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St Patricks Community Hospital, OSV-0000661, 24 October 2017

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**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Patrick's Community Hospital
Centre ID:	OSV-0000661
Centre address:	Summerhill, Carrick on Shannon, Leitrim.
Telephone number:	071 962 0011
Email address:	michellem.quinn@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Geraldine Mullarkey
Lead inspector:	Sonia McCague
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	41
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following an application to vary registration conditions. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 24 October 2017 10:30 To: 24 October 2017 19:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

The centre is registered to accommodate a maximum of 85 residents. The registration period expires in June 2018. This report sets out the findings of an inspection carried out following an application received September 2017 to vary and remove conditions of the registration.

Representation by the provider was submitted to the Health Information and Quality Authority (HIQA) 8 March 2016 to support the current registration. The information provided included the provision of a 'New Replacement Community Hospital' by the end of 2021 and upgrade the existing premises by the end of December 2016.

The application to vary related to decreasing resident numbers from 85 to 46 and to remove a condition applied by the Chief Inspector to complete the refurbishment of wards by the end of December 2016.

Changes had occurred to the management structure since the previous registration renewal inspection. However, the registered provider remained the same.

The person in charge worked in the centre from June 2016 and took over the role of

the person in charge 18 July 2016 (according to the notification submitted). She was present at the last inspection in October 2016. Her responsibilities included management of the day services operating within the building. The person participating in management (assistant director of nursing) was in post from April 2016, and the area manager has been the provider representative since February 2016. The area manager had responsibilities for five other centre's, as well as home care, community and voluntary services.

The person in charge and deputy facilitated the inspection and the provider nominee was available at the feedback meeting. During the course of this announced inspection, the inspector met with and observed residents and staff. Their views were listened to, practices were observed and documentation was reviewed. The feedback received in relation to the reconfiguring of the premises was positive as an interim measure until the completion of a new build for residents by 2021.

Following the reconfiguration of wards within the premises, the centre now had capacity to accommodate a maximum of 46 residents within three ground floor areas identified as Dr. McGarry ward, Sheemore ward and Monsignor Young Unit. The unit previously occupied on the first floor (Rivermead Unit) was vacant. Plans to provide a short stay service in this unit were under consideration but it was to be excluded from the registration of the designated centre. Male and female residents were integrated and accommodated in each area which was a change in ward occupancy from previous inspections.

Solicited information received by the Health Information and Quality Authority (HIQA) and actions required following the previous inspection were also reviewed. Some of these were found to be fully addressed. Further improvement was required in relation to the communication of complaints management, staff training and recreational activities.

While significant improvements had been made to the premises in both wards as required by the condition of registration applied, further improvements were required in governance and management systems and arrangements, staff training and arrangements, risk management, fire safety, management of responsive behaviours and social engagement outside of planned and or group events.

These findings are discussed within the body of the report and included within the action plan at the end for response.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose was reviewed, updated and amended appropriately.

It detailed the aims, objectives and ethos of the centre, outlined the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the regulations.

The provider representative and person in charge understood following their meeting on 11 September 2017 that it was necessary to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Arrangements were in place for the governance, leadership and management of the

centre. The person in charge reported to the provider representative, and was supported by an assistant director of nursing, two clinical nurse managers, nurses, care attendants, catering, housekeeping, administration and maintenance staff. Dedicated activity personnel were not outlined within the organisational structure but some activity support was provided by occupational therapy (OT) assistants who were based in the day hospital and reported directly to their line manager. Improvement in daily recreational activities should be developed further and this is included in the action plan for outcome 18. Medical and a range of allied healthcare professionals also supported the management team and provided timely services to residents.

A range of audits to monitor and review the quality of care, outcomes and service provisions were in place. Quality and safety committees, management and staff meetings were held to review, discuss and make decisions based on monthly and quarterly audit and monitoring findings.

Reporting structures were in place and incident management systems maintained to inform management decisions. The inspector reviewed records of the national incident management system (NIMS) audit and found gaps in the detailing of relevant information, reporting arrangements and follow-up measures. Therefore the effectiveness of this audit process required improvement to ensure the quality and safety of the service is being consistently monitored and reviewed accordingly. Recorded incidents of aggression and violence were high but staff working with residents involved had not completed suitable training to respond. Additionally, the lack of awareness by management that there were no emergency call facilities in one unit did not demonstrate adequate oversight or investigation, and review of the arrangements in place following incidents occurring. From discussions with staff and observations, the inspector concluded that improvements were required to ensure that those in charge were fully informed of behavioural changes in residents, fire safety procedures and management arrangements necessary for management of a safe and appropriate service.

Some staff working in the centre had gaps in their induction, appraisal and training (discussed in outcome 18) and were unfamiliar with emergency procedures. Difficulties were encountered by management in relation to changes in practices proposed. The inspector was told of reluctance by some staff in the implementation of policies such as safeguarding. This may compromise the safe delivery and oversight of the service.

Changes in management, staff resources, resident numbers and accommodation had occurred, however, change management and a shift in the culture of the organisation was slow in making progress. The refurbishment of wards in the centre was to be completed by December 2016 and had been achieved six months later. An application to vary the time frame set out within the condition of the existing registration had not been submitted on expiry of the condition. A provider meeting was held on 11 September 2017 in this regard.

'An annual review of the quality and safety of care provided' that had been completed in October 2017 was available. The report identified key operational areas that had been considered and a summary of recommendations for a quality improvement plan (QIP) to be implemented. Painting of Monsignor Young unit was identified in the QIP and to be

completed 'Early 2018' and quality and safety 'walk arounds' were to commence by the end of October 2017. The report appeared to reflect recent findings rather than an annual overview that might include key performance indicators and details such as the number of admissions, discharges, deaths, events, activities, staff turnover and absenteeism, training completed and required, number and nature of complaints and compliments, a summary of medicine management audit outcomes and falls and incidents.

Management were to review the admission criteria for a resident accommodated in the dementia unit where all other residents were over 65 years.

Judgment:

Non Compliant - Moderate

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

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

Findings:

Measures were in place to protect residents from being harmed or suffering abuse.

A policy which provided guidance for staff to identify and manage incidents of elder abuse was in place. Information on the various types of abuse, assessment, reporting and investigation of incidences was available. Provisions of training and availability of policies and procedures was in place to support staff. During discussions with the inspector, residents confirmed that they felt safe and secure in the centre due to the measures taken, such as the secured entrance and support and care provided by the staff team. The management of resident's finances and property was not examined on this inspection.

Training records available identified that most staff had attended training to identify and manage incidents of elder abuse; however, some staff had not completed training in safeguarding.

A high number of notifications of alleged abuse and episodes of responsive behaviours were notified to HIQA since the previous inspection. From a review of the incident records these events were ongoing and prevalent in two areas, Dr. Mc Garry and Monsignor Young Unit. The person in charge was aware of the necessity to make referrals to external agencies, and had referred some incidents to the local safeguarding

team and Garda. Protocols included that residents and or their next of kin were informed accordingly. The Inspector followed up on the outcomes and management plans put in place following incidents and saw that measures such as 'one-to-one' staffing was determined necessary to supervise and support residents. However, a rationale for removal and or adjustments to one-to-one safety measures was unclear when discussed with management and staff and incidents of aggression and violence towards residents or staff had occurred when one-to-one provisions were in place.

The inspector followed up on notifications including those of a serious injury. Staff had learnt from incidents that had occurred and measures were put in place to mitigate risk and safeguard residents to ensure no delays in investigation, treatment or interventions re-occur.

A significant number of responsive behaviours and episodes of aggression and violence between residents and towards staff was evident and on-going. Prior to this inspection and since the last inspection, 11 notifications of alleged, suspected or actual abuse were reported up to 23 June 2017. In addition and following a review of the incident management audit system between 24 June and 8 October 2017, six further incidents of aggression and violence in Monsignor Young unit and three in Dr. McGarry ward were reported. All staff working in these areas had not completed training in professional management of aggression and violence that was considered necessary and mandatory.

The Inspector also noted that agency staff worked in both areas supporting residents with responsive behaviours. It was unclear if they had appropriate skills to support positive behaviour or trained in professional management of aggression and violence (PMAV). The management of responsive behaviour and activity and or stimuli in the dementia unit where up to 18 residents of varying dependency and age were accommodated was not optimal and required review in accordance with international averages (12 or less).

A policy reflecting the national guidance principles was available to guide restraint use. Staff aimed to promote a restraint free environment that was reflected in the centre's policy. A rate of 25% was reported for bedrail restraint. Risk assessments had been completed and records of decisions regarding the use of bedrails were available and subject to review. Chemical restraint was not reported, however, in a sample of medicine administration records reviewed, the inspector confirmed some use of p.r.n. medicines (a medicine only taken as the need arises). Staff and management were required to review practices in association with their policy in this regard.

Training to ensure staff had up-to-date knowledge and skills, appropriate to their role, to respond to and manage responsive behaviour was a requirement from a previous inspection that was not fully addressed.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and

protected.

Theme:

Safe care and support

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

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

Findings:

The centre had policies and procedures in place to ensure that the health and safety of residents, visitors and staff were promoted and protected. A risk management system and register was in place which assessed identified risks, and outlined the measures and actions in place to mitigate and control such risks. An up-to-date health and safety statement for 2017 was also available. However, as indicated in outcome 2, the arrangements for emergency call facilities and associated procedures in the event of aggressive or violent episodes required review in line with regulation 26. The risk of staff without relevant training that were rostered to work together was communicated to the person in charge for response.

Hazard identification and assessment of risks were found to be required in relation to communication systems and the emergency response procedures in areas where residents had responsive behaviours and aggressive behaviour. The risk and appropriateness of using the porch of Dr. McGarry ward corridor as a smoking area was required to be assessed to ensure adequate controls were put in place. An incident stating that a resident did not return to the centre from an outing and was located in the town was not reported or considered to be an unexplained absence. This incident should be reviewed with regard to regulation 26.

Reasonable arrangements consistent with the national guidelines and standards for the prevention and control of healthcare associated infections were in place. Staff had access to handwashing facilities and sanitisers at the entrance and in corridors. Staff and visitors were seen using these on entry during the inspection. The standard of cleanliness throughout the centre was excellent.

Arrangements were in place in relation to the servicing of fire safety equipment, emergency lighting and alarm systems at appropriate intervals. Fire exits were checked and in the main were unobstructed with suitable means of escape for residents, staff and visitors.

As previously mentioned, the arrangement of a resident smoking in a porch that was a designated emergency exit route required review. The recent completion of an enclosed garden adjoining the Monsignor Young unit with a locked gate with no easily accessible key to unlock it and exit and absence of an emergency key at the internal fire exit door (replaced on inspection) leading out of the identified fire exit to the enclosed garden required review and was responded to immediately during the inspection. Staff in this unit, and management, were unclear if the designated fire exit was to be used in an emergency.

The inspector reviewed the fire drill records available and spoke with a number of staff and found that all staff had not completed fire safety training, participated in a simulated fire evacuation drill or received formal induction to safety procedures.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

Suitable arrangements were in place to ensure each resident's wellbeing and welfare was maintained by a high standard of nursing care and appropriate medical care and allied healthcare.

From an examination of a sample of residents' records and care plans and discussions with residents and staff, the inspector found that the nursing and medical care needs of residents were assessed and appropriate interventions and or treatment plans were implemented accordingly.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained and shared between providers and services. A selection of care records and plans were reviewed.

An assessment prior to a resident's admission formed part of the centre's admission policy and practice. Documented assessments of activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep, were maintained. Social and recreational assessments and plans were also completed in the sample reviewed. 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. The development of care plans was carried out in consultation with residents or their representatives and information received on admission. Each resident's care plan was subject to a formal review at least every four months.

Palliative care services were available but not in use by any resident at this time. Equipment such as syringe drivers for symptom control was available. There were two residents that had pressure ulcers, one was healing and the other was attributed to vascular disease and preventive interventions were in place. Access to a tissue viability nurse was available locally, as well as a range of other allied healthcare professionals and the community psychiatric team.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:
Effective care and support

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

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

Findings:

The centre was built in 1841 and has been used as a care facility since 1928 and extended in the 1970's and 1998. It is a two-storey building and in addition to the residential centre the building accommodates a day hospital, outpatient departments and an attic conversion which were not used by residents of the centre, but a common main entrance is used to access all services.

The age and layout of the building presented significant challenges to supporting residents' needs. The Inspector found that while the physical environment has been improved greatly and reconfigured to enhance personal space and facilities, it did not fully comply with regulatory requirements and standards. This has been well documented, reported and acknowledged by the provider following previous inspections. The premises consisted mainly of ward-type accommodation and the physical environment was limited in achieving the aims and objectives as set out in the statement of purpose, and of a home. Plans to complete a new build by 2021 that would accommodate residents was proposed and the existing residential parts of the centre may be operated entirely for short stay care or primary care services.

The centre's registration to accommodate a maximum of 85 residents expires in June 2018. Following the reconfiguration of wards within the premises, the centre now had capacity to accommodate a maximum of 46 residents within three ground floor areas identified as Dr. McGarry ward, Sheemore ward and Monsignor Young Unit. The unit on the first floor (Rivermead Unit) was vacant. Plans to provide a short stay service in this

unit were under consideration but it was to be excluded from the registration of the designated centre.

As a result of the re-configuration of Sheemore and Dr. McGarry wards and the exclusion of Rivermeade Unit on the first floor as part of the residential centre, there was a significant reduction in resident numbers. Since the previous registration inspection in March 2015, Dr. McGarry ward had reduced occupancy from 20 to 14 and Sheemore ward had reduced occupancy from 20 to 14. Entry and exit to both wards and the units was key-code controlled.

The Monsignor Young Unit remained unchanged and is an 18-bedded unit catering for residents with dementia. The unit consists of seven small single rooms, three-three bedded rooms and one two-bedded room. All shared bedrooms were en-suite and two sets of independent cubicle style toilet and shower facilities were available to others. These were identifiable by red doors and signage, but signage was positioned high and required reviewed. This unit had separate sitting and dining rooms and a spacious room dedicated for palliative care had been completed to facilitate a resident and their family.

Sheemore layout comprises two single rooms (13.8m² -14.7m²) and five 'cubicles'. Three 'cubicles' had two beds and two had three beds with call-bells, curtain screening around each bed and a wash hand basin per 'cubicle' and bedroom. Adequate support equipment was available to residents, and independent sanitary facilities had been provided to meet resident numbers and dependency and were completed to a high standard.

Dr McGarry layout comprises three single rooms (8.9m² -14.7m²) and five 'cubicles'. Three 'cubicles' had two beds and two had three beds with call-bells, curtain screening around each bed and a wash hand basin per 'cubicle' and bedroom. Adequate support equipment was available to residents, and independent sanitary facilities had been provided to meet resident numbers and dependency and were completed to a high standard.

Significant improvements to the décor of resident bedroom accommodation, sitting and dining rooms and sanitary facilities were noted in Dr. McGarry and Sheemore wards. However, while staff interactions and care practices promoted privacy, further improvements were required to promote resident privacy and dignity in bedroom (cubicle) areas in both wards. Beds were visible along open corridors by those passing through the wards. Discussions in relation to screening and partitioning cubicles from corridors were on-going and to be decided.

In addition, due to the previous culture and practice of residents sitting at or by their bed, more encouragement to meet in communal areas for social engagement away from the bed area was required. For example, the sitting room in Sheemore ward had been closed off from the entrance corridor which greatly improved resident privacy and facilitated engagement and activity without disruption by those entering or exiting. While its size could not accommodate all 14 residents, it could facilitate more than the two residents seen using it, and the newly created quiet room at the other end of ward could cater for others. The quiet room was equipped with activity items and had a table in the centre. However, it was used as a storage room and was cluttered with three

large modified chairs and hoists, limiting its use as intended.

Similarly, the newly refurbished assistive bathroom in Dr. McGarry had excess equipment such as seated weigh scales in addition to the new and necessary assistive equipment including a 'ruby shower trolley' and a supine shower trolley. A review of storage and safety arrangements in Sheemore unit was required to ensure the security of the linen room where residents' excess clothes were stored. This room was unlocked and accessible to the public despite having a main key lock and individual lockers within. These findings were brought to the attention of management for response.

The focus of achieving the condition of registration relating to the reconfiguration of wards seemed to detract attention from the premises of Monsignor Young Unit. Many areas of the environment and premises required improvement such as the layout of beds, bedroom furniture, and the restriction of access to communal bathroom facilities for the majority of residents as a result of one resident's behaviour. The management of responsive behaviour and activity or stimuli in this busy unit, where up to 18 residents of varying dependency and age were accommodated, was not optimal and required review in accordance with international averages (12 or less). This is discussed further in outcome 7.

The refurbished wards had new call-bell facilities and they were mostly made up of an open plan ward layout with 'cubicles' that enabled passing supervision and communication. However, there were no call-bell facilities or appropriate communication methods seen in Monsignor Young Unit, and the person in charge and person participating in management (management) were unaware of this during our walk around. This is discussed further in outcome 2. Improvements were also required in relation to communication systems and emergency response procedures in this unit where residents had responsive behaviours and aggressive behaviour. This is discussed further in outcome 8. The Inspector was told that some staff carried their own personal alarm and others showed the inspector a whistle that they carried and used to alert other staff that they needed assistance. This practice and system was not known to management also and the lack of emergency call facilities in this unit has been highlighted in previous inspections.

Hand rails were available in circulating corridors and grab-rails were in place in communal bathrooms. Security locks in locker compartments and privacy locks on bathroom and toilet doors were also seen in the re-configured wards. Colour contrasting fittings in sanitary facilities were in the refurbished wards but not noted in the bathrooms inspected in Monsignor Young Unit which was a dementia specific unit.

It was evident that the focus of upgrading and reconfiguring the Sheemore and Dr. McGarry wards had detracted from the maintenance of Monsignor Young Unit which was in need of repair and refurbishment. Management told the inspector that a plan to paint and upgrade this unit was in place and to be carried out but a time frame was not known. A review of the maintenance arrangements and improvement in recording and report systems was required. The inspector noted a metal cover over a shower waste of a bedroom en-suite and a malodour from a room. Management followed up on this during the inspection and later informed the inspector it had been a temporary measure that was to be addressed.

Loose wiring was also noted over the double doors at the rear entry and exit of Monsignor Young Unit. The inspector also found floor cover staining around toilets, paint chipped and architrave damage, an out-of-service panel system (that gave an impression that rooms were linked to alarm devices which were not available) and gaps under doors to the main building in need of attention.

The absence of a complete set of bedroom furniture for each resident in the unit was noted such as no bed table or arm chair. The layout or position of beds and furniture out of reach or outside screened space required review and it was unclear to management as to why it had been set out like this. The view directly into residents' bedrooms and bed spaces from outdoor areas and internal courtyards required review to ensure suitable privacy arrangements were in place. During the inspection privacy curtains were put in place along the corridor of a ward to promote privacy for residents in the open plan 'cubicles' who could be seen when the inspector was walking outside towards the main entrance of the centre.

Overall, much improvement was found with the reduced occupancy following the refurbishment of communal and bedroom areas and upgrading the décor and facilities in Dr McGarry and Sheemore wards. Male and female residents were integrated and accommodated in each ward area which was a change from previous inspections. But inherent and ongoing privacy deficiencies in the design and layout highlighted above and previously remained. Significant improvement in the layout, décor and maintenance management of Monsignor Young Unit was also needed.

A sheltered outdoor sensory garden with seating, benches and water features was available centrally within the main building and outside of the wards. This facility provided good outdoor space for the residents to use with support and assistance, dependent on their abilities. The use of this area was to be explored for one resident being facilitated by staff and management to smoke within the porch area of Dr. McGarry ward as this arrangement was not suitable. This is discussed further in outcome 8. All residents, regardless of their medical condition, have access to outdoors can enjoy the sensory garden. There was an enclosed adjoining garden with pathways and attractive plants and features recently completed. This was accessible via a main sitting room and fire exit door, as well as an internal courtyard within Monsignor Young unit that had raised planters, including lavender. The addition of hens and their coop as well as the centre's pet dog was enjoyed by many residents. Residents also had a church within the hospital building which was available to all residents for prayer, services and reflection.

There was a shop which included a coffee dock and snacks which was available to both the residents and their families. Additionally the canteen onsite is open to residents and their families for food and refreshments daily. Kitchenettes on wards also carried a stock of snacks and had provisions for hot and cold drinks at all times.

Funding approval, a commencement date and a time-bound plan and date for the 'New Replacement Community Hospital' to be completed by the end of 2021 remains outstanding.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

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

Findings:

The action required from the previous inspection in relation to the maintaining records of feedback given to complainants was followed up .

This had been addressed in complaints management at unit level; however, further improvement was required in relation to the communication of complaints between management and staff of Monsignor Young Unit when received directly by them.

Staff were not aware of an active complaint relating to a resident in their unit and a summary or copy of the complaint was not shared with relevant staff to investigate, affect change and implement improvements locally. This is included in the action plan of outcome 2.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

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

Findings:

The action required from the previous inspection was followed up and found to have been completed.

Arrangements had been put in place for residents of Monsignor Young unit to be informed and consulted when changes were made to the room they were accommodated in. Changes did occur on occasion, primarily to facilitate end-of-life care.

A room dedicated for end of life and palliative care was available in Monsignor Young Unit that could facilitate the resident and family to stay within it.

Staff told the inspector that residents on wards would be accommodated in the single bedrooms available. Information in this regard took place on admission and consultation with residents or family was carried out when necessary.

Improvements related to promoting residents' privacy and dignity in wards is reported in outcome 12.

Judgment:
Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

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

Findings:

The inspector found there were sufficient staff levels and skill-mix on duty during the inspection to meet the healthcare needs of 40 residents. One resident was in hospital and there were five vacancies. Four vacancies were in Monsignor Young Unit and one in Dr. McGarry ward.

Residents' dependencies were determined using a validated assessment tool. Thirty nine residents were assessed as maximum dependency and one was rated as high dependency. Staff dedicated to support daily social activities for residents of the centre were not included in the whole time equivalent numbers to promote engagement and social inclusion, and to encourage residents away from their bed spaces as referenced in outcome 12.

Some staff working in the centre had rotated from other areas or transferred from other

services and centres. The use of agency staff was observed as a weekly requirement to fulfil staffing requirements. Staffing numbers, training, experience and skill-mix required review due to training gaps found and incidents occurring that is discussed here and in outcomes 2, 7 and 8.

During the inspector observations, the role and functions of the staff member identified as providing one-to-one support was unclear. The associated care plan was also unclear. Additionally some staff wore uniforms and others did not which might complicate matters for residents. An initiative to move away from using uniforms was highlighted by management and was being resisted by staff for various reasons that required follow-up by management.

Staff training and development was reviewed. A staff training programme was in place and a record of training for staff was made available. Relevant training was completed by some staff that included care for residents with dementia, medicine management, nutrition, end of life, responsive behaviours, infection control and health and safety. However, gaps were found in mandatory training such as moving and handling, fire safety, safeguarding, responsive behaviours and PMAV, first aid and cardio pulmonary resuscitation (CPR) training for some staff, and this was communicated to the person in charge for response.

Staff files were not examined on this inspection. The person in charge provided an assurance to check the availability and completion of Garda vetting for all staff.

The inspector was told that there were no volunteers involved in the centre. A declaration that all staff working in the designated centre is required along with the action plan response to this inspection report.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St Patrick's Community Hospital
Centre ID:	OSV-0000661
Date of inspection:	24/10/2017
Date of response:	7/12/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Confirmation of funding approval with a time bound plan/date to include the commencement date of the 'New Replacement Community Hospital' by the end of 2021 remains outstanding.

1. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient

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

resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

The design team for the new unit is appointed and has been working on the Stage 1 report which will be ready for consideration by National Director of Estates in the coming weeks.

The project is planned to form part of a bundle of PPP projects countrywide and Estates recently advertised for the overall PPP design team/ technical advisors on the tenders. The exact time-frame for development at Carrick On Shannon will be agreed in conjunction with all the other developments in the PPP process.

Attached is the draft emerging plan of the new unit for information, this is subject to discussion with the service and County Council and is by no means the completed design, merely a feasibility report.

The flood mitigation measures required at the site are still a major risk to the project and will have to be agreed with the Co Co before proceeding to the next stage.

Proposed Timescale: 30/06/2018

Theme:

Governance, Leadership and Management

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

The annual review of the quality and safety of care provided completed in October 2017 reflected recent findings rather than an annual overview of key performance indicators.

2. Action Required:

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

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

The Provider Nominee has reviewed the format of the Annual Review and is implementing the HIQA annual Report to include the recommendations from the inspector.

Proposed Timescale: 30/11/2017

Theme:

Governance, Leadership and Management

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

Gap in the reporting structures, audits and incident management systems found

required improvement to ensure all incidents were sufficiently monitored and escalated to inform improvements..

Oversight arrangements required improvement to ensure adequate investigation and review following incidents and accidents.

Incidents of aggression and violence were high and staff had not completed suitable training for their role and responsibility.

Management were not aware of the lack of emergency call facilities in Monsignor Young unit and did not demonstrate sufficient knowledge of the arrangements in place,

Management and staff were not fully informed of behavioural changes in residents, fire safety procedures and management arrangements necessary to promote a safe service.

The management of responsive behaviour in association with the activity/stimuli levels in the dementia unit where up to 18 residents of varying dependency and age were accommodated required review in accordance with international averages (12 or less).

Some staff working in the centre had gaps in their induction, appraisal and training (discussed in outcome 18) and were unfamiliar with emergency procedures.

Changes in management, staff resources, resident numbers and accommodation had occurred, however, the culture of the organisation was slow in making progress.

Difficulties were encountered by management in relation to changes in policy and practices proposed. The Inspector was told of a reluctance by some staff in the implementation of policies such as safeguarding which compromises resident safety.

The refurbishment of wards had not been completed by December 2016 in accordance with the condition of registration.

Management were to review the admission criteria for resident accommodated in the dementia unit where all other residents were over 65 years.

An active complaint under investigation was not communicated to relevant staff to affect change, review practices or implement improvements locally.

A declaration that all staff working in the designated centre had Garda Vetting was required along with the action plan response to this inspection report.

3. Action Required:

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

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

1. Registered Provider has monthly Quality & Risk meetings with all Persons in Charge. The Person in Charge has reviewed the reporting system and changes have been made

to improve the reporting system. The Person in Charge (PIC) and the Assistant Director of Nursing (ADON) Person Participating in Management (PPIM) have developed a new reporting, recording and review document which record's the issues of concern raised during the daily ward rounds by the PIC . Communication processes are now streamlined between CNM's Quality & Safety Group and the daily unit rounds.

2. Additional PMAV training sessions and Safeguarding of Vulnerable adults training sessions are scheduled for the first quarter of 2018.

3. The existing staff security system/emergency call facilities in Monsignor Young Unit are being repaired and will be used by all staff to ensure their safety.

4. The service need for Dementia beds in Sligo/Leitrim indicates all 18 beds available are needed to meet the current service need. The new build plans include two 10 bedded units for those with dementia in line with international averages (12 or less).

5. All new staff will complete an induction programme prior to commencing their first shift in the designated centre. All new staff will be given dates for mandatory training when they commence employment in the designated unit.

6. All residents have a pre admission assessment carried out prior to admission to determine if the designated centre can cater for their needs. These may include MDT meetings with the resident and their family. Independent advocates for the resident may also attend.

7. The active complaint under investigation has been communicated to relevant staff to affect change/review practices or implement improvements.

Proposed Timescale:

1. A new reporting, recording and review document was introduced. Completed 30th November 2017.

The structure of the meetings between the Nurse Management, the CNM's and the Quality and Safety Meetings has been re structured: Completed 30th November 2017

2. PMAV training sessions and Safeguarding of Vulnerable adults training sessions are scheduled for the first quarter of 2018. To be completed by 30th June 2018

3. Security System/emergency call facilities in Monsignor Young Unit will be repaired. To be completed 31st December 2017

4. The New Build will include two 10 bedded dementia units in line with international averages (12 or less). Time frame to be determined by based on outcome of the tender process

5. A new induction programme will roll out from 30th November 2017. To be completed 30th November 2017

6. Further MDT to be held 2nd week of December to review the appropriateness of the resident placement in unit to the dementia unit. To be completed 31st December 2017

7. The staff have been given a copy of the complaint under investigation and the an update on the investigation to date.: Completed 30th November 2017

Proposed Timescale: 30/06/2018

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Chemical restraint was not reported and seen used in a sample of medicine administration records reviewed.

4. Action Required:

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

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

The daily physical restraint document now includes a section on chemical restraint. It includes the date, time, drug dose, method of administration. These will be entered into the quarterly reports on the HIQA Portal

Proposed Timescale: 30/11/2017

Theme:

Safe care and support

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

All staff did not have up-to-date training to ensure they had sufficient knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. This was a requirement from the previous inspection that was not fully addressed.

Responsive behaviours and episodes of aggression and violence between residents and towards staff was evident and on-going.

5. Action Required:

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

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

PMAV training has been completed by some staff currently working in the designated centre. Training sessions are planned for the first quarter 2018 with priority being given to nursing and HCA Staff who still have to complete training.

Proposed Timescale: 30/06/2018

Theme:

Safe care and support

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

Measures and arrangements of 'one to one' staff was unclear as incidents of aggression and violence had occurred and re-occurred when one to one provisions were in place.

Ensure adequate responses and safeguarding measures are in place to ensure no delays in investigation, treatment or interventions re-occur.

6. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

All staff that have not completed PMAV will have completed the training by 30th June 2018. The CNM's during their unit meetings with staff will ensure staff are informed of the outcomes of the CNM meetings, Quality and Safety Meetings and the Hospital Safeguarding meetings and understand the rationale for the use and removal of all one to one supervision plans. Each unit has a communication book for staff to update themselves and to read minutes from meetings relevant to their unit.

Proposed Timescale: 30/06/2018

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Risk assess the adequacy of emergency arrangements in place. A lack of emergency call facilities and associated procedures adopted by staff in the event of aggressive or violent episodes required review and assessment.

Staff were without relevant training and were rostered to work together posing a risk. This was communicated to the person in charge for response and assessment.

A risk assessment of using the porch of Dr. McGarry ward corridor as a smoking area was to be assessed to ensure adequate controls were put in place.

An incident stating that a resident did not return to the centre from an outing and was located in the town was not reported or considered to be an unexplained absence should be reviewed with regard to regulation 26.

7. Action Required:

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

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

1. All staff who have not be completed PMAV will have completed the training by 30th June 2018.
2. The existing staff security system/emergency call facilities in Monsignor Young Unit is being repaired and will be used by all staff to ensure their safety
3. A review of all mandatory training has taken place and staff have been made aware that all training should take place in the rolling timeframe period and not in the calendar year. CNM's and all managers have been provided with a copy of the mandatory training records and will receive monthly updated training logs and will roster staff to attend training within the timeframe to ensure compliant.
4. The smoking area has been decommissioned as no longer required and the designated centre and the surrounding hospital is a Tobacco free Campus. All potential residents will be informed that the designated centre and the surrounding hospital is a Tobacco free Campus prior to them taking up residence.

Proposed Timescale:

1. All staff in the designated centre to have completed PMAV training by quarter 30th June 2018.
2. Security System/emergency call facilities in Monsignor Young Unit will be repaired. To be completed 31st December 2017.
3. A record of the Training log was given to CNM's and all managers to enable them to roster staff to attend training within the timeframe to ensure compliant. Completed 30th November 2017
4. Decommission of smoking area: Completed 30th November 2017.
5. Statement of Purpose to include section stating the designated centre and the surrounding hospital is a Tobacco free Campus. To be completed 31st December 2017

Proposed Timescale: 30/06/2018

Theme:

Safe care and support

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

The arrangement of a resident smoking in a porch that was a designated emergency exit route required review.

The enclosed garden adjoining the Monsignor Young unit had a locked gate with no easily accessible key to unlock it.

Staff in this unit, and management, were unclear if the designated fire exit was to be used in the event of an emergency.

8. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

1. The smoking room has been decommissioned, the designated centre and the surrounding hospital is a Tobacco free Campus. All potential residents will be informed that the designated centre and the surrounding hospital is a Tobacco free Campus prior to them taking up residence and this will be documented in the Residents Guide and the Statement of Purpose.
2. The Fire Safety Officer has conducted an inspection of the designated centre on Thursday 30th November and advised on how to safeguard and provide security to those residents with dementia from wandering out of the unit while providing a safe exit in the case of a fire.
3. Fire drills carried out monthly both day and night. All staff are aware what doors are fire exit doors and what doors to be used as the route of evacuation in the event of a fire.

Proposed Timescale:

1. Decommission of smoking area: Completed 30th November 2017
2. The lock on the gate is now a combination lock. Each member of staff on duty carries a key ring with keys to all the locked doors and a tag with the code for combination lock for the gate. Completed 30th November 2017
3. Instructions and guidance from the Fire Officer to ensure the unit is compliant with Fire Regulations. To be completed 31st December 2017

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

Some staff had not completed fire safety training, had not participated in a simulated fire evacuation drill or received formal induction to safety procedures in this centre.

9. Action Required:

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

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

All staff who has not attended fire training have been rostered to attend the next fire training session in 8th December 2018. All staff have been made aware that fire training must be completed within the rolling 12 month period and not the calendar year. All CNM's and managers have been provided with a copy of the mandatory training log and they will roster staff to attend training within the rolling 12 months. Fire drills both during the day and the night will be carried out monthly and submitted to the Nursing Office for review. Any areas of concern will be identified and actioned.

Proposed Timescale:

All staff will have completed fire training and be compliant by 8th December 2017 for the rolling year 2017. To be completed 31st December 2017

All CNMS and Managers have received a copy of the mandatory training log allowing them to roster staff to attend fire training within the rolling 12 month period. Completed 30th November 2017

Proposed Timescale: 31/12/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Monsignor young unit was in need of repair and refurbishment and a review of the maintenance arrangements was required as follows:

- A metal cover over a shower waste of a bedroom en-suite and a malodour from the room
- Loose wiring was also noted over the double doors at the rear enter/exit of Monsignor Young unit
- Floor cover staining around toilets,
- Paint chipped and architrave damage
- An out of service panel system that gave an impression that rooms were linked to alarm devices and were not available
- Gaps under doors to the main building were noted for attention.
- The absence of a complete set of bedroom furniture for each resident in the unit was noted such as no bed table or arm chair, and the layout or position of beds and furniture was out of reach or outside the bed screening space which was unclear
- The view directly into residents' bedrooms/bed spaces from outdoor areas and internal courtyards required review to ensure suitable privacy arrangements were in place.
- There were no call-bell facilities or appropriate communication methods seen in Monsignor Young unit, and the person in charge and person participating in management (management) were unaware of this during our walk around.

A review of storage arrangements throughout was required to ensure communal facilities were not obstructed,

The security of the linen room used for the storage of excess residents property required improvement.

Wards did not have separate sitting and dining rooms.

Optimum use of existing spaces and rooms could be improved.

The quiet room was used as a storage room and was cluttered with three large modified chairs and hoists, limiting its use as intended.

Further improvements were required to promote resident privacy and dignity in bedroom (cubicle) areas in both wards.

Beds were visible along open corridors by those passing through the wards.

10. Action Required:

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

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

1. The Person in Charge is currently completing a business case for painting of the Monsignor Young Unit to support a more Dementia Friendly environment. This will include repainting of the unit, and replacing damaged flooring in the bathroom and toilet.
2. The existing staff security system/emergency call facilities in Monsignor Young Unit is being repaired and will be used by all staff to ensure their safety and the display panel is being repaired.
3. The gaps between the doors connecting Monsignor Young Unit and the hospital were addressed in 25th October 2017.
4. The absence of complete set of bedroom furniture for each resident has been addressed.
5. All staff have been made aware of the importance of ensuring that residents have their items including bed tables and chairs within their reach.
6. Curtains have been ordered for all residents' room that are overlooked.
7. The Person in Charge is currently reviewing the research available to ascertain the most suitable call system for a dementia unit.
8. The Person in Charge, ADON and the CNM's has reviewed the storage areas for equipment. Staff have been made aware of the importance of storing equipment in the correct spaces. The Person in Charge and the ADON to monitor the storage of equipment on their daily rounds and address immediately with staff on duty. The CNM's to monitor their units and ensure excess equipment is not stored at unit level.
9. Staff have been made aware of the importance of protecting the residents belonging and ensuring that the linen room in Sheemore Unit is locked.
10. Following a meeting with the residents they have decided to call the "cubicles" "suites" and they have decided on the type of partition they want. Fire officer has advised on the appropriate materials.

Proposed Timescale:

1. The painting and replacement of floor covering in areas where required in the Monsignor Young Unit to completed by 30th June 2018.
2. The Security System/emergency call facilities in Monsignor Young Unit will be repaired and in use from 31st December 2017
3. The gaps between the doors connecting Monsignor Young Unit and the hospital were addressed. Completed 25th October 2017.
4. All residents have a complete set of bedroom furniture: Completed 25th October 2017
5. The Person in Charge and the CNM's to monitor that all residents have access to their belongings and personal items at all times. 25th October 2017
6. Curtains have been ordered and will be in place by 31st December 2017.
7. Decision on the most suitable call system to be made and plan of installation in place by 30th June 2018.
8. The Person in Charge and the ADON to monitor the storage of equipment on their daily rounds and address immediately. The CNM's to monitor their units and ensure excess equipment is not stored at unit level. 25th October 2017
9. The Person in Charge, the ADON and the CNM's to monitor the linen room door. Monitoring System in place since 30th November 2017.
10. The partitions in the suites to be in place by 30th June 2018

Proposed Timescale: 30/06/2018

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Staffing numbers, training/experience and skill mix required review due to training gaps found.

The role and responsibilities of a staff member providing one to one was unclear.

Staff dedicated to support daily social activities for residents were not included in the whole time equivalent numbers.

11. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

1. A review of the training records took place in November 2017. The Person in Charge

is working with the Practice Development Co ordinator to agree dates for additional training to ensure all staff have the necessary training.

2. Staff have been made aware that training is within the rolling period and not the calendar year. Following national agreements all staff will now undertake Safeguarding Vulnerable Adults training.

3. All staff have been made aware of the outcomes of the Hospital Safeguarding meetings and the rationale for one to one supervision.

4. The CNM's are rostering HCA's daily to provide social activities for residents and this is to be reflected in the daily allocation documentation.

The Register provider is confirming that all staff working in the Centre are Garda Vetted and that the centre is working with the Data Controller to ensure where staff Garda Vetting needs to be reviewed that this is completed in a timely manner

.Proposed Timescale:

1. Review of the training logs and action plan in place to ensure the CNM's and Managers know when to roster staff for training. 30th November 2017

2. Safeguarding of Vulnerable adults training sessions are scheduled for the 2018. To be completed by 30th June 2018

3. The CNM's during their unit meetings with staff will ensure staff are informed of the Hospital Safeguarding meetings and understand the rational for the use and removal of all one to one supervision plans. Each unit has a communication book for staff to update themselves and to read minutes from meetings relevant to their unit.

Completed 30th November 2017

4. The CNM's are rostering HCA's daily to provide social activities for residents and this is to be reflected in the daily allocation documentation. Completed 30th November 2017

Proposed Timescale: 30/06/2018

Theme:

Workforce

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

Gaps in staff mandatory training such as moving and handling, fire safety training, safeguarding, responsive behaviours/PMAV, first aid and cardio pulmonary resuscitation (CPR) for some staff was found.

12. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

A review of the training records has been undertaken by the Person in Charge and a training plan is currently being developed in association with the Practice Development Co ordinator. Dates have been given to staff for fire safety training, cardio pulmonary resuscitation (CPR), PMAV and safeguarding vulnerable adults.

Proposed Timescale: 30/06/2018

Theme:
Workforce

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

Some staff rotated from other areas or transferred from other services and centres had not completed a formal induction to this centre.

13. Action Required:

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

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

All new staff will complete an induction programme prior to commencing their first shift in the designated centre. All new staff will be given dates for mandatory training when they commence employment in the designated unit. Induction Programme developed by Person in Charge and the Practice Development Co ordinator .

Proposed Timescale: 30/11/2017