds for male and female residents. The rooms comprised of six twin rooms, five treble rooms, two five-bedded rooms and two six-bedded rooms. There were 33 residents at the time of inspection. The Thomand ward is located on the first floor, providing 28 beds for male residents, the rooms comprised of one six-bedded ward, one four-bedded, a 12-bedded ward, two twin rooms and two single rooms. There were 18 residents at the time of inspection. The Shannon ward, located on the first floor and providing 32 beds for female residents. It comprised of eight four-bedded rooms. There was also a single room available on the ward should a resident need it; for example, for infection control purposes or end-of-life care. There were 30 residents on the days of inspection.

In total, registration was being sought for 109 beds. At the time of inspection, in addition to the residents in the three wards mentioned above, there were three residents accommodated in long-term care in Plassey ward. This ward was assigned for "discharge to home" and rehabilitation and not part of the application for registration. These three residents had been residents in Plassey ward for a number of years and according to staff, did not wish to transfer to the long term units. The space provided for these residents was restricted and the management team were aware of the limitations of the accommodation. They saw the arrangement as an

interim measure to facilitate the expressed wish of the three residents who had been living there for several years.

Overall, the premises presented significant constraints in meeting residents' individual and collective needs in a comfortable way. The layout and structure of the wards was such that the privacy and dignity of residents was compromised. Many of the bedrooms were cramped. There were 28 beds in excess of the number of residents and it was clear from inspection that a number of these beds were not in regular use. Maintaining these additional beds added to the cramped nature of the units. The area surrounding many of the beds was restricted with little or no room to accommodate a chair for the resident. Storage space for personal belongings was limited and the majority of residents did not have lockable storage space and some did not have their own wardrobes. Some items of furniture were in good repair especially in the Shannon ward; however, other items were in need of replacement for example damaged bed side lockers. Most residents did not have call beds.

A designated dining space and a variety of seating areas were provided for residents on the Sarsfield ward but the Thomand and Shannon wards had insufficient dining and communal space. In particular the day room in the Thomand ward was small for the number of residents. Private space for residents was available in a room on the ground floor, but because of its location it was rarely used by residents. In twin rooms the screens were not circulating the bed to offer privacy to both residents. Many of the bedrooms, in particular the multi-occupancy rooms, were below the recommended minimum size.

In Thomand ward there were four toilets (all assisted toilets) and two showers for a capacity of 28 residents; in Sarsfield ward there were 12 toilets (four were assisted) and three showers for a capacity of 49 residents and in Shannon ward there were four toilets (one of which was an assisted toilet) and two showers for a capacity of 32. The recommended ratio of toilets to residents is 1:6. The Shannon ward was significantly below these recommended requirements and Thomand ward was below them to a lesser degree. More significantly all three wards did not have the recommended number of shower/bath facilities which are 1:11. However, since the wards were not fully occupied at time of inspection the shower/bath facilities sufficed in number for the Sarsfield and Thomand wards but were insufficient for the number of residents accommodated on the Shannon ward.

There was a lack of storage capacity for equipment, for example; commodes, cleaning trolleys and linen trolleys were stored in bathrooms and in vacant bedrooms. Equipment was good and all wards had access to a functioning mechanical lift. A kitchenette facility was available in each ward from where meals were served having been brought there from the kitchen. Staff facilities were available and included changing, showering, storage and dining facilities.

Although the centre had plenty of garden area with pathways and seating, the gardens were not secure and opened on to the main car park which had access to the main road. In practice residents had limited access to the outdoors and this was reflected in their comments to inspectors. On the grounds ample car parking was provided.

## **7. Records and documentation to kept at a designated centre**

### **Outcome 16**

*The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).*

#### **References:**

Part 6: The records to be kept in a designated centre

Regulation 26: Insurance Cover

Regulation 27: Operating Policies and Procedures

Standard 1: Information

Standard 29: Management Systems

Standard 32: Register and Residents' Records

### **Inspection findings**

*\* Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

#### **Resident's guide**

Substantial compliance

Improvements required\*

#### **Records in relation to residents (Schedule 3)**

Substantial compliance

Improvements required\*

#### **General records (Schedule 4)**

Substantial compliance

Improvements required\*

#### **Operating policies and procedures (Schedule 5)**

Substantial compliance

Improvements required\*

#### **Directory of residents**

Substantial compliance

Improvements required\*

### **Staffing records**

Substantial compliance

Improvements required\*

Not all staff had three references on file. Some of the references provided were from current work colleagues. In one instance all three references for one employee were from in-house staff. Some staff files had no photographic identification, nor did they have a certificate of medical fitness.

### **Medical records**

Substantial compliance

Improvements required\*

### **Insurance cover**

Substantial compliance

Improvements required\*

### **Outcome 17**

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

#### **References:**

Regulation 36: Notification of Incidents

Standard 29: Management Systems

Standard 30: Quality Assurance and Continuous Improvement

Standard 32: Register and Residents' Records

### **Inspection findings**

Previously it was identified that a notification with regards to an accident at the centre had not been submitted to the Health Information and Quality Authority. This was remedied. However, it was noted on this inspection that notifications regarding absconscion had not been notified nor notifications regarding residents who were admitted to the centre with a grade 2 or more pressure sore. All such instances must be reported to the Chief Inspector for social services.

**Outcome 18**

*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.*

**References:**

Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre

Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre

Standard 27: Operational Management

**Inspection findings**

There were appropriate arrangements in place for the absence of the person in charge.

There have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

## Closing the visit

At the close of the inspection visit a feedback meeting was held with Maria Bridgeman, provider; Majella Cussen, person in charge; Ann McMorrow, acting assistant director of nursing; Anne Bowen CNM3; Deirdre Shortt CNM2; Anne Brosnan and Margaret Cusack CNM1 and Eileen Brett, manager, to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

### **Acknowledgements**

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

### ***REPORT COMPILED BY***

Margaret O'Regan  
Inspector of Social Services  
Social Services Inspectorate  
Health Information and Quality Authority

11 June 2011

**Provider's response to inspection report\***

<b>Centre:</b>	St Camillus' Hospital
<b>Centre ID:</b>	0640
<b>Date of inspection:</b>	30 May 2011, 31 May 2011 and 1 June 2011
<b>Date of response:</b>	30 June 2011

**Requirements**

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

***Outcome 1: Statement of purpose and quality management***

**1. The provider is failing to comply with a regulatory requirement in the following respect:**

The statement of purpose did not comply with all the requirements as set out in Schedule 1 of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). It did not fully achieve the aims or the objectives set out due to the limitations of the premises.

**Action required:**

The statement of purpose must include all items listed in Schedule 1 of the regulations including the room sizes, the exclusion criteria for admission, a detailed statement of the type of nursing care provided and an up to date organisational structure.

**Action required:**

The aims and objectives set out in the statement of purpose should be achievable.

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

<b>Reference:</b> Health Act 2007 Regulation 5: Statement of Purpose Standard 28: Statement of Purpose	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  The statement of purpose is being reviewed at the moment and will be forwarded to the inspector when completed.	15 July 2011

***Outcome 2: Reviewing and improving the quality and safety of care***

<b>2. The provider is failing to comply with a regulatory requirement in the following respect:</b>  The audit systems in place must be measurable against outcomes for residents and changes made to practices. These changes must be recorded and the system of quality control must provide for consultation with residents and their representatives.	
<b>Action required:</b>  The quality of the reviews should be improved to include a more detailed account of changes implemented such as the changes to medication dosages.	
<b>Action required:</b>  Relatives and their representatives should be consulted in a more dynamic manner in relation to changes to practices.	
<b>Reference:</b> Health Act 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  The audit procedure will be improved to include detailed recording of actions/changes to be implemented to improve outcomes for residents. A procedure of feedback to residents/relatives will be put in place.	30 September 2011

***Outcome 3: Complaints procedures***

<b>3. The provider is failing to comply with a regulatory requirement in the following respect:</b>  A visitors concern had not been recorded in the complaints log.	
<b>Action required:</b>  All complaints must be fully and properly recorded.	
<b>Reference:</b> Health Act 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  All complaints will be recorded in the complaints log including those death with at ward level.	1 July 2011

***Outcome 4: Safeguarding and safety***

<b>4. The person in charge is failing to comply with a regulatory requirement in the following respect:</b>  Not all staff had received the mandatory training in elder abuse prevention and detection.	
<b>Action required:</b>  All staff must be trained in the prevention, detection and management of elder abuse.	
<b>Reference:</b> Health Act 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  A commitment to continuous training in elder abuse has been established and will continue using in house trainers and the senior case worker in elder abuse.	Continuous

***Outcome 5: Health and safety and risk management***

**5. The provider is failing to comply with a regulatory requirement in the following respect:**

Physical alterations are required to be made to the premises to ensure adequate arrangements are in place for the containment of fires and before a fire safety certificate can be issued.

**Action required:**

The items highlighted by the fire consultant must be attended to immediately.

**Reference:**

Health Act 2007  
Regulation 32: Fire Precautions and Records.  
Standard 26: Health and Safety

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

**Timescale:**

Provider's response:

A proposal has been submitted to the senior operations manager regarding funding required to address the items highlighted by fire the consultant in the fire safety compliance survey report of 5 May 2011.

31 December 2011

***Outcome 7: Health and social care needs***

**7. The provider and the person in charge are failing to comply with a regulatory requirement in the following respect:**

Many residents spent long periods of the day in bed with little meaningful activity provided. Other residents expressed a wish to avail of more outdoor activities.

Orientation aids such as clocks and notice boards were inaccurate.

Personal care practices such as showers and baths were seen not to be undertaken as frequently as should be. Many residents appeared to spend excessively long periods in bed.

Each resident's social care needs were not set out in a care plan.

Inadequate assessments had taken place with regards to the use of physical restraint. Consent was sought from relatives for the use of restraint when the decision to use it must be with the residents or based on the nurses informed opinion following an assessment.

<b>Action required:</b>	
Residents must be given opportunities for participation in meaningful and purposeful activity both inside and outside the centre, that suit his/her needs, preferences and capacities. Particular consideration must be given to;	
<ul style="list-style-type: none"> <li>▪ residents with dementia and other cognitive impairments</li> <li>▪ residents with communication difficulties and</li> <li>▪ residents with physical or learning disabilities.</li> </ul>	
<b>Action required:</b>	
Orientation aids must be accurate to achieve their desired purpose.	
<b>Action required:</b>	
Personal care practices must be appropriate to the needs of residents. This includes	
<ul style="list-style-type: none"> <li>▪ frequent showering and washing of residents' hair</li> <li>▪ opportunities for residents to sit out for periods during the day</li> <li>▪ opportunities for residents to engage in social activities pertinent to their needs.</li> </ul>	
<b>Action required:</b>	
Each resident's social needs must be set out in a care plan.	
<b>Action required:</b>	
An assessment must take place prior to the use of any restraint. A distinction must be made between involving relatives in the decision making process as opposed to relatives consenting to their relative being restrained.	
<b>Reference:</b>	
Health Act 2007 Regulation 6: General Welfare and Protection Regulation 8: Assessment and Care Plan Regulation 25: Medical Records Standard 11: The Resident's Care Plan Standard 18: Routines and Expectations	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  The activity programme will continue to be developed and extended to include meaningful and purposeful activity both inside and outside the centre, in conjunction with resident's preferences and in consultation with relatives/volunteers.	31 August 2011

Training on communicating with residents with dementia and behaviours that challenge will commence in September 2011	31 December 2011
All clocks and orientation aids are now kept up-to-date and at correct time.	Immediately
Re-evaluation of personal care practices will take place in conjunction with the resident/relative, taking cognisance of each individual's preference and choice, while maintaining person-centred care as best practice over task-orientated care.	Immediately
Care plan documentation group will continue to advance the social care plan, individualised to meet each residents needs in a person centred way.	Continuous
The practice of relatives consenting for restrain will stop immediately. The discussion with relative relating to restrain will be documented in the care plan.	Immediately
Two nurses attended "Train the Trainer" on "Use of Restraint in Residential Care Units" on 22 June 2011. They will inform staff in St Camillus' on appropriate assessments to be undertaken prior to restraint being initiated. New policy and documentation will be created for St Camillus' Hospital.	31 October 2011

***Outcome 9: Food and nutrition***

**9. The provider and person in charge is failing to comply with a regulatory requirement in the following respect:**

There were inadequate dining facilities available to residents, curtailing residences' independence at meal times.

Some modified consistency diets were presented in a less than appetising manner.

**Action required:**

Each resident must receive meals in pleasant surroundings at times convenient to them, and in such a manner as to promote their independence.

**Action required:**

Modified consistency diets must be presented in a manner which is attractive and appealing in terms of texture, flavour and appearance, in order to maintain appetite and nutrition.

<b>Reference:</b> Health Act 2007 Regulation 19: Premises Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes Standard 25: Physical Environment	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  A proposal has been submitted to the senior operation manager regarding funding required to address inadequate dining facilities for residents  Multidisciplinary meal and mealtime group which includes catering, speech and language therapy (SALT), dietician, management, nursing and care staff will examine and improve on presentation and consistency of meals appropriate to each residents needs in order to maintain appetite and nutrition.  Residents will be invited to join the group.	31 December 2011  31 October 2011  15 July 2011

***Outcome 11: Residents' rights, dignity and consultation***

<b>11. The provider is failing to comply with a regulatory requirement in the following respect:</b>  Meetings had taken place with residents through a resident's forum. However, it was not clear what actions had taken place as a result of these meetings or if other residents and/or their families were aware of decisions taken.
<b>Action required:</b>  Each resident's rights to consultation and participation in the organisation of the service must be respected and facilitated. Residents and/or their families, insofar as is reasonably practicable, must be facilitated to be consulted about and facilitated to participate in the operation of the centre. Actions and decisions taken at residents meetings must be recorded and circulated to other residents and/or their families.
<b>Reference:</b> Health Act 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 2: Consultation and Participation

<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>A template will be developed to formalise decisions, actions, responsible persons, following residents meetings and same will be displayed on ward notice boards to inform residents and relatives.</p>	30 August 2011

***Outcome 12: Residents' clothing and personal property and possessions***

**12. The provider and person in charge is failing to comply with a regulatory requirement in the following respect:**

There was inadequate space available to residents for personal possessions, such as adequate clothes storage space and adequate locked storage space.

Laundry arrangements did not adequately facilitate residents' personal clothing being cared for in accordance with their washing instructions. There were also deficits in the arrangement in place for clothes to be returned to the correct residents.

**Action required:**

Adequate space must be provided for a reasonable number of personal possessions and that each resident is facilitated to retain control over their personal possessions.

**Action required:**

Adequate facilities, insofar as is reasonably practicable, must be provided for residents to have their clothes washed, dried and ironed and adequate arrangements must be in place for their clothes to be sorted and kept separately.

**Reference:**

- Health Act 2007
- Regulation 7: Residents' Personal Property and Possessions
- Regulation 19: Premises
- Standard 4: Privacy and Dignity
- Standard 25: Physical Environment

<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>A process began in May as outlined in the fit person entry document to provide all residents with a locked storage space.</p>	1 September 2011

<p>Given that laundry facilities on site are the centralized laundry facility for the HSE Mid-West, we will engage with the laundry and care staff to improve the practice regarding the laundry and care of personal items for residents.</p> <p>Staff on wards will advise relatives when purchasing items of clothing to ensure that they are suitable for machine washing and tumble drying and should be labelled prior to wearing as per hospital information booklet.</p>	<p>15 September 2011</p> <p>8 July 2011</p>
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***Outcome 14: Suitable staffing***

<p><b>14. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>The staff files did not have all the required documents as per Schedule 1 of the regulations, such as photographic identification, medical certification of fitness, and three references. Many of the references supplied were from work colleagues, which is not best practice.</p> <p>Not all staff had mandatory training in elder abuse, detection, prevention and management.</p>	
<p><b>Action required:</b></p> <p>Staff must not be employed unless they have submitted the information and documents specified in Schedule 2 of the regulations.</p>	
<p><b>Action required:</b></p> <p>All necessary arrangements must be made, including the training of staff, to prevent residents being harmed or suffering abuse or being placed at risk of harm or abuse.</p>	
<p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>Health Act 2007</li> <li>Regulation 6: General Welfare and Protection</li> <li>Regulation 18: Recruitment</li> <li>Standard 8: Protection</li> <li>Standard 22: Recruitment</li> </ul>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>All personnel files are being examined to ascertain if required documentation specified in Schedule 2 is on file. Where gaps are identified measures will be taken to address same.</p>	<p>1 December 2011</p>

***Outcome 15: Safe and suitable premises***

**15. The provider is failing to comply with a regulatory requirement in the following respect:**

The physical design and layout of the centre dates to the 1800s and does not meet the needs of each resident in terms of sufficient space, sufficient privacy or sufficient sanitary facilities.

There is a general lack of adequate storage arrangements for equipment in the centre.

For many of the residents there is not a suitable outdoor area available to them.

**Action required:**

The physical design and layout of the premises must meet the needs of each resident.

**Action required:**

There must be adequate private and communal accommodation provided for residents; including adequate sitting, recreational and dining space provided separately from the resident's private accommodation.

**Action required:**

There must be provided at appropriate places in the premises sufficient numbers of lavatories, wash-hand basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection.

**Action required:**

Suitable provision must be made for the storage of equipment.

**Action required:**

Suitable storage facilities must be provided for residents' use.

**Action required:**

The external grounds must be made safe for residents to use.

**Reference:**

Health Act 2007  
Regulation 19: Premises  
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>A proposal has been submitted to the senior operations manager regarding funding required to address the inadequacies relating to the physical layout and design of the centre, storage space, private and communal accommodation and sanitary facilities.</p> <p>A garden design team have been engaged to design a garden suitable for residents use within the grounds.</p> <p>Development of the garden project will take place on a phased basis.</p>	<p>31 December 2011</p> <p>31 May 2011</p> <p>1 August 2012</p>

***Outcome 17: Notification of incidents***

**17. The person in charge is failing to comply with a regulatory requirement in the following respect:**

Notices of unexplained absences by residents had not been notified to the Health Information and Quality Authority as is required by regulations. There had been instances where residents had been admitted to the centre with a pressure sore but notices of these sores had not been submitted to the Authority.

**Action required:**

Notice must be given to the Chief Inspector without delay of the occurrence of any serious injury to a resident, including a grade two pressure sore or above.

**Action required:**

Notice must be given to the Chief Inspector without delay of the occurrence in the centre of any unexplained absence of a resident from the centre.

**Reference:**

Health Act 2007  
Regulation 36: Notification of Incidents  
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>All pressure ulcers grade 2 or above will be notified to the Chief Inspector on the NF03 - Any serious injury to a resident form.</p>	<p>30 June 2011</p>

<p>In the event of an unexplained absence of a resident from St Camillus' Hospital the Chief Inspector will be notified on appropriate documentation.</p>	
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**Any comments the provider may wish to make:**

**Provider's response:**

The management and staff at St Camillus' Hospital welcome the report following the registration inspection of 30 May 2011, 31 May 2011 and 1 June 2011. We recognise that the findings provide an opportunity for learning which will lead to improvements in the quality of service outcomes for our residents.

We are committed to continuous quality improvement as highlighted throughout the report by the inspectors. We will work together with the inspectorate in the future to further enhance the quality of service provided to our residents in accordance with the statutory regulations and best practice as defined in the standards.

We wish to take this opportunity to thank the Health Information and Quality Authority's inspectors for the courteous and professional manner in which they conducted the inspection process.

**Provider's name:** Ms Maria Bridgeman on behalf of Health Service Executive

**Date:** 30 June 2011