Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	St Oliver Plunkett
Centre ID:	0539
Centre address:	Dublin Road
	Dundalk
	Co Louth
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Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive (HSE)
Person in charge:	Kay O'Keeffe
Date of inspection:	15, 16 and 17 February 2011
Time inspection took place:	**Day 1 Start:** 12:00 hrs **Completion:** 19:15 hrs **Day 2 Start:** 09:00 hrs **Completion:** 17:30 hrs **Day 3 Start:** 09:00 hrs **Completion:** 17:10 hrs
Lead inspector:	Siobhan Kennedy
Support inspector:	Sonia Mc Cague
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☐ **Follow up inspection** ☒ **Announced** ☐ **Unannounced**

About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice - this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

Registration inspections are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of the duty is a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, the report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.

About the centre

Description of services and premises

St. Oliver Plunkett Hospital is operated by the HSE. It is a single-storey building that opened in 1987. Accommodation is available for 92 residents in four separate units. It provides respite, convalescent, rehabilitation and palliative care (long and short term) to older persons in the Louth region assessed as requiring general nursing and/or dementia care.

With the exception of the laundry service (which is located in a building outside the centre) all other general services, for example, office accommodation, dining room and kitchen are found in close proximity of the main entrance to the centre and the reception area. From this area residents' bedrooms and communal facilities are located via corridors in three units referred to as "wards". Two wards, St Cecelia's and St Patrick's accommodate female residents. St Joseph's ward is for male residents. Each ward has 25 beds. In the main, bedroom accommodation in the wards consists of six four-bedded rooms and either one or two single bedrooms. The centre of each ward has five single toilets, a bath and shower room, a serving kitchen, a cleaning store, a sluice room and a linen store. Communal areas are combined sitting and dinning space two of which are open plan. A nurse's station is found at the entrance to each ward. An adjoining corridor to the wards contains staff (male and female) changing rooms and treatment room. There are visitors' facilities including toilets and an oratory. A designated smoking room is available in St Joseph's ward.

A separate self-contained unit known as St Gerard ward has been established specifically for residents with Alzheimer's and dementia (in total 17 beds for male and female residents). Bedroom and communal accommodation is primarily located in three corridors. A fourth corridor is used mainly for storage with the exception of one bedroom used by a resident who accesses the dementia unit via a key pad code on the door. Bedroom accommodation is made up of six single rooms, one two bedded room and three rooms

with three beds. Many of the three-bedded rooms share toilets and wash hand basins. There is a large modern dining room, three communal day/sitting rooms, a hairdressing room, a sluice and cleaning rooms.

Enclosed gardens and court yards are available for use by residents, relatives and visitors. Car parking is available to the front, side and rear of the centre.

Residents have access to a medical officer, occupational therapy, physiotherapy, speech and language therapy, podiatry services, complimentary therapies, a hairdresser and chaplains.

St Ann's day hospital is available for use by residents from the centre. It has its own separate entrance located adjacent to the main dining room and the recreational room.

Location

St. Oliver Plunkett hospital is situated in the grounds of the Louth County Hospital on the Dublin Road which is within 10 minutes walking distance of Dundalk town centre.

Date centre was first established:	1987
Number of residents on the date of inspection	85

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	46	26	12	1

Management structure

Kay O'Keeffe, the person in charge, reports directly to an area coordinator for the HSE Dublin North East and subsequently to a local health manager, Brighide Lynch who is the nominated person on behalf of the provider.

The person in charge is supported in her role by a management team of two assistant directors of nursing and a team of clinical nurse managers each of whom supervise a number of staff nurses and care assistants. Catering, cleaning and administration staff report to the person in charge.

Summary of findings from this inspection

This was an announced registration inspection which took place over three days and was the third inspection carried out by the Authority. As part of the registration process, the provider has to satisfy the Chief Inspector of Social Services that he/she is fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

As part of the application for registration the provider was requested to submit relevant documentation to the Authority including completion of the Fit Person Self Assessment. The documentation was reviewed by inspectors to inform the inspection process. In order to assess the fitness of the provider and the person in charge, '"fit person" interviews were held. The inspection methodology also included discussions with residents, relatives, the provider, the person in charge, nursing, caring and catering staff, observation of care practices and examination of records and the premises.

The provider had applied to register the centre for 92 residents and at the time of this inspection, 85 residents were being accommodated. All residents were over 65 years of age.

The overall view of the inspectors was that the provider and person in charge had good knowledge of the relevant legislation and Authority's standards. They demonstrated that they had a clear direction for the service in that they had substantially reduced beds to provide additional space for each resident and had a commitment to continual improvement. The centre was well managed as in the main systems and practices were in place to manage risk and keep residents safe. A requirement made at the previous inspection about having in place all documents specified in the regulations for the persons working at the centre had been fully actioned.

Staff presented as a dedicated and commited team who had knowledge of residents' needs and implemented caring programmes to address these. On inspection, residents who communicated with inspectors conveyed that they received a good standard of service, appropriate care and were treated with courtesy and respect. Residents communicated with inspectors about the range of activities available and invited inspectors to view their extensive art work and meet the facilitator who was in the centre providing 'tai chi' sessions. Residents were complimentary in their comments on the quality of life within the centre. They also spoke positively about the management and staff team, referring to them as 'supportive' and 'helpful'.

Residents' health, personal and social care needs were assessed and reviewed on an on-going basis, within a care planning process that reflected a person-centred philosophy of care. Emphasis was firmly placed on health promotion, independence and meaningful activity.

The Action Plan at the end of this report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and the *National Quality Standards for Residential Care Settings for Older People in Ireland.* Primarily these related to the environment.

Residents' and relatives' comments

Individual questionnaires were completed by 34 residents and 35 relatives and forwarded to the Authority prior to the inspection. In addition, inspectors ascertained the views of residents and relatives during the inspection. These were highly complimentary of all aspects of care provided and the facilities and services. Residents were satisfied with the laundry service, the provision of new lockers for their clothing and the management of their finances and personal possessions.

Respondents reported that the person in charge and staff team were approachable and knowledgeable regarding residents' care and condition. Residents and relatives commented that staff were considerate and caring. In the main, staffing levels were considered satisfactory with the exception of two relatives who believed that the staffing levels on duty during the day and at night were not adequate particularly if there were staff members off on sick leave.

Residents considered that their health care needs were well addressed, for example, they knew that the doctor was present in the centre five days a week and could be contacted if medical attention was required. Residents and relatives confirmed that they had been consulted in relation to the provision of care planning. They were aware of the complaints policy and procedure and reported that communication within the centre was of a good standard. It was also reported that staff encouraged residents to be as independent as possible. Above all, those who contributed their views were enthusiastic about the creative art classes and the light physical exercise programmes. Relatives and residents were keen to talk to inspectors and show them the developments in the gardens and outdoor space which had been brought about by their involvement in the centre. Residents and relatives were able to attend parties and go to Mass together. It was evident from the views expressed that the centre was very much part of community life with lots of things going on.

Some relatives suggested that the flooring should be replaced in certain areas where it had become worn particularly in the one of the sitting rooms.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

During the fit person interview, the provider demonstrated that she had good knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

She has a background in nursing and over 14 years managerial experience in services related to the care of older persons. She has qualifications in health services management and was undertaking further training. She was very familiar with the centre as previously she was the Director of Nursing and has worked at a senior management level in the HSE since 2007. Although she was not involved in compiling the fit person self assessment form she had knowledge of the content of the document and during the fit person interview described the philosophy of care underpinning the centre and the different roles of the provider and the person in charge. She communicated the systems and processes in place to respond to requirements that may necessitate significant expenditure.

The person in charge, Kay O Keeffe had a minimum of three years experience in the area of geriatric nursing within the previous six years. She is a registered general and psychiatric nurse who worked full-time at the centre, had been in a managerial position in the centre since 2000, and had been in her current position since 2007. She has qualifications in management, psychology, pharmacology, coronary care nursing and clinical teaching. She stated that she had completed the fit person entry self assessment programme in consultation with staff and residents.

The action required from the previous follow up inspection had been addressed. The person in charge and staff team facilitated the inspection process by having documentation available for examination. The person in charge was aware of her obligations to maintain a record of all incidents occurring in the centre and to formally notify the Chief Inspector.

Inspectors interviewed Josephine Marron as she had been nominated to cover when the person in charge was absent. She demonstrated that she had the requisite knowledge

and skills to carry out the duties and responsibilities of the position. She is a trained nurse and had established good working relationships with staff and professionals.

Correspondence was received by the Authority dated 5 February 2010 from the HSE State Claims Agency confirming that appropriate insurance for the centre and residents was in place.

Inspectors examined the documentation held in respect of four staff working at the centre. This information was current and had been maintained in accordance with the relevant legislation.

The information referred to as the directory of residents was collated electronically. This was examined by an inspector and was seen to be in compliance with the relevant legislation.

Contracts of care were agreed with residents and those examined detailed the services to be provided for that resident and the fees to be charged.

A corporate risk management policy and procedure was available and covered the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm. It had been adapted to identify and asses the risks throughout the centre and a record was available of the precautions in place to control the risks. Staff were trained in this area and the risks that could not be resolved within the centre were referred to line management to be addressed. Records were clear and comprehensive. An example highlighted was the faulty dish washer. While this had been repaired on many occasions there were still difficulties and the provider had been alerted so that it could be replaced.

The plan for responding to emergencies was comprehensive. It covered systems failure in respect of electricity, water supplies and heating as well as a major incident. Staff had training in the moving and handling of residents. On inspection, some risks were identified and these are highlighted below.

Some improvements required

The statement of purpose was examined by inspectors. While it contained most information required by legislation, it omitted the number and the size of some of the rooms, details regarding some aspects of the premises which constituted the designated centre and clarification of the resident group.

Although the Authority received correspondence, dated 7 October 2009 from the fire safety engineer confirming that all statutory requirements relating to fire safety had been complied with, this did not meet the requirements of legislation.

Inspectors found that in the main adequate precautions had been taken against the risk of fire however; the following areas required further improvement:

- fire evacuation procedures were not conducive to safe evacuation as some of the signs /plans to be followed in the event of fire were not displayed in a prominent place,

- all staff were not clear regarding the numbering of residents' rooms as there were two sets of numbers on doors,
- contracted cleaning staff were not familiar with the evacuation procedures and
- a new fire alarm system had been installed however, many of the original directional signs which related to the decommissioned system had not been removed.

The corporate risk management policy and procedure had not been implemented throughout the centre as the following risks were identified on inspection. The hot water temperature was above the maximum temperature of 43°C. For example, inspectors recorded temperatures as high as 49.1°C in one of the bathrooms. In addition, the radiator temperatures were high and in one instance, inspectors recorded a temperature of 47.6°C.

Although a new residents' alarm call system had been installed it was not available in a bedroom (number 33), a combined bathroom and toilet (rooms 110 and 111) and in one of the shower rooms. Inspectors found that there were difficulties between the previous and current systems operating. In some parts of the centre when the system was tested by inspectors the light above the outside of the door lit up but did show up on the main panel which staff checked, or a flashing light was displayed but there was no audible sound to draw staff's attention. At some bedsides, the call bell was not working due to loose connections. The risk assessment for use of bed rails did not include the low lying position of the bed rails on the floor when they were not in use which presented as a trip hazard particularly in a bedroom (number 16).The doors of all of the facilities located in the central area of the wards opened out onto the corridor which posed a risk to residents when using the corridors. Two trolleys and equipment such as the blood pressure monitor were stored on the corridor and obstructed residents when using the handrails. Although the dishwasher had given considerable problems and had been alerted on the risk register it had not been replaced. A number of storage areas contained a variety of hazardous products and/or records and were unlocked.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

The provider and person in charge explained during their interviews that a person-centred approach to care was the philosophy and principle that underpinned the delivery of services at the centre. This was evident regarding the range and choice of opportunities and activities that were provided for residents to participate in.

A part time activity co-ordinator based in the day hospital provided a service to the wards and organised a monthly timetable of events in consultation with residents. A daily programme was displayed on each ward and residents chose the event they wished to attend. Activities were numerous, for example, music therapy, sing-a-long sessions, basketball, bingo, origami, hand massage and baking. Birthdays and other special occasions such as anniversaries were celebrated. There are two sensory/relaxation rooms and these were popular with residents. Residents were keen to tell inspectors about the yearly art exhibition where residents got the opportunity to display their creative pieces and to share the occasion with their friends and family members. On the day of the inspection volunteers were in the centre with a variety of dogs. This provided great excitement for residents. Inspectors also heard about an intergenerational project which ran during school term time in conjunction with one of the local primary schools. This involved children visiting on a monthly basis to provide entertainment and activities for and with residents. Occasional outings to local venues and special events in the community also took place. The centre has an oratory and two priests visited residents and celebrated mass three times a week. A Church of Ireland service was held once a week. Services are televised and relayed to bedrooms for those unable to attend in person. There was suitable private areas separate from residents' own private rooms for residents to receive visitors and a record of visitors was maintained.

Two trained advocates who form part of the "Nestling Project" visit the centre on a regular basis and arranged outings which helped to maintain contacts with the local community.

There were opportunities for residents and relatives to be involved in the running of the centre. A residents' and relatives' forum had been established. Inspectors read the minutes of some of the meetings and saw that the development of the gardens was as a result of these meetings. The chairperson of the relatives' forum took the opportunity to meet the inspectors and explained their role and involvement in fund raising which had

contributed to substantial environmental improvements in the centre, for example, the provision of new bedside furniture.

Many volunteers provided services to the centre. Inspectors found that those working in the centre were vetted appropriate to their role and level of involvement. Their roles and responsibilities were set out in a written agreement between the centre and the individuals.

There was a written operational policy and procedure relating to residents' fees and personal property and possessions which staff were familiar with and had implemented when managing residents monies. Records randomly selected were up to date. Residents had a secure facility where they could hold personal possessions safely.

A written operational policy and procedure on the handling and investigation of complaints was available. The procedure identified the key persons responsible for investigating residents' complaints and residents and relatives interviewed were familiar with the procedure which was advertised throughout the centre.

Inspectors saw that the lunchtime meal was nutritious and provided choices in relation to the main meal, deserts and refreshments with the meal. The food was well presented and in portions suitable to residents' appetite. The quality of food was described as "good" and there was extra food and/or supplements available daily. Fresh drinking water, milk and juices were provided to residents throughout the day and hot drinks were available between meals and on request. An environmental health inspection report dated 10 November 2010 was issued and an action plan had been drawn up to address the matters highlighted in the report. Non-compliant areas related primarily to food temperatures, staff training and the premises.

Some improvements required

All necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse were not taken in that contract cleaners who worked at the centre had not participated in on-site training in the protection of residents from abuse. Also inspectors observed practices where residents' safety could be compromised. For example members of a local community group using the residents' dining room accessed the centre via the residents' front door. The main entrance to St Gerard's ward (leading to a residents' private open plan sitting space) was used by staff coming to work in the centre and work men accessing the building.

Residents' right to privacy was not fully adhered to. The sitting rooms in two of the wards were open plan to a corridor at either end with the result that staff and members of the public walked through the residents' private sitting space to access the corridors.
and the curtains on the entrance to some of the multi occupied bed rooms and on the screens between the beds didn't close fully and/or were not hung properly. Some windows facing unto external public areas were insufficiently blinded.

Residents' right to choice was not protected in all circumstances. Residents who chose to have lunch in the centre's dining room had to vacate it by 13:15 hours as a local

community group of approximately 20- 25 persons used it during the week (up to 13.45 hours) for their meal. An inspector observed that a resident and her visitor who were having a late lunch had difficulty leaving the dining room due to the congestion.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an on-going basis, within a care planning process that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

There was an admission policy and procedure which was used by management to determine if the centre was suitable to meet the needs of prospective residents. It also assisted staff on duty who admitted residents to conduct the process in a comprehensive and respectful manner. Inspectors saw records confirming that on admission, residents' belongings were checked and recorded. There was a written operational policy and procedure on the temporary absence and discharge of residents.

Residents were facilitated to have good medical treatment. Care records showed that residents had access to a medical officer and their general practitioner (GP) on an ongoing weekly or as required basis. An on-call GP emergency service was also available. Allied Health Professional (AHP) services such as physiotherapy, occupational therapy, dietetics and chiropody were readily accessible. The day hospital service on site provided a good physiotherapy service to residents. Appointments and follow-up appointments were evident in the care plans.

Inspectors saw that there were systems in place to monitor and improve the quality of life and care provided to residents, for example, with regard to health care, rehabilitation and well-being. Individual assessments were carried out in respect of each resident regarding a number of health care issues for example continence, nutrition, accidental injuries, falls and pressure sores, moving and handling, and skin care. Documentation confirmed that these assessments were subject to regular review. Staff used validated tools to risk assess residents. For example, the Waterlow scale was used to identify the risk of developing pressure sores. Residents were weighed on a monthly basis, a record was maintained and appropriate action taken such as referral to the dietician with regard to undue weight gain or loss.

There was a written operational policy and procedure on the monitoring and documentation of residents' nutritional intake and the Adapted Nutritional Risk Assessment tool is used to risk assess their needs.

Inspectors reviewed a sample of residents' care plans. All the components of the care planning process were in place, for example assessment of needs, objectives of care and treatment plans. The information was relevant and up to date. The majority of residents and relatives confirmed in the written questionnaires that they were consulted with regard to the development and review of residents' care plans. The Authority had been appropriately notified of incidents, accidents and of any pressure area above grade 2.

Inspectors considered that the practices in relation to the management of medicines were safe. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines and staff were familiar with these. Practices were appropriate and suitable, for example, a record was made that medicines were administered, medicines returned to the pharmacy were recorded, all residents had photographic identification and there was evidence of reviews on a three monthly basis.

There was a health and safety statement for 2011 and some staff had been trained in this area and training in food safety was ongoing.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

Correspondence was received by the Authority dated 14 September 2010 from the HSE Estates manager confirming that the centre met planning and development regulations.

The physical environment was spacious, pleasantly decorated, and in the main well maintained. CCTV monitored the communal areas and points of entry and exit from the centre but did not intrude on residents' privacy. Some residents showed their bedrooms to inspectors. Many had availed of the opportunity to bring in personal belongings such as pictures, ornaments and photos. The recently developed outdoor spaces and gardens could be viewed from many parts of the centre including residents' bedrooms. They contained colourful shrubs, raised flowerbeds, garden ornaments, safe pathways, and patio furniture.

Some improvements required

Inspectors found that there were a number of aspects of the premises which were not in accordance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Some of the residents' bedroom accommodation did not meet the minimum 9.3 square meters usable floor space for example the measurements in five of the single bedrooms in the dementia unit were approximate 8 square meters and a single room in St Cecelia's ward measured 8.7 square meters. A number of beds were taken out of the multiple occupancy bedrooms in order to provide more space for residents. However, the overhead screens had not been removed and therefore the additional space was not fully utilised.

Inspectors observed that the centre's communal space was not used effectively in order to ensure compliance with the standards having regards to separate sitting, dining and recreational space for residents. Although there was a large dining room available, the majority of residents remained in the open plan sitting spaces in the wards to have their lunch time meal. There was only one dining table in the wards.

Inspectors found that some aspects of premises were not kept in a good state of repair. For example a shower and toilet room (number 38), was in need of upgrading. In one of the sluice rooms on the ward there was damage to a wall at floor level. There was no cold water in a cleaning room (number 75). Some wall and floor tiles were missing. Floor covering was missing or in need of replacement in certain areas throughout the centre for example in the residents' sitting room in the dementia unit, staff room, corridor, nurse's station and the entrance to St Josephs ward. The kicker board of the cupboards in the kitchen in St Patrick's ward was damaged. Cupboard doors were loose in a serving kitchen (number 86) and a sensory light did not come on when entering a bathroom. The locking system on some doors of toilets and bedroom did not operate and the doors to some shared toilets did not close fully. Some wardrobe doors did not close tightly and many did not have hand handles but had snib locks at the top of the door which were difficult for residents to reach.

In the main, there were good practices and systems in place to control infection however the following issues were identified; the laundry facilities which are located outside the main building were not clean and hygienic, some radiators had chipped paint and were rusted, floor tiles in bathrooms and floor mounted grab rails at toilets were rusted, linen skips were stored in some bath and shower rooms, the enamel was worn off the base and legs of bedside tables and new sinks had been installed but with in the existing wooden surround which was made of formica and in many instances this was worn down exposing the chip wood.

The paint work on the walls in many areas throughout the centre was not well maintained. This included for example, bedrooms where fittings and fixtures had been removed, wing A in St Josephs ward, areas where new lighting had been installed and walls which have been stained from the use of hand sanitizers.

There were insufficient numbers of wash hand basins in the centre for example in the hairdressing room, drugs room, a sluice room, in one of the wards and a four-bedded room.

A number of storage areas and the cleaning room contained a variety of hazardous products and were unsuitable for storage due to insufficient mechanical and /or natural ventilation. The sluice room in the dementia unit did not have mechanical ventilation and it was not possible to access the windows as these were located close to ceiling level. There was no natural ventilation in the hairdressing room and the fan was not working.

In the dementia unit the cleaning trolley was stored in the cleaning room and could only be accessed by going through the sluice room. There were areas of rust on the legs of the stainless steel sink/shelf.

A single bedroom in St Cecilia's was not prepared for occupancy as it was storing records.

The signage on toilet doors was not always accurate in that a designated female toilet was used by both male and female residents. A shower room was identified as a bathroom.

Externally the sensory light located at the entrance of the centre did not come on at night-time. The path around the centre had been poorly maintained, was uneven and had potholes.

Minor improvements required

Inspectors considered that the three wardrobes positioned in a row in the shared bedrooms were not easily distinguishable by individual residents.

There were no small tables for residents to set down their drinks.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and the informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

Inspectors examined the maintenance of records in relation to accidents/incidents. These contained relevant information regarding where and when the incident took place. The records were kept in a safe and secure place. Staff informed inspectors that they were made available to the resident to whom the records referred and were available for inspection and monitoring purposes in accordance with the regulations. Staff managing the records knew that they should be retained for a period of not less than seven years after the resident to whom they related to ceased to be resident in the centre.

There was a written and operational policy and set of procedures in respect of communication. The policy was descriptive regarding the methods employed to communicate with residents. The procedures highlighted the requirement that each resident should be facilitated and encouraged to communicate and that this was subject to ongoing assessment and review. There was information about general communications regarding the operation of the centre.

Inspectors found that there were many good practices in respect of the provision of information, which assisted residents and staff to be involved in decision-making. Notice boards were strategically placed throughout the centre, for example in the dining room, where residents could readily obtain information in relation to the menu.

The complaints procedure and general information were displayed on notice boards. This information was current and relevant to the areas where it was displayed.

Residents had access to a telephone which they could use in a private area. Inspectors were informed that letters addressed to residents were delivered on the day they were received and residents had been assisted to vote in previous elections. Residents had access to radio, television, local newspapers and could make a telephone call in private.

Inspectors observed staff taking time to communicate with residents speaking slowly and sensitively and repeating information to ensure that it had been understood. Inspectors also saw staff communicate with relatives and professionals, updating them on the residents' condition and health.

Good communication arrangements were in place with regard to ensuring the up to date health care needs of residents. This was conducted at “handover meetings” which took place when there was a change in the staff group.

There was a resident’s guide that included aspects of the statement of purpose a standard form of contract for the provision of services and facilities to residents, the most recent inspection report and the address of the Chief Inspector.

Some improvements required

A falls risk assessment in respect of one resident provided contradictory information. In addition, while the most up to date speech and language therapy guidance was on display for a resident and staff in the resident’s bedroom the previous one had not been removed.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

During the fit person interviews the provider and person in charge described the need to ensure that adequate staffing levels and skill mix were in place for the provision of good quality of care to residents. Overall, inspectors found high quality of care provided to residents from a motivated and dedicated staff team. A staff member told inspectors that she was able to influence the rota and request planned and emergency time off. Staff confirmed that good relationships existed between the various grades of staff and management and expressed their sense of satisfaction from working with residents and their families. Inspectors found staff to be well informed and knowledgeable of their roles and responsibilities. Residents were complimentary of the staff team and commented on their caring nature.

Staff confirmed that they felt encouraged and supported by the person in charge to carry out their work. Various methods for supervising different grades of staff were adopted by management. This entailed mainly observation and instruction.

In the main, staff members had access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

Records in relation to training were well maintained and provided evidence of staff attendance at training and the course content. Staff members were aware, commensurate with their role, of the provisions of the relevant legislation and Authority's standards, the statement of purpose and policies and procedures dealing with the general welfare and protection of residents.

There was evidence that all nursing staff had current An Bord Altranais registration.

Closing the visit

At the close of the inspection visit, a feedback meeting was held with the provider, person in charge and staff members to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

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

REPORT COMPILED BY

Siobhan Kennedy
Inspector of Social Services

Social Services Inspectorate
Health Information and Quality Authority

Date 18 March 2011

Chronology of previous HIQA inspection	
Date of previous inspection	**Type of inspection:**
19 - 20 October 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
13 July 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report

Centre:	St. Oliver Plunkett Hospital
Centre ID as provided by the Authority:	0539
Date of inspection:	15, 16 and 17 February 2011
Date of response:	08 June 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 *(*Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

1. The provider has failed to comply with a regulatory requirement in the following respect:

The corporate risk management policy and procedure had not been implemented /actioned throughout the centre as a number of risks were identified on inspection.

Action required:

1.1 Make sure that radiators have a surface temperature no higher than 43°C.

Action required:

1.2 Make sure that hot water is provided to a maximum temperature of 43° C.

Action required:

1.3 Ensure that the residents' call system is available to residents throughout the centre and in particular in bedroom (number 33), a combined bathroom and toilet (rooms 110 and 111) in one of the shower rooms and in the wards at all bedsides.

Action required: 1.4 Make sure that the risk assessment for use of bed rails includes the low lying position of the bed rails on the floor when they are not in use which may present a trip hazard particularly in bedroom number 16.	
Action required: 1.5 Ensure that the doors of all of the facilities located in the central area of the wards opening out onto the corridor do not pose risks for residents using the corridors.	
Action required: 1.6 Make sure that the corridors and residents' hand rails are not obstructed by trolleys or other items of storage for example blood pressure monitors.	
Action required: 1.7 Take adequate precautions regarding the storing of creams and hazardous lotions so that they are not in unlocked stores and rooms.	
Action required: 1.8 Replace the dishwasher.	
Action required: 1.9 Store hazardous products and records safely.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Action 1.1 A consultation process has taken place in conjunction with the maintenance dept. and radiators are now programmed to maintain a surface temperature of 43°C. An audit tool will be established to monitor the effectiveness of this system	 June 2011 June 2011

Action 1.2 A consultation process has taken place with the maintenance dept. to seek advice on addressing this matter and mixer taps have been recommended for all wash hand basins. We are currently awaiting quotes for this work. Monthly audits will be established to monitor the effectiveness of same.	June 2011
1.3 A quote has been received to extend the call bell system to the Dementia unit, and to all bathrooms & toilets & shower rooms throughout the centre. The maintenance dept. to remove old call bell system which has been decommissioned.	September 2011
1.4 The risk assessment for the use of bed rails has been revised to address the potential risk posed by the position of the bedrails on the floor when not in use The bedrail identified (Rm.16) by the inspector as a trip hazard was removed at the time of inspection. All new beds purchased recently and in the future will have integrated bed rails.	June 2011
1.5 No incidents have been reported in relation to this issue to date however, hazard signs have now been placed on all doors to address this potential risk.	June 2011
1.6 Reconfiguration of how equipment is stored is currently being reviewed by the ward teams and all staff have been advised of the importance of safe storage of equipment.	June 2011
1.7 All staff have been updated on the safe storage of creams/lotions. A locked cupboard has been provided for the storage of gloves & lotions in the toilet area in the Dementia unit.	June 2011
1.8 The dishwasher has been repaired and currently fit for purpose. Process is underway to obtain quotes for a new dishwasher and it has been addressed as a priority in the 2011 minor capital requirements.	June 2011
1.9 The cleaning staff have been updated on the safe storage of chemicals. A new lock has been provided on the internal door to the filing room.	June 2011

2.The provider has failed to comply with a regulatory requirement in the following respect: Adequate precautions had not been taken against the risk of fire.	
Action required: 2.1 Provide to the Chief Inspector written confirmation from a competent person that the centre complies with all the statutory requirements of the fire authority.	
Action required: 2.2 Display the procedures to be followed in the event of fire in a prominent place in the designated centre.	
Action required: 2.3 Make adequate arrangements for the evacuation of all people in the centre by having clear numbering on residents' bedroom doors. Ensure that all staff are familiar with the numbering system.	
Action required: 2.4 Provide suitable training for staff in fire safety and prevention including contracted cleaning staff.	
Action required: 2.5 Make adequate arrangements for the evacuation of all people in the centre by removing directional signs, which have been decommissioned.	
Reference: Health Act, 2007 Regulation 32: Fire precautions and records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 2.1 A Fire Risk Assessment will be carried out on the premises and following this a Fire Declaration will be signed off to confirm that the centre complies with all the statutory requirements of the fire authority. 2.2 The fire plans have been updated by the fire officer and the procedure	 July 2011 June 2011

to be followed in the event of a fire has been displayed in a prominent place in all wards and in the main reception area. 2.3 The door numbers in the dementia unit have been updated to correspond with the numbers on the fire plan 2.4 Mandatory training is ongoing. All contract cleaning staff have completed fire training in March 2011. 2.5 A consultation process has taken place with the maintenance dept. to remove signs which have been decommissioned.	 June 2011 June 2011 June 2011

3. The provider has failed to comply with a regulatory requirement in the following respect: The design and layout of the centre was not suitable for its stated purpose and did not meet residents; individual and collective needs in a comfortable and homely way.
Action required: 3.1 Ensure that residents' bedroom accommodation meets the minimum of 9.3 square meters usable floor space for example five of the single bedrooms in the dementia unit were approximate 8 square meters and a single room in St Cecelia's ward measured 8.7 square meters.
Action required: 3.2 Ensure the size and layout of rooms occupied or used by residents are suitable for their needs by removing the overhead screens in bedrooms so that residents can utilise the additional space.
Action required: 3.3 Ensure that the centre's communal space is used effectively in order to be compliant with the standards regarding having separate sitting and dinning space for residents.
Action required: 3.4 Ensure the premises are kept in a good state of repair: ▪ refurbish an assisted shower room (number 38) ▪ repair the damage to one of the walls at floor level in a sluice room on the ward and install a wash hand basin ▪ ensure that there is cold water in the cleaning room (number 75) ▪ replace missing wall and floor tiles

- replace floor covering in certain areas throughout the centre for example in the residents' sitting room, (dementia unit) staff room, corridor, nurse's station and the entrance to St Josephs ward
- replace the kicker board of the cupboards in the kitchen in St Patrick's ward
- replace cupboard doors which were loose in a serving kitchen (number 86)
- repair a sensory light which did not come on when entering a bathroom
- make sure that the locking system on some toilet and bedrooms doors operate
- ensure that all doors are a good fit and close fully, for example the doors to some shared toilets and ward rope doors
- put handles on all wardrobe doors and
- repair the fan in the hairdressing room.

Action required:

3.5 Provide adequate ventilation (mechanical and /or natural to the external air) in storage and cleaning rooms which contain hazardous substances and in the sluice and hairdressing rooms in the dementia unit.

Action required:

3.6 Keep all parts of the designated centre clean and suitably decorated:

- make sure that the laundry facilities are clean and hygienic
- take remedial action to address the chipped paint and areas of rust on some radiators, floor tiles in bathrooms, on the legs of the stainless steel sink and shelving in the sluice room in the dementia unit and on the floors where grab rails are mounted close to toilets
- store linen skips appropriately and not in the bath and shower rooms
- repair / replace bedside tables where the enamel has worn off the base and legs
- repair / replace the surround of the new sinks, which have been installed
- review the cleaning room in the dementia unit so that it is not necessary to access it via the sluice room
- redecorate the walls and skirting boards of some areas through out the centre for example bedrooms where fittings and fixtures had been removed, wing A in St Josephs ward, areas where new lighting had been installed and walls which have been stained from the use of hand sanitizers.

Action required:

3.7 Provide sufficient numbers of wash hand basins fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises for example in each bedroom (a four bedded room), the hairdressing and sluice rooms on the wards and drugs rooms.

Action required:

3.8 Provide and maintain external grounds, which are suitable and safe for use by

residents making sure the sensory light located at the entrance of the centre is working at night time and that the path around the centre which is uneven and has potholes is repaired.	
Action required: 3.9 Provide appropriate signage on toilets and bedroom doors.	
Action required: 3.10 Have all bedrooms prepared for occupancy for example a single bedroom in St Cecilia's ward and not used for storage.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 3.1 A consultation process has taken place in conjunction with the technical services dept., estates management and the risk management dept. to develop a costed plan to address the changes required to the physical design of the environment in order to meet standard 25. Estates management will organise for a feasibility study to be carried out and subsequently the actions required to meet the standard will be prioritised. Quotations will be sought to make the required adaptations based on the recommendations of the feasibility study. These quotes will be forwarded to the General Manager for approval and will be dependant on budgetary availability. 3.2 Work has already commenced in relation to the redesigning of overhead curtain rails in the multi-occupancy rooms so that residents can utilize the additional space. 3.3 Currently Ladywell Psychiatric Day Care Services utilize the main dining area in St. Oliver's between 1.15 – 1.45pm. A consultation process will begin immediately in conjunction with the Management of this service to relocate their dining services. This will allow a second sitting @ 1.15pm to facilitate all residents who wish to have their meal in the dining room.	June 2011 September 2011 September 2011 June 2011

3.4 Funding has been approved for the provision of 3 new kitchenettes at ward level and the Maintenance dept are currently in the process of obtaining quotes for this work. The Regional Estates Dept is in the process of assessing and reviewing the centre with regards to the standards required to meet the relevant legislation which will include all of the items addressed in this section. On completion of the feasibility study a plan will be devised with the Estates dept to address the deficits and matters identified within this report will be prioritised within this plan. Quotations will be sought to make the required adaptations based on the recommendations of the feasibility study. These quotes will be forwarded to the General Manager for approval and will be dependant on budgetary availability. 3.5 A consultation process has taken place with estates management and the maintenance dept. and the feasibility study will address the ventilation system in the areas required. Quotations will be sought to make the required adaptations based on the recommendations of the feasibility study. These quotes will be forwarded to the General Manager for approval and will be dependant on budgetary availability. 3.6 The laundry department has been completely re-decorated and the cleaner's room in the dementia unit has been relocated to a more suitable area. A comprehensive maintenance programme will be established to address the items identified in this section. 3.7 Funding has been approved in the 2011 minor capital budget for the provision of hands free sinks. The Maintenance Dept. is currently obtaining quotes for this work. 3.8 The sensory light at the entrance has been replaced. The need for resurfacing of grounds, upgrading of footpaths and road marking has been prioritised in the 2011 minor capital requirements. 3.9 Signage on toilets & bedroom doors have been updated. 3.10 The single room in St Cecilia's ward has been converted into a	July 2011 September 2011 September 2011 September2011 June 2011 September 2011 September 2011 June 2011 September 2011

Nurses office. The Statement of purpose has been updated to reflect same.	June 2011

4. The provider has failed to comply with a regulatory requirement in the following respect: The statement of purpose did not contain all the information required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	
Action required: Compile a statement of purpose, which includes all the matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) to include clarification of the resident group, identification of all aspects of the premises which constitutes the designated centre for example rooms currently used for storage (room numbers 25, 27, 28, 29, 30,, 34, 35,, 36, and 37) and the number and size of rooms.	
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 4.0 The statement of purpose has since been updated to comply with legislation. The revised copy clarifies the resident group, identifies all aspects of the premises which constitutes the designated centre and the number & size of each room.	March 2011

5. The provider has failed to comply with a regulatory requirement in the following respect: Residents' rights, to privacy, dignity and choice were not protected in all circumstances.
Action required: 5.1 Make sure that residents from the wards have the choice to use the main dinning room in the centre at a time suitable to them.

Action required:

5.2 Make sure that practices involving staff and members of the public using the centre are not intrusive regarding residents' communal space.

Action required:

5.3 Provide residents with privacy to the extent that each resident is able to undertake personal activities in private. Make sure that the curtains on the entrance to multi occupied bed rooms and on screens between the beds close fully and/or are hung properly. Curtain / blind the windows facing unto external public areas.

Reference:

Health Act, 2007
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
5.1 A consultation process will begin immediately in conjunction with the Psychiatric Day Care Services to relocate their dining services. This will allow a second sitting @1.45pm to facilitate all residents who wish to have their meal in the main dining room.	September 2011
Consultation will also take place with residents from the wards and their relatives to ensure choice of dining area is facilitated.	July 2011
5.2 Following consultation with the Maintenance Dept the residents and the relatives it was agreed that both corridors to the dining area would be cordoned off during mealtimes to protect residents privacy.	July 2011
The seating arrangement in the main lounge areas at ward level has been redesigned to protect resident's dignity & privacy.	Completed
Plans to relocate the entrance door to the staff changing room in St Gerard's sitting room has been approved and is going to tender.	August 2011
5.3 Quotes are currently being obtained for the provision of net curtains for windows facing on to the garden areas. Work has already commenced on redesigning the overhead curtain rails. The curtains will then be altered to fit the new rails and ensure that the resident's privacy is protected.	July 2011

6. The provider has failed to comply with a regulatory requirement in the following respect:

All necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse were not taken.

Action required:

Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse by ensuring that contract cleaners who work at the centre have participated in on-site training in the protection of residents from abuse.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: 6.0 In St. Oliver's we are committed to best practice and training on the subject of elder abuse. Training on elder abuse for all contract cleaning staff was provided on the 1 March and 7 march 2011 and refresher training on elder abuse for all staff at the centre is provided on an ongoing basis by the Senior Case Worker in Elder Abuse and the Asst. Director of Nursing.	Ongoing

7 The provider has failed to comply with a regulatory requirement in the following respect:

Contradictory information was made available to a resident.

Action required:

Ensure that information provided to residents is accurate and not contradictory for example with regard to falls risk assessments and speech and language therapy guidance.

Reference:

Health Act, 2007
Regulation 21: Provision of Information to Residents
Standard 1: Information

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 7.0 All staff have been advised in relation to the importance of the provision of up to date & accurate information on all documents pertaining to residents. Training will be provided on the legal implications of documentation for Nursing Staff. A system has been established to ensure that key workers will monitor resident information on a weekly basis	 March 2011 July 2011 June 2011

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	**Best practice recommendations**
Standard 25: Physical Environment	It is recommended that the three wardrobes positioned in a row in the shared bedrooms are easily distinguishable by individual residents. **Provider's response:** Resident's names and photograph if appropriate will be used to distinguish individual resident's lockers. June2011
	It is recommended that small tables are made available for residents when they are having refreshments. **Provider's response:** Stacking tables will be provided for this purpose. August 2011

Any comments the provider may wish to make:

Provider's response:

The Provider and the Person in Charge would like to thank the Inspectors for their professional manner in which they undertook the inspection.

Provider's name: Brighide M. Lynch
Date: 8 June 2011