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Phoenix Park Community Nursing Units, OSV-0000476, 28 August 2019

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**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Phoenix Park Community Nursing Units
Name of provider:	Health Service Executive
Address of centre:	St Mary's Hospital, Phoenix Park, Dublin 20
Type of inspection:	Unannounced
Date of inspection:	28 August 2019
Centre ID:	OSV-0000476
Fieldwork ID:	MON-0024257

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Phoenix Park Community Nursing Units consists of two purpose-built buildings, Teach Iosa, 100 beds and Teach Cara, 50 beds, providing residential care for up to 150 male and female residents over the age of 18 years, of all levels of dependency. Both buildings have two storeys, and are divided into six units. It is located on the St. Mary's Hospital Campus, Phoenix Park in Dublin.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	147
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
28 August 2019	09:30hrs to 18:30hrs	Deirdre O'Hara	Lead
29 August 2019	08:20hrs to 17:00hrs	Deirdre O'Hara	Lead
28 August 2019	09:30hrs to 18:30hrs	Gearoid Harrahill	Support
29 August 2019	09:30hrs to 17:00hrs	Gearoid Harrahill	Support
28 August 2019	09:30hrs to 18:30hrs	Sonia McCague	Support
29 August 2019	08:55hrs to 17:00hrs	Sonia McCague	Support

What residents told us and what inspectors observed

The inspection was carried out following the receipt of information about privacy and dignity in the centre.

Residents who communicated with the inspectors were positive with regard to the control they had in their daily lives and the choices that they could make. Residents told inspectors they were satisfied with their daily routines, activity plans and interactions with the wider community.

Residents and family members were complementary regarding staff members. They felt comfortable about speaking to those in charge if they were unhappy with something in the centre and were confident that appropriate action would be taken.

Residents expressed satisfaction regarding the provision of services and were happy with the care, support and assistance provided by staff. Residents said that the staff were very kind and polite to them.

Residents also indicated that they liked the food and there was plenty of choice. There was a bus available to residents for weekly outings and trips. Residents had been sightseeing in areas around Kildare and North Dublin. There were outings to a café in the Phoenix park grounds and residents were supported to go out shopping with companions and to meet with friends. A trip to the theatre was planned for another resident. An artist attended the centre weekly and exhibitions were held of the residents artistic work in the centre.

Capacity and capability

The service provided a safe environment and ensured that residents' health and social care needs were well met. Improvements were required with some aspects of governance and management arrangements, training and development for staff and a number of policies that had exceeded their date for review.

There were systems in place to monitor the service although this did not allow for effective centre specific monitoring due to the combined approach with St. Marys hospital and requires further development to ensure safe and effective care is being delivered and monitored.

Senior managers from the hospital and the designated centre met regularly at different committees and meetings. These committees reviewed incidents and accidents at the quality and safety committee, auditing of both clinical and non-clinical data and multidisciplinary team meetings to review care delivery. Findings

and learning from the data analysed were then shared with staff at staff meetings. While this allowed a close relationship with the hospital, some aspects of the wider structure did not meet the requirements of the designated centre regulations for example,

- Some policies required by schedule 5 of the regulations were out of date and had not been reviewed within the three yearly requirement and were not specific to the designated centre.
- Records relating to personnel and Garda vetting were not maintained in the designated centre. When requested, the personnel records arrived from the main hospital. However it is a requirement of the regulation that records are kept in the designated centre.
- Staff had been provided with training in safeguarding of vulnerable adults, fire safety and safe manual handling. The centre had a policy on training and development but there were discrepancies regarding the identification of mandatory training and time frames within which all staff were required to receive refresher training.
- There was little evidence of structured arrangements for staff appraisals.

The centre had a statement of purpose and it was available in the centre. However this was not accurate and needed to be updated. The inspectors were given assurances that amendments required would be made and a copy forwarded to the Chief Inspector.

There was suitable and sufficient staffing and skill-mix in place to deliver a good standard of care in the units. Inspectors found that there were arrangements in place to ensure that there was adequate clinical supervision and direction for staff by the nurse managers. The two persons in charge were experienced in care of the older person and were supported in their roles by senior managers, nurse managers and the multidisciplinary team.

The volunteers that attended the centre had Garda vetting disclosures available and their roles and responsibilities were in their file for inspectors to review.

Regulation 14: Persons in charge

There were two full time persons in charge of the centre, who were registered nurses with the required experience in the area of nursing older people. They were supported by the director of nursing, hospital manager and nursing staff.

During the inspection they demonstrated their knowledge of the regulations, the standards and statutory responsibilities. There was ample evidence of ongoing professional development.

Judgment: Compliant

Regulation 16: Training and staff development

The centre had a policy on training and staff development which was updated in 2019. There was little evidence of structured arrangements for staff appraisal which was not referenced in this policy.

A number of staff had been provided with training in safeguarding of vulnerable adults, fire safety and safe manual handling, however there were numerous examples on all units of staff not being provided with refresher courses on mandatory training. A number of staff on each unit either had not been provided with fire safety training or were overdue to be provided with refresher training within the time frames identified by centre policies. A significant number of staff were out of date for refresher training in manual handling and safeguarding as outlined in the centres policy.

Other training offered to staff included care planning, cardio-pulmonary resuscitation (CPR), caring for people with dementia or cognitive impairment, or responding to people exhibiting behavioural or psychological symptoms of dementia.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider has maintained a directory of residents in the centre,

Improvement was required to include all details specified in Schedule 3 of the regulations. For example records for some residents did not contain a date on which a resident was first admitted to the centre, or contact details for next of kin or the residents general practitioner details.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had the required documentation related to insurance on site.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre had sufficient resources to ensure effective delivery of care in accordance with the centres statement of purpose.

There was a clearly defined management structure that identified the lines of authority and accountability. The organisational structure was outlined in the statement of purpose.

There were management systems in place but this did not support constant and effective monitoring to ensure that the service provided was safe, appropriate and effectively monitored. This was as a result of a combined approach with another organisation that shared the campus. Management meetings and policies were not centre specific and risk assessments and risk register were were being developed. During management team meetings clinical and non-clinical data were reviewed. Clinical audits were carried out which analysed accidents, complaints, medications, pressure ulcers and others. The results of audits and meetings were shared with staff for learning. Trending of incidents had commenced recently in the centre.

There was an annual review of the quality and safety of care delivered to residents. While residents and family feedback was included, the results of this review did not to demonstrate how improvements have been made to address concerns or complaints.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose available in the centre. It was last updated in March 2018. This required review to ensure that the information required under Schedule 1 was up-to-date and accurate. Examples of this were the names of the provider was not identified and key stakeholders names were included in the documented were no longer working in the centre, the registration expiry date was documented as being 18/06/2019.

Judgment: Substantially compliant

Regulation 30: Volunteers

Each person working in the centre on a voluntary basis had a file which contained an agreement in writing of their duties in the centre as well as evidence of vetting

by An Garda Síochána.

Judgment: Compliant

Regulation 34: Complaints procedure

An accessible and effective complaints procedure was in place. Residents' complaints and concerns were listened to and acted upon in a timely, supported and effective manner. There was evidence that residents and other complainants were satisfied with measures put in place in response to their complaint.

Judgment: Compliant

Regulation 4: Written policies and procedures

While the provider had policies required by Schedule 5 of the regulations, many of the policies had not been updated and had exceeded their stated revision date. Many of the policies were not specific to the designated centre or included information on stakeholders who were no longer involved with the service.

Some policies were contradictory with procedures followed. For example, the policy on staff development was inconsistent on training cycles and made no reference to appraisal, induction or supervision arrangements for staff, there were discrepancies in the policy regarding which training sessions were and were not mandatory for all staff working in the centre and the instructions regarding vetting disclosures for staff was not in line with the National Vetting Bureau (Children and Vulnerable Adults) Act 2012.

Judgment: Substantially compliant

Quality and safety

Overall, the findings showed that on the day of inspection, the designated centre was providing good quality care and support to residents. However improvements were required in relation to premises, risk management, fire drills, medical and pharmaceutical services, care plans and residents rights.

While there was a risk management policy and an emergency plan in place to guide staff the centre specific risk register did not identify centre specific risks. It was not available to the person in charge or in the centre on the first day of inspection. Risks

and incidents were discussed at the quality and safety committee as a combined approach with St. Marys Hospital resulting in the centre risks not being discussed individually making it difficult to identify which risks were pertaining to the centre.

The trending and tracking of incidents had recently commenced with regards to incidents. A variety of data was reviewed which included slips, trips and falls, self-injurious behaviour, ergonomics, fire and medications and other incidents. In addition to this, a tracking system was put in place to identify actions that needed to be taken, a responsible person and the progress made. The evidence of action completion required further development to confirm agreed steps had been taken.

Inspectors were satisfied that residents' health and social care needs were met to a good standard. There were effective systems in place for the assessment, planning, implementation and review of health and social care needs of residents. End-of-life care was also an integral part of the service provided. A small number of inconsistencies were noted in some records and improvement was needed with regards to medication administration, behavioural monitoring and associated care plan records.

Residents were provided with support that promoted a positive approach to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were observed to be led by residents wishes and residents responded well to staff.

There was a choice of meals and a varied menu offered daily. However improvements was required with regard to choices of location for residents in one unit to enjoy their meals. There was restricted space for eight residents in the sitting room that was converted to a dining room at the times when meals were served. Large catering equipment was stored in this room at this time and staff did not have sufficient space to discreetly assist residents. This was an outstanding finding from the last inspection and the experience for residents remained the same. During the inspection, senior management discussed alternative locations for dining, which would offer residents more choice. Inspectors observed that there was a daily varied menu choice offered and residents that spoke with inspectors said they enjoyed the food at the centre.

There were dedicated activity staff, who were supported by care staff to provide residents with a range of activities. On several different occasions inspectors observed residents engaged in activity groups, which were running in the different units at the same time. Residents' religious and civil rights were upheld through regular access to religious services and arrangements made to facilitate residents to vote in a nearby polling station.

The residents' committee met regularly and residents were consulted with regard to their care and the service provided. The provider said they valued residents' views and provided them with opportunities to participate in the running of the centre. However feedback to residents regarding the actions taken as a result of points raised by residents at these meetings were not made available.

There were sufficient fire prevention measures in place in the centre, and equipment was monitored and serviced regularly. While fire drills had taken place and there were personal evacuation plans in place for all residents, examples were seen that did not clearly outline to staff the method by which they could assist residents to evacuate in the event of an emergency. A significant number of staff required either training or refresher training in fire safety, fire drill timing and staff resources were required to provide assurances that residents will be evacuated in a safe and timely manner. Staff knowledge was satisfactory regarding emergency procedures.

Residents said they felt safe in the centre and spoke positively about the care team and management in the centre. Staff who spoke with inspectors knew residents well and were knowledgeable regarding their individual needs. A safeguarding policy was in place.

Overall there was evidence of safe medication management practices. There was a policy in place relating to medicines. A drugs and therapeutic committee maintained oversight of medicine practices in the centre. Improvements needed to be made to monitoring, cleanliness and prn medication.

Regulation 13: End of life

End of life care needs were discussed with residents and relatives on admission. It was discussed again with those involved in developing care plans and any decisions made by the resident were recorded. Residents were asked about their wishes in relation to the care they wanted to receive, which included arrangements, persons and preferences about where they were to be cared for and who was to support decisions.

Treatment and resuscitation preferences, where expressed, were recorded in the resident medical notes and reflected in an associated care plan having involved all relevant parties. A review of care plans were undertaken three monthly.

Staff in the centre were aware of the appropriate comfort and care requirements for residents at end of life, and were able to make arrangements for friends and family to be with the resident if that was their choice. Religious and cultural preferences were respected and facilitated.

Judgment: Compliant

Regulation 17: Premises

Overall the designated centre was safe and suitable for use by people living in the building. The building was clean, in a good state of maintenance, and was well lit

and heated. All areas of the buildings were free of steps and trip hazards, and hallways were lined with handrails for assistance. Residents were observed navigating safely through the centre alone or with assistance. Multiple lifts allowed safe travel between storeys. Residents had access to safe and secure outdoor areas in the form of nicely featured courtyard gardens.

Bedrooms had been personalised and decorated based on residents' preferences. Shared bedrooms were large and included screening between bed spaces for privacy. All bathrooms, showers and en-suite facilities were accessible for people with mobility requirements. There were multiple communal areas available, including space in which residents could receive their visitors in private. Kitchen facilities were on site and each unit had a kitchenette from which food could be prepared and served to each dining area when received from the main kitchen.

Five of the six units had sufficient dining space in which resident could comfortably enjoy their meals independently or with assistance. However, the Setanta unit did not have a dedicated dining space outside of the residents' private accommodation in which to have meals. Staff were required to convert the unit's living room and a small private day room into dining areas at mealtimes, moving furniture and residents around throughout the day and requiring some residents to return to their bedrooms. Despite this change of room function, there still was not enough space during mealtimes for residents to have a choice other than their bedrooms in which to dine. During lunchtime on both days of inspection, space in the main communal area was limited to accommodating eight of the twenty-five residents on the unit, with up to three additional people in the smaller sitting room. The other residents were served in their bedrooms from a tray trolley. The area being used for dining was also not comfortable or suitable in size and layout for these residents, and staff assisting residents to eat their meals in this room did not have space to sit beside residents.

Judgment: Not compliant

Regulation 18: Food and nutrition

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. To ensure residents were being supported appropriately their weights were checked as required and at least on a monthly basis. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dietitians, speech and language and occupational therapists where appropriate. Nutritional and fluid intake records when required were maintained. The inspectors observed residents at mealtimes in the dining rooms, and saw that a choice of meals and varied menu was offered daily. The dining experience for residents of one unit required improvement as outlined under regulation 9.

There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements, and sufficient staff available to support and assist residents.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place, there were measures and actions in place to guide staff with regards to abuse, unexplained absence of any resident, accidental injury to resident, visitor or staff, aggression and violence and self-harm. Trending of incidents to allow management monitor incidents had recently started in the centre. Trending data with regards to slips, trips and falls, self injurious behaviour, violence and aggression, ergonomics, fire, medication and others were discussed at the quality and safety meeting.

There was a register of risks but risks identified on the day of inspection were not included in the risk register for example the lift breaking down, also the risk relating choice for residents with regards to the dining on one of the units, there was no further follow up measures or actions put in place to manage this risk once the initial control measures that were put in place were unsuccessful.

The risks already identified were not readily available to the persons in charge or in the designated centre at the time of inspection as specified in the centres safety statement.

There was a plan in place to guide staff in the event of a major incident.

Judgment: Compliant

Regulation 28: Fire precautions

The building was equipped with appropriate features and equipment to detect, contain and extinguish fire, which were subject to routine checks and servicing. Staff were knowledgeable about emergency procedures and progressive horizontal evacuation of residents to a place of safety. The centre had a personal evacuation plan for each resident which listed equipment and assistance requirements to evacuate during the day or night and notes on whether the person was likely to refuse assistance or wander.

Following the previous inspection the provider committed to having regular practice evacuation drills on each unit. Evidence of the drills performed did not identify how long it would take to evacuate compartments of the units and as such did not provide assurance that the resources and procedures were sufficient to achieve

timely and efficient evacuation at any given time.

While staff were familiar with evacuation procedures, inspectors found that a number of staff on each unit either had not been provided with fire safety training or were overdue to be provided with refresher training, as per the time frames identified in the centre's policy. This is addressed under Regulation 16.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The designated centre had written policies and procedures which related to the administration, transcribing, storage, disposal and transfer of medicines. This policy was overdue for review.

A drug and therapeutic committee maintained oversight of medicine practices in the centre and medications were stored safely in the centre.

However in one fridge, medicine that required refrigeration were not stored at the required temperature, despite fridges being checked daily. Inspectors found that medication fridges and tablet crushers were not clean. There was good evidence of documentation and hand hygiene practices during drug administration rounds.

Recording of prn (as required medication) needed improvement. Examples were seen where there was no clear direction for staff when to give the prn medication or there were inconsistencies in associated care plans and behavioural monitoring records.

Medicines that were out-of-date or no longer required were securely stored and disposed of appropriately.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors found that the nursing and medical care needs of residents were assessed and appropriate interventions and treatment plans were being implemented accordingly. There was evidence of a range of assessment tools being used to monitor areas such as the risk of falls, malnutrition, cognition, depression, pain, mobility and skin integrity.

However, some inconsistencies in behavioural monitoring records and associated care plans and medicine administration records were found. For example, gaps are

identified in the behavioural monitoring assessment documentation. The antecedents, behaviour and interventions used were not recorded as required and outlined within the centre's policy and the resident's care plan had not been updated as changes occurred. As a result, insufficient guidance was available to ensure that interventions such as PRN (a medicine only taken as the need arises) was used appropriately and was subject to an evaluation.

Judgment: Substantially compliant

Regulation 6: Health care

Suitable arrangements were in place to ensure each resident's health, well-being and welfare was maintained by a high standard of nursing, medical and allied health care.

Residents had daily access to medical officers and regular access to consultant geriatrician services. There was evidence of access to specialist and allied health care professionals to assess, recommend supports and meet the care needs of residents. Residents had appropriate access to optical, dental and chiropody services and upon referral could access palliative care specialists, dieticians, occupational therapy, physiotherapy and speech and language professionals available on-site. Social and mental health services were also provided, as and when required. Specialists in other areas such as dementia and diabetes were available within the vast multi-disciplinary team employed by the provider.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A restraint-free environment in line with the national policy was promoted in practices reviewed. The centre's policy reflected the national guidance document and was available to guide restraint usage as a last resort. Due to their medical conditions, some residents had responsive behaviours. During the inspection, staff were observed approaching residents in a sensitive and appropriate manner, and the residents responded positively to techniques and approaches adopted by staff.

Judgment: Compliant

Regulation 8: Protection

Policies, protocols and measures were in place, and being implemented, to protect residents from being harmed or suffering abuse. Residents who spoke with inspectors said they felt safe within the service. An investigation had taken place as a result of the receipt of information regarding privacy and dignity for residents in the centre. The management team had dealt with this by following the centres safeguarding policy and there was a robust response made by management to ensure the safety of residents.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were facilitated and encouraged to participate in the organisation and running of the centre. Resident feedback was welcomed by the provider and person in charge. Residents' meetings were convened and minutes were available.

There were limitations in one of the units with regard to resident choice where to have their meals. The use of the rooms in this way also resulted in staff being unable to discreetly support residents during meal times and residents having no access to a living room to relax, read, watch television or socialise as the living room is turned into a busy dining area. This was found on the previous inspection and since then the provider had trialled alternatives such as having two sittings, or accommodating residents in the dining area of a different unit. However these were not successful and the outcome for residents remained unchanged.

Residents' rights to privacy and dignity were upheld by staff through respectful interactions, and honouring the resident's choices on a day to day basis. Inspectors observed that staff were courteous, kind and gentle with residents and addressed them by their preferred name. Staff were observed to knock and wait for permission before entering the resident's bedroom and before commencing care or assistance.

There was a varied activity programme in place and residents could choose what they wished to attend. If they did not wish to join in group activities there was opportunities for one-to-one time with activity staff or they were facilitated to pursue their own interests independently. Television, radio and newspapers were available for residents. Staff was observed reading newspapers with the residents and discussing local and national news items. Some residents had newspaper reserved especially for them.

Residents had access to regular religious services in the centre and access to external advocacy services. Residents who wished to participate in recent elections had been supported to do so in a nearby polling station.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Phoenix Park Community Nursing Units OSV-0000476

Inspection ID: MON-0024257

Date of inspection: 29/08/2019

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non-compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider’s response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>A review of all staff training records has commenced and will be completed by Oct. 31st 2019. Following completion of this review a list of staff overdue for mandatory training will be supplied to each department manager. Managers will prioritise these staff members to attend the relevant training.</p> <p>The Department of Nursing endeavours to ensure that all nursing staff receive high quality education, training and support throughout their work cycle within the broader campus. To this end a professional development planning document has recently been developed to provide an overview of the supportive and developmental processes on offer (Professional Development Plan for Nurses & Midwives, Office of the Nursing & Midwifery Services Director) A supportive roll out plan has also been devised since the HIQA inspection, detailing the commencement of PDPs in November 2019 with senior nursing management in order to role model this valuable process. PDPs will in turn be rolled out on a phased basis commencing with Clinical Nurse Managers who in turn will roll this initiative out to their staff nurses during 2020.</p> <p>It is the policy of the designated centre to provide induction and orientation processes for all new staff. This is provided both locally in each department, in addition to a general induction programme. On commencing work in the designated centre staff should formally meet with their manager at least every 3 months as part of their probationary period review. On successful completion of a probationary period, staff should meet with their manager on an annual basis to complete a Professional Development Plan. In the event that a staff member is not achieving or maintaining the required professional standard through formative feedback given by their manager, a supportive plan will be introduced to provide additional learning and development. A supportive plan may be introduced at any phase of the employment cycle at the discretion of the line manager and with the agreement of the staff member.</p>	

Regulation 19: Directory of residents	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 19: Directory of residents:</p> <p>Administrative staff have contacted the HSE ICT Service Desk to make the changes sought by the Inspection Team.</p> <p>An exercise is underway to rectify any gaps in information in the current Directory of Residents. Following this exercise updated admission sheets will be added to the Directory of Residents.</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The existing regular designated centre management meeting attended by both PIC's, the Director of Nursing, Hospital Manager and Maintenance Manager will be expanded to include representation from the allied health and social care professional team and medical team. The Registered Provider Representative will also be invited to attend. A terms of reference for this group will be established, The agenda will be structured on themes in the HIQA national standards which are outcome based. Minutes of meetings will be held by the PIC's for review by HIQA.</p> <p>Work is underway to make the 20 key policies required by the Health Act designated centre specific rather than campus specific. Any of the policies overdue for review will be prioritised for discussion at the next Policy Development Working Group meetings.</p> <p>The risk register for the designated centre will be held separately to the risk register held for the remainder of the campus.</p> <p>Any meetings held on site with a joint focus on both the designated centre and the remainder of the campus will be managed and minutes taken in a format that makes designated centre specific issues readily identifiable.</p> <p>Future iterations of the annual review of the quality and safety of care delivered to residents in the designated centre will include a section on the improvements made to service delivery on foot of any complaints or concerns raised.</p>	

Regulation 3: Statement of purpose	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 3: Statement of purpose:</p> <p>This action completed and an amended Statement of Purpose submitted to HIQA on the 15th October 2019.</p>	
Regulation 4: Written policies and procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:</p> <p>A local policy, procedure, protocol and guideline oversight group was established in 2018 to monitor all local policy development, evaluation, audit and review. An action plan will be developed on 19/11/19 at the next policy committee meeting to ensure timely review of the relevant policies.</p> <p>Staff members have attended HSE Policy Development training in line with the HSE PPPGs framework. In addition, key personnel have been delegated the responsibility for reviewing these policies through this oversight committee and review of these policies had commenced at the time of the inspection. There are a large number of policies on campus in order to provide staff with guidance on evidence based care. Priority in relation to review timescales has been given to those polices which are required by legislation and regulation.</p> <p>The content of all policies in the designated centre are pertinent and relevant to the centre but some currently have a title which incorporates the remainder of the campus. As polices are reviewed going forward, the oversight policy committee will meet on November 19th 2019 to discuss the re-titling and updating of designated policies.</p>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>A suitable additional room for dining has been identified on the ground floor to accommodate a number of Setanta Ward residents at lunch time.</p>	

A business case is being developed to refurbish this room. This will be submitted to the Hospital Manager for approval as soon as quotations have been received. Staffing reconfiguration will be required and plans for same have been submitted to senior management.

To address this action in the longer term a funding submission has being made through the National Capital Service Planning process 2020 to develop a new dining space directly adjacent to the ward. A decision is awaited in relation to this matter.

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
This compliance plan response from the registered provider did not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Mandatory Fire training is in place on site. All staff must attend this training annually.

The fire officer has been informed of additional requirements identified during the inspection and has duly incorporated these issues into training sessions.

Additional fire safety equipment has been ordered and is expected to be delivered by 30th November 2019 (fire blankets & burn kits).

Fire drills and mock evacuations are part of mandatory fire training. A schedule will be developed by 20/11/2019 for planned mock evacuation and fire drills.

The fire policy has recommendations in section 8 & 9 in relation to emergency evacuation of residents to a safe place. All future fire drills will have timing included.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

All issues regarding cleanliness of fridges and tablet crushers raised during the inspection have been addressed. At the next practice development meeting on 25th October 2019 with ward managers the most efficient way of maintaining a high standard of hygiene in relation to these medical devices and monitoring of same will be agreed. Temperature checks of the fridge will be recorded at least once daily.

A policy, procedure, protocol and guideline oversight group was established in 2018 to monitor all local policy development, evaluation, audit and review. The medication policy had been identified by this group as requiring a review and a detailed review of its contents was carried out. The medication policy review had been completed prior to the date of the inspection. The medication policy was signed off on 8th October 2019 and has been disseminated to all clinical departments.

A review of all medication prescription sheets has commenced and will be completed in the period October –December 2019. All PRN psychotropic medications will have a clear rationale for their use.

Associated care plans and behavioural monitoring records going forward will reflect the supportive activities carried out by staff as appropriate before administering PRN medication.

Regulation 5: Individual assessment and care plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

- Currently there are on-going education sessions available for staff on Documentation & Care planning and Managing Responsive Behaviour.
- The process of reviewing training records in relation to Documentation & Care planning and Managing Responsive Behaviour has commenced. All Clinical Nurse Managers will be notified of staff who are due for training (due date 15/11/19).
- The compliance with documentation on behavioural monitoring records, associated care plan and use of PRN medication on supporting and managing behaviours will be monitored through audits. These audits are due for completion by 13/12/19
- Spot checks will be carried out by CNSp Gerontology and will be completed by 31/12/2019 and three monthly thereafter as required.
- Further ward based (group or individual) documentation support will be commenced by CNSp Gerontology by end of Q4 2019.

Regulation 9: Residents' rights	Not Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A suitable additional room for dining has been identified on the ground floor to

accommodate a number of Setanta Ward residents at lunch time.

A business case is being developed to refurbish this room. This will be submitted to the Hospital Manager for approval as soon as quotations have been received. Staffing reconfiguration will be required and plans for same have been submitted to senior management.

To address this action in the longer term a funding submission has being made through the National Capital Service Planning process 2020 to develop a new dining space directly adjacent to the ward. A decision is awaited in relation to this matter.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/10/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/11/2019
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	27/03/2020
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	20/12/2019
Regulation 23(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	20/12/2019

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	17/04/2020
Regulation 28(1)(d)	The registered provider shall 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	Not Compliant	Orange	20/12/2019

	control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	20/12/2019
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	20/12/2019
Regulation 29(5)	The person in charge shall 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	Substantially Compliant	Yellow	27/03/2020

	resident's pharmacist regarding the appropriate use of the product.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	15/10/2019
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	15/10/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	19/11/2019
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	27/03/2020

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	27/03/2020
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	27/03/2020