Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Leopardstown Park Hospital
Name of provider:	Leopardstown Park Hospital
Address of centre:	Foxrock, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	03 March 2021
Centre ID:	OSV-0000667
Fieldwork ID:	MON-0032152

About the designated centre

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

The centre provides care for adults who have long term needs for residential care. The centre provides services for residents with low dependency through to those residents who are maximum dependency and require full time nursing care, including care for residents who have dementia and for residents who need end of life care. Accommodation is provided across eight units. Clevis unit has 29 beds and provides accommodation and services for residents who have low dependencies. The unit is located in a period built house and separate from the main hospital premises. The other seven units provide accommodation and services for residents with higher levels of need and are located within the main hospital building. Enniskerry has 13 beds, Kiltiernan 14 beds, Kilgobbin 13 beds and Tibradden 12 beds. Three of these units have two single rooms and the fourth unit, Kiltiernan has three single rooms. The remaining accommodation is provided in a nightingale type open ward with five bay areas accommodating two or three residents in each bay. Glencullen and Glencree commonly known as the Glens units are more recently built and provide accommodation for 27 residents on each, in a mix of single and multi-occupancy rooms. Djouce unit provides accommodation and services for eight respite residents and two long term residents in a mixture of single, twin and multi-occupancy rooms. Each unit has its own shower rooms and toilet facilities, most of which are wheelchair accessible. Communal dining rooms are available on all units, and in addition Djouce unit and the Glens have separate communal lounges. There are garden areas to the front and rear of the property with seating available for residents. There is a large car park to the front of the building with some disabled parking spaces available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	107

How we inspect

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
Wednesday 3 March 2021	07:45hrs to 17:15hrs	Siobhan Nunn	Lead
Thursday 4 March 2021	09:00hrs to 17:30hrs	Siobhan Nunn	Lead
Thursday 18 March 2021	09:00hrs to 14:30hrs	Siobhan Nunn	Lead
Wednesday 3 March 2021	09:00hrs to 17:15hrs	Michael Dunne	Support
Thursday 4 March 2021	09:00hrs to 17:30hrs	Michael Dunne	Support
Wednesday 3 March 2021	07:45hrs to 17:15hrs	Susan Cliffe	Support
Wednesday 3 March 2021	09:00hrs to 17:15hrs	Helen Lindsey	Support
Thursday 18 March 2021	09:00hrs to 14:30hrs	Helen Lindsey	Support
Thursday 4 March 2021	09:00hrs to 17:30hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

The overall feedback from residents was that they were happy with the care they received from staff in the designated centre. They expressed their preference to have more space to store their belongings in private, and were missing contact with their families and friends. Inspectors observed that areas of the centre were in poor repair and that the layout of the units prevented many residents from fulfilling their rights to enjoy daily activities in private and exercise choice over their environment.

This was an unannounced risk inspection in response to a COVID-19 outbreak and to follow up actions from the previous inspection. The inspection was completed over a three day period. Inspectors spoke in detail with twenty eight residents during that time.

A number of residents said that they were happy with the care they received, and that staff worked hard to keep them safe during COVID-19 outbreaks in the centre. Residents expressed sadness at not being able to receive visits from family and friends due to COVID-19 restrictions. Residents spoke about having to share wardrobe space and said that they would prefer to have their own wardrobes which would enable them to keep their clothes completely separate. In one room a chair had to be moved to allow residents to gain access to their wardrobe. Inspectors observed that a number of en suite bathrooms did not have separate storage space for resident's to store toiletries.

There were some single rooms where residents were able to spend time privately and make choices about their activities and how they wished to spend their time in private without impacting on others in the centre. However with the exception of the Clevis Unit and Djouce unit which was unoccupied at the time of the inspection the layout of most of the accommodation did not allow residents to live their lives privately, which is a key component of their human rights.

Inspectors observed that in the nightingale wards the residents did not have privacy, and were impacted by other people in their bedroom space. There was insufficient space behind some curtains for two staff to provide personal care as the curtains did not meet. Therefore it was possible to see the resident receiving care in their bed. On the third day of inspection, inspectors noted that there were unpleasant smells associated with the provision of personal care throughout one of the nightingale wards.

There was significant noise created by the daily activities being delivered in the nightingale wards. For example, staff were providing individual care to residents and talking to the residents and their colleague about the care being delivered. This discussion could be overheard by others in the ward. The light in the room streamed in through large windows. While there were blinds to reduce the glare, the majority of blinds were opened in the morning, so the light level was increased in the whole

area, causing residents to wake up.

Inspectors observed periods of time where there were radios, televisions, conversations and vacuuming taking place, while other residents were sleeping. Activities were being provided for residents who were up in the morning in the bedroom area, which disturbed those who were relaxing by their beds, or trying to sleep. When asked why the communal area was not used, staff said they usually didn't use the room until the afternoon. The communal areas in the nightingale units were observed to be laid out in an institutional manner, with comfortable chairs lined up against windows on one side of the room and wheelchairs lined up against the windows on the opposite side of the room. This area was not configured to produce a homely environment in which residents could choose to relax while looking out on the gardens, watching television, chat together or engage in other activities.

In two nightingale units windows were frosted on the bottom third of the window so residents could not see out. Saloon doors on two toilets could not be locked and needed repair. Bedroom areas appeared clinical and were not personalised and the nurses' station was located in the middle of the bed spaces. When inspectors returned on the second day of inspection, it was noted that, following feedback to the provider, two residents had moved in to single rooms, and therefore were afforded more privacy.

Examples were seen where the privacy curtains in some shared bedrooms were positioned so that they reduced residents access to communal parts of the room, to natural light, and also to the en suite facilities, again this was impacting on residents privacy and ability to make choices about how they spent their time.

Inspectors concluded following these observations that there were institutional practices ongoing in the centre, which impacted on the quality of the residents lives**.** While the provider had been given this feedback over repeated inspections, there had been little improvement in the lived experience of the residents.

Inspectors observed staff interacting with residents in a friendly and caring manner during lunch, and providing support to residents with their meals. The serving of breakfast was observed by inspectors on two units. On one unit a resident asked for ''coffee and toast'' and had to repeat the request several times before the items were provided after 40 minutes. On the second unit delays were not observed as the unit had additional staff undergoing training, who were available to assist.

Activities were being provided in some units that were interesting to residents, and they appeared to be engaged and enjoying themselves. However, inspectors observed a number of residents, with the highest number of examples in the nightingale units, where they spend significant time in bed, or by their bedside with little or no social interaction, other than the daily activities going on around them. One resident said the felt they were 'forgotten'. There were televisions in communal areas and by some beds, but some residents did not have access to a television. The provider had also made tablets available to support video calls to families and friends. Inspectors observed that any calls made in communal areas could be

overheard, and so could not be made in private.

Inspectors noted there were a number of residents with different cultural backgrounds. The knowledge of staff about residents varied greatly. Following a review of documentation and speaking with staff it was evident that residents' first language, religion and preferred activities were not known in all cases. In some cases the staff were not aware of the detail in individual records and there was insufficient information recorded in other records.

Overall residents quality of life was impacted negatively by their environment and the institutional practices observed. Residents stated that staff on the ground were excellent and could not do enough for them. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered**.**

Capacity and capability

Insufficient resources were available to repair and improve the living space provided for residents. Resources had not been made available to action ongoing plans to replace existing buildings. Although monitoring systems were in place gaps were identified by inspectors in arrangements for medication management, infection prevention and control, complaints, training, residents possessions, premises and visiting. Inspectors found that there were clear lines of accountability and responsibility within governance and management arrangements, including for the prevention and control of healthcare-associated infection at the centre. Although the systems and structures were in place the majority of residents continued to live in an institutionalised environment which did not enhance their wellbeing.

The registered provider is the Board of Leopardstown Park Hospital. At the time of the inspection the Board had finished on the 4th September 2020 and a new board was in the process of being appointed. The day-to-day management of the centre was overseen by the CEO and organised by the PIC (person in charge) who was assisted by an assistant director of nursing and senior nurses.

The designated centre was experiencing an ongoing outbreak of COVID-19 which was notified to the Chief Inspector on the 7th December 2020. Sadly six residents passed away. They had experienced a previous outbreak between April 2020 and mid June 2020.

Inspectors identified some examples of good practice in the management of COVID-19. The outbreak had so far been contained within two units. However, despite local infection control efforts the outbreak had continued since early December 2020. Senior management reported that they had acted to implement Public Health recommendations. Inspectors were informed that while the outbreak had not been formally declared over by Public Health there were no active cases of COVID-19 and

transmission based precautions had been removed on the second day of the inspection.

Inspectors reviewed actions required from the previous inspection and found that improvements had been made in staffing. A full complement of staff was in place and a management rota had been developed to inform staff of the management support available each day. Staff worked hard to support residents despite the restraints of the physical environment in the designated centre, and the restrictions required to prevent the transmission of infection. Gaps in mandatory training were identified by inspectors, which occurred as a result of COVID -19 restrictions. Most staff were knowledgeable about the assessed needs of residents although improvement was required by some staff in their knowledge of the needs and preferences of non-Irish residents.

A number of actions related to premises remained incomplete. Although the number of beds in each bay of the nightingale units had been reduced to 2 by the third day of the inspection, the area had not been reconfigured to allow residents to enjoy the extra space in private or to increase their storage facilities. There continued to be insufficient storage in the Glens, as equipment was stored in residents communal bathrooms.

There was a comprehensive programme of audits carried out at regular intervals to monitor the quality and safety of care delivered to residents. Results were reported to a number of board sub-committees, however a number of concerns identified by inspectors had not been identified or addressed by these systems. For example the management of covert medication, inadequate storage of personal possessions and the needs of non-Irish residents. Infection prevention and control audits covered a range of topics including donning and doffing PPE and hand hygiene. Audits of compliance with COVID-19 guidelines were also undertaken.

A comprehensive complaints procedure was in place and residents reported that they were happy to speak to staff if they had any concerns.Staff were aware of their responsibilities in relation to the management of complaints however improvement was required in the the completion of records relating to the outcome and satisfaction levels of complainants.

Regulation 15: Staffing

The designated centre had a sufficient number and skill mix of staff to meet residents' assessed needs. There were at least four nurses on duty in the centre at all times. A rota was reviewed which detailed CNM and person in charge (PIC) cover at all times.

The staff team included allied health staff who were available to assess residents and provide guidance to the nursing and care teams in relation to mobility, food and nutrition, equipment and communication strategies.

The centre had a fixed number of agency staff employed to supplement the permanent staff team and they also employed a bank of staff to cover when needed. Improvements had been made with regard to lunch time staffing. Inspectors observed that there were sufficient staff available to assist residents with their meals.

Judgment: Compliant

Regulation 16: Training and staff development

A number of staff had received post graduate infection prevention and control qualifications. Inspectors were informed that online infection prevention and control training was supplemented by face to face training sessions in the centre. Additional training for staff in response to the COVID-19 pandemic had also taken place.

A training matrix was in place showing all the mandatory and relevant courses completed by staff. However in the records reviewed there were some gaps in mandatory training. Documentation reviewed indicated that the 2020 training schedule had not been completed due to the impact of COVID-19. However in the records reviewed, there was some gaps in mandatory training, including safeguarding training.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not made resources available to ensure that residents had suitable accommodation and facilities to meet their individual and collective needs. The proposal to replace existing buildings continued to remain at the development stage where it has been for a number of years. There were no timescales for the work to commence although new premises would make a marked improvement in the lives of residents in the designated centre.

Deficits in the upkeep of existing buildings were identified by inspectors, including mould on the walls of a storage room, a number of damaged surfaces and a bedpan washer which was broken for over 3 months. Residents continued to require adequate facilities to store their personal belongings. Resources had not been made available to maintain residents living areas appropriately. There was no clear plan to achieve compliance with the Health Act 2007 (Care and Welfare of residents in designated centres for older people) (Amendment) Regulations 2016 S.I. 293.

Although management systems were in place to monitor services, improvements were required in medication management, oversight of staff training and complaints.

An annual review of the quality and safety of care was completed in 2020, which included the results of a survey in which 67 residents participated. The management response and actions required as a result of the feedback from the survey were not documented.

Judgment: Not compliant

Regulation 34: Complaints procedure

Notice boards throughout the centre displayed details of how to complain and residents said that they would talk to staff if they had a complaint. The complaints policy was reviewed in November 2020 and contained guidance for staff about the different stages of the complaints procedure and their role.

Electronic recording of complaints had commenced in 2019 in order to centralise information and make it more accessible to staff. A review of fifteen closed complaints by inspectors revealed that five had gaps in recording outcomes and satisfaction levels.

Judgment: Substantially compliant

Quality and safety

Residents living in the nightingale units and the multi occupancy rooms experienced a poor quality of life due to the impact of the environment on their lived experience and due to institutional based practices which often reduced residents ability to exercise choice in their daily lives.

While some residents were satisfied with their accommodation, and were engaging in meaningful social activities, and making choices about their lives, this was not the case for all of residents in the centre. Inspectors observed institutional practices, and a lack of privacy and choice for residents in many areas of their daily lives. These issues had been raised with the provider over multiple inspections since 2017 but there was little improvement for residents, especially in the nightingale units, and are described in detail under the previous section 'what residents told us and what we observed'.

Storage facilities for residents living in the nightingale units were found to be inadequate.The lack of storage facilities meant that residents could only store a minimum of their personal items. For example the single bedrooms in the nightingale units provided wardrobe storage space of only 12 inches in diameter. While residents accommodated in the multi-occupancy bays did not always have their own personal storage facilities within easy reach and had to rely on staff to

access items for them.

In shared bedrooms storage facilities for residents clothes were also found to be inadequate as wardrobes did not allow for the separation of one resident's clothes from another. There was insufficient space available for residents to store their personal items as inspectors noted a resident storing their personal items in a bag at the side of a wardrobe. Inspectors found other examples where the location of seating hampered residents from accessing their clothes as other resident's chairs were placed in front of their wardrobe doors.

Discussion with staff and review of documentation showed that weekly COVID-19 management team meetings were convened to advise and oversee the management of COVID-19 at the centre. Staff were assigned to different zones in the building and there were additional measures in place to ensure staff minimised their movements around the centre in order to reduce the risk of spreading infection between units. Overall equipment and the environment in the units inspected were generally clean with some exceptions.

Although measures were in place to protect residents from COVID -19, improvements were required to ensure that residents quality of life was enhanced and their wishes respected,at the time of the inspection window visits were not being facilitated.

The centre also had a number of effective assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists, the use of colour coded cleaning cloths. Overall equipment in the units inspected were generally clean with some exceptions. However further improvements were required in respect of premises and infection prevention and control, which were interdependent. For example there was a lack of appropriate storage space in the centre resulting in the inappropriate storage of equipment. Barriers to effective hand hygiene practice were also identified during the course of this inspection.

Inspectors observed food served to residents at breakfast time and during a lunchtime meal service. Residents were provided with food and drink adequate for their needs however a review regarding the serving of food during breakfast time was required. This was to ensure residents received a choice of meals and that they were sufficient numbers of staff available to provide this support. Residents were seen not to be offered sufficient choice during a breakfast service for example not all residents were offered a choice of boiled eggs or coffee despite these food being available. Tea and toast were observed to be prepared up to one hour before some residents received their breakfast. Some residents were offered tea only once while others mentioned it was lukewarm. A review was also required to ensure the dining experience for residents in the nightingale units is one where there is a relaxed atmosphere and takes into account residents privacy and dignity requirements.

Care plans describing residents food and nutrition requirements were based mainly on residents medical needs with input sourced from relevant professionals. Inspectors found however that there were no alternative food choices available for

resident's from different cultural origins. Inspectors were informed that residents were now more familiar with a western diet but noted that from time to time family members did bring in food that was consistent with the residents origins. While the majority of end of life care plans reflected the wishes of the resident and described in detail end of life interventions, some care plans did not give sufficient detail regarding the religious needs of residents who were from a different cultural origin.

Overall resident healthcare needs were well managed with timely referrals made to specialist services when required. There was evidence of audit and monitoring to ensure healthcare services met the needs of the residents although inspectors noted that one resident using specialist equipment had yet to have this equipment reviewed to ensure that it still met their requirements. Some documentation required improvement such as the formulation of care plans to describe resident medication routines where medication was administered via a covert route.

A team had been established to address concerns of abuse when they arose within the designated centre. A representative from human resources, social work and management reviewed allegations of abuse and ensured that action was taken to protect residents when required. Good links had been established with the local safeguarding team and the local Gardaí which facilitated easy access to advice and support, when dealing with concerns.

In some areas of the centre there was a developed activities program, and staff were seen leading residents in games, music sessions, and social history discussions. There were examples of activities programs in place, and the art classes continued to be popular with resident art displayed proudly through the centre.

There were residents meetings, lead by the social worker. Records showed that the format and timing of the meeting were being reviewed to ensure it was accessible to as many residents as possible. There was access to independent advocacy, this was advertised through the centre, and the social worker was able to give information directly to residents.

Regulation 11: Visits

Staff worked hard to assist residents to maintain contact with their family and friends by facilitating phone and video calls, reading cards and letters from loved ones and helping residents to write letters. After Christmas arrangements were made for families to have limited visits on compassionate grounds and records of visitors were maintained for the purpose of contact tracing.

The centre’s visiting policy was updated in October 2020 and thus did not reflect the Health Protection Surveillance Centre’s visiting guidance which was published in December 2020. Window visits were not taking place at the time of the inspection.

Judgment: Substantially compliant

Regulation 12: Personal possessions

The layout of a number of multi-occupancy rooms and bays located in the nightingale units meant that not all residents could gain access to their personal belongings and possessions. While the provider had made some changes to the layout of the nightingale units by reducing the number of residents from three bedded bays to two there was no improvement seen for residents regarding the availability and access to appropriate storage facilities.

A number of shared wardrobes were present in double rooms which resulted in residents being unable to store their belongings separately. Inspectors observed en suite bathrooms where individual storage units were not available for residents to store toiletries discreetly.

Judgment: Not compliant

Regulation 13: End of life

Residents who were on an end of life pathway had comfort measures in place to ensure that their particular care needs were met. Daily care records reflected the monitoring of residents' symptoms and treatments offered. Compassionate visits were arranged where appropriate with family members supported to visit residents. There was communication seen where relatives were engaged concerning care interventions for residents who were deteriorating. Arrangements for anticipatory prescribing were in place and there was evidence of communication with the community palliative care team for timely intervention. Records seen confirmed that CPR (Cardio Pulmonary Resuscitation) and DNAR (Do not attempt Resuscitation) documentation were in place and were reviewed by appropriate personnel on a three monthly basis.

Whilst the majority of end of life care plans reflected the religious needs and interventions for individual residents, improvements were needed to ensure that the religious needs of residents from a different culture were appropriately met.

Judgment: Substantially compliant

Regulation 17: Premises

The physical layout of the nightingale units created an institutional environment in

which residents wellbeing could not be enhanced. The occupancy of these units had been reduced to 2 residents per bay, but the area required reconfiguration to allow residents to benefit from the additional space.

A number of maintenance and infrastructural issues were identified which had the potential to impact on infection prevention and control measures. For example;

- Some surfaces, finishings and furniture was worn and poorly maintained and as such could not be effectively cleaned.
- Facilities for and access to hand wash sinks in the areas inspected was inadequate. For example access to some hand hygiene sinks was obstructed by beds. Wall mounted soap dispensers were not available at all sinks. Outlets of the majority of hand hygiene sinks appeared unclean.
- Sealant between some sinks and walls was not intact which did not facilitate effective cleaning.
- Inspectors were informed that the bedpan washer on one unit was out of order since December 2020. Following manual cleaning a bedpan viewed was visibly unclean. Inadequate disinfection of bedpans increases the risk of cross-infection.
- Storage space was limited. As a result there was inappropriate storage of equipment, clean and sterile supplies throughout the centre.
- Staff changed in a room used to store clean supplies and equipment on one unit inspected, resulting in a risk of cross contamination.

Judgment: Not compliant

Regulation 18: Food and nutrition

Food was prepared in the designated centres kitchen which was located a significant distance from resident's accommodation. All meals were transported to residents' units in heated container's (bain marie) via a mechanical transporter.

A lunch time meal service in one of the centres dining rooms was seen to be well managed with sufficient numbers of staff available to support residents to enjoy their meal. The menu of the day was advertised in the dining room on a whiteboard and on tables with residents were seen to be offered a choice of meal. The dining experience was a pleasant one for residents with many residents indicating that they found the food tasty and well prepared. The layout of the nightingale units however meant the dining experience for residents in these areas was less pleasant. For example there was communal noise which filtered through the unit and did not provide for a comfortable dining environment.

The menu was seen to operate on a four week cycle with food and nutrition oversight provided by a nutritional committee with input from dietitans and the speech and language therapist. There was a policy and procedure in place to guide staff towards ensuring residents were provided with good nutrition and adequate

fluids. There was evidence of menu choices however, on some days the choice was very limited. For example an apple desert was served three different ways.

Adequate staff are required for the breakfast meal service, to ensure that food is served freshly, including tea and toast. An improved choice of food needs to be provided for residents at breakfast time on a daily basis.

Whilst there was good overview of food provision from a medical perspective, inspectors did not find that residents' cultural needs received the same input. This will be explored further under regulation 5, individualised assessment and care plan.

Judgment: Substantially compliant

Regulation 27: Infection control

- Staff had been trained on infection prevention measures, however inspectors observed that personal protective equipment such as gloves were used inappropriately by staff during the course of the inspection. For example gloves were not removed immediately after providing care to residents.
- A staff member was observed applying alcohol hand gel to their gloves. Gloves should be treated as single use items and discarded after use.
- A staff member was observed washing a resident's glasses and disposing of a soft drink down the hand wash sink. Hand hygiene sinks should be dedicated for hand hygiene only.
- A staff member was observed attending to a resident without first performing hand hygiene. Effective hand hygiene minimise the risk of infection between a healthcare workers, residents, and the environment.
- The centre had introduced a tagging system to identify equipment and areas that had been cleaned however, this system had not been consistently applied at the time of inspection. For example the date on a sticker outside one resident's rooms indicated it had been cleaned two weeks ago.
- A cleaning trolley viewed had dirt embedded in the crevices. Equipment used for cleaning should not contribute to dispersal of dust or micro-organisms. Inspectors were informed that new cleaning trolleys were being procured.
- The covers of several foam mattresses and pillows were worn and cracked. These items could not effectively be decontaminated between uses, which presented an infection risk.
- Spare moving and handling slings were hung on the back of doors in dirty utility rooms which posed a risk of contamination.
  The kitchen on one unit was unclean. Ingrained dirt was observed on the floor and under appliances. The crevices of cupboards and the surround of the milk dispenser were not clean.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors observed a resident receiving crushed covert medication on the first day of inspection. On review of the documentation the decision to administer medication in this way was not recorded and there was no information about how the arrangement was to be reviewed. Staff were unable to explain the process by which the covert medication had been started or the review procedure in place to monitor the arrangement. In the course of the discussion staff identified another resident who had a similar arrangement and inspectors found that evidence of decision making in this case was also absent.

In discussion with managers on the third day of inspection a request had been sent on the 4th March to medically review the covert medication arrangements but this had not been completed.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were based on a comprehensive assessment of resident's needs. They were generally well constructed and were supported by validated risk assessments however, some care plans did not adequately address the social and cultural care needs of all the residents in the centre. The formulation of care plans to guide staff address residents' cultural needs in a more holistic manner required review to ensure that their specific needs were met.

There was evidence of regular review and monitoring to ensure that care plans were updated on a regular basis. Inspectors found that not all residents had a care plan in place for assessed interventions for example 2 residents who were in receipt of covert medication did not have a care plan in place for this intervention.

Judgment: Substantially compliant

Regulation 6: Health care

The provider ensured that residents had access to a range of primary, specialist and allied health professionals to maintain residents health care needs. A range of in house services included physiotherapy, dietetics, occupational therapy and speech and language therapy. A medical officer attended the centre Monday to Friday with psychiatry of later life input provided by a geriatrician based at a local hospital. Other services such as chiropody and optical services were accessed through

community referral.

Resident healthcare records indicated that where specialist intervention was sought and received that his was recorded accurately in their care notes. Residents who lost weight during the pandemic were provided with post COVID-19 rehabilitation input with an additional dietetic service covering an extra two days per week.

Residents had their medication reviewed on a regular basis and there was evidence of regular reviews carried out internally by the occupational therapist and physiotherapist. Inspectors noted that a review for a resident using specialist equipment was required to ensure that it still met their needs.

Judgment: Compliant

Regulation 8: Protection

The safeguarding policy was reviewed in July 2020 and the PIC and social worker were nominated as designated officers for safeguarding within the designated centre.

Inspectors reviewed records of three concerns of abuse that had been notified to the Chief Inspector. The allegations had been investigated appropriately and protective action had been taken.

Judgment: Compliant

Regulation 9: Residents' rights

For many of the residents in the centre, their rights were not being fully upheld.

- The provider had not ensured that the centre was being operated to ensure residents racial origin, cultural and linguistic backgrounds were being identified and catered for. For example staff had incorrectly assumed a residents religion and their preference in music.
- Due to the layout of a number of bedrooms, including the nightingale wards, not all residents could undertake activities in private
- Due to the lack of personal space for some residents, they were not able to communicate freely and privately
- Where residents were exercising choice in multi-occupancy rooms this was having a detrimental impact on other residents, specifically in relation to noise levels that could not be controlled by the other residents impacted

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Leopardstown Park Hospital OSV-0000667

Inspection ID: MON-0032152

Date of inspection: 18/03/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The designated center moved to a blended, including online, mandatory training program during the pandemic, this allowed us to continue staff training, all be it at a reduced capacity for face to face training. Mandatory training such as BLS was extended by 12 months by the training provider, therefore while our records may have shown BLS expiry for a number of staff members, their training date had been extended. We have now updated our training metrics to reflect this. As part of the staff training and development plan, the PIC & PPIM in conjunction with the mandatory training group will continue to review the ongoing provision and uptake of mandatory training. Day to day oversight of the designated centres training programmes is provided by senior nursing managers and the HR department who monitor attendance.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A review of the nightingale units is underway, with a view to best utilize additional space created for residents. Extensive resources €1.5 million was spent on maintenance in 2020 in relation to day to	

day maintenance, projects and fire safety systems and resources will continue to be made available for maintenance.

The maintenance team in conjunction with IPC and housekeeping are conducting regular site walk arounds to identify any areas that may not have been reported, to facilitate prompt immediate action.

A maintenance committee is in place, they report into the IQS Committee.

Action plan for medication management, training and complaints please see relevant regulation.

A clinical audit group has been established to ensure oversight of all reviews and audits carried out and to ensure documentation is available to demonstrate required actions are ongoing or completed.

The design team is at stage 2B with an imminent planning application for 125 bed development.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The centre's complaints policy is written in accordance with the HSE Policy "Your Service, Your Say". The Complaints Procedure is displayed prominently throughout the service and the PIC & PPIM will continue to ensure that residents and their representatives are aware of how to make a complaint.

The PIC & PPIM will continue to acknowledge all complaints promptly, investigate them thoroughly and respond to a complainant as soon as possible within a designated timeframe.

The PIC & PPIM will continue to ensure that the complainant is aware of the procedure and named person to appeal to if they remain dissatisfied with the original response.

All complaints received are logged onto the electronic care record. This facilitates real-time complaints monitoring and reviews, which are regularly undertaken by the PIC.
The reference to gaps in complaints records have been resolved and the PIC has confirmed that the specific records referenced in the report are compliant with the regulations.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
The Designated centre has at all times complied with HPSC and public health visiting guidelines. Following a review and risk assessment carried out in line with HPSC guidance it was identified that the layout of the designated centre does not allow for visiting at windows while still allowing for privacy and dignity of all residents.

Suggestions of specific areas for window visiting made by the inspectors were reviewed, however the utilisation of these suggested areas would have breached fire safety regulations.

The PIC & PPIM will continue to review visiting arrangements in conjunction with Covid contingency planning and any updated guidances issued.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
A full review of storage requirements will be undertaken. This will include consultation with residents through the use of a satisfaction survey, individual discussions and it will be scheduled as an agenda item at the next Residents' Forum meeting in June 2021.

We are in process of reviewing all multi-occupancy rooms and this will include storage requirements or access to personal possessions within bedrooms. Additional wardrobes have already been provided in the nightingale areas.

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
A review of all end of life care plans has taken place. 3 care plans identified during inspection have been updated.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A review of the nightingale units is underway, with a view to best utilize additional space created for residents.

The maintenance team in conjunction with IPC and housekeeping are conducting regular site walk arounds to identify any areas that may not have been reported, to facilitate prompt immediate action.
A maintenance committee is in place, they report into the Integrated Quality Safety & Risk Committee.

The design team is at Stage 2B with an imminent planning application for 125 bed development.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Residents are consulted with and offered a choice of food. Residents of differing ethnic origins are catered to with a varying menu including the addition of herbs and spices to their meals. The PIC in conjunction with catering, dietetics and speech & language therapy will continue to review resident menus.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The PIC & PPIM have an agreed updated audit programme in place for infection prevention and control. The infection prevention and control policy has been updated as part of routine review of policies and is under continuous review in line with emerging recommendation.

Specific cleaning schedules are in place for all parts of the premises with safety data sheet (MSDS) for all environmental cleaning products and manufacturer's instructions for preparation of cleaning and disinfectant solutions. Some cleaning trolleys have been replaced as planned in March 2021.

Signage on hand washing sinks has been updated. Hand washing sinks are now easily identifiable.

All staff have completed training in Hand Hygiene, PPE Donning and Doffing and breaking the Chain of Infection. Staff supervision is in place to ensure training is implemented in practice and adherence to infection prevention and control policies by staff.

A separate area has been identified for the storage of moving and handling equipment.

Following a review of the mattresses and pillows; a replacement schedule has commenced in consultation with the PIC & PPIM to replace mattresses and bedding as required.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The care plans have been updated to reflect accurately the rationale for either covert or crushed medications. Training has been provided to staff and will be on going as required.

An audit programme has been agreed for both covert and crushed medications. A review system is now in place at all resident Interdisciplinary Team meetings to assess, plan, implement and evaluate the use of covert and/or crushed medications. The Community psychiatric team and or Geriatrician are also consulted where appropriate.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The 3 residents within the centre who have a less common cultural background have had care plans reviewed and updated as required, taking into account their personal preferences regarding their cultural needs.

The care plans have been updated to reflect accurately the rational for either covert and/or crushed medications. Training has been provided to staff and will be on going as

required.

An audit programme has been agreed for both covert and crushed medications. A review system is now in place at all resident IDT meetings to assess, plan, implement and evaluate the use of covert and or crushed medications. The community psychiatric team and or geriatrician are also consulted where appropriate.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Care plans have been updated to give further additional information relating to the 3 residents cultural linguistic needs and to enhance further the existing care plans.

A review of the nightingale units is underway, with a view to best utilize additional space created for residents.

The design team is at stage 2B with an imminent planning application for 125 bed development.

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 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	31/12/2021
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in	Not Compliant	Orange	27/05/2021

	particular, that a resident uses and retains control over his or her clothes.			
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	27/05/2021
Regulation 13(1)(b)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the religious and cultural needs of the resident concerned are, in so far as is reasonably practicable, met.	Substantially Compliant	Yellow	26/03/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	26/03/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Not Compliant	Orange	27/08/2021

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	31/12/2023
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	26/03/2021
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	13/05/2021
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	06/08/2021
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Orange	26/03/2021

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	27/08/2021
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 resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	26/03/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which	Substantially Compliant	Yellow	26/03/2021

	includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	26/03/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate	Substantially Compliant	Yellow	26/03/2021

	that resident's family.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	05/03/2021
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	05/03/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	05/03/2021
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	26/03/2021
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure	Not Compliant	Orange	31/12/2021

	that a resident may undertake personal activities in private.			
Regulation 9(3)(c)(iii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident telephone facilities, which may be accessed privately.	Not Compliant	Orange	31/12/2021
Regulation 9(4)	The person in charge shall make staff aware of the matters referred to in paragraph (1) as respects each resident in a designated centre.	Not Compliant	Orange	07/03/2021