Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Mount Alvernia Hospital
Centre ID:	0723
Centre address:	Newberry Mallow Co Cork
Telephone number:	022-21405
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Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive (HSE)
Person authorised to act on behalf of the provider:	Gretta Crowley
Person in charge:	Julia Kelleher
Date of inspection:	20 September 2011 and 21 September 2011
Time inspection took place:	**Day-1 Start:** 09:30hrs **Completion:**18:45hrs **Day-2 Start:** 09:00hrs **Completion:**17:30hrs
Lead inspector:	Caroline Connelly
Support inspector(s):	Breeda Desmond
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **Unannounced**

About registration

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

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

Under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

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

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

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

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

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

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

About the centre

Location of centre and description of services and premises

Mount Alvernia Hospital is situated in large landscaped grounds two miles south west of Mallow town in Co Cork and generally provides care for residents with Alzheimer's, dementia and enduring mental health illness. It is registered for 55 residents and there were 47 residents living there on the day of inspection.

The centre consists of two buildings where resident accommodation is provided; the main hospital and St Camillus unit.

In the main hospital, administration and staff offices are on the ground floor. Resident accommodation is on the second floor and third floor. Clyda is a 15-bedded unit on the second floor which has four double bedrooms, three single bedrooms and one four-bedded room. There is a large sitting room and a dining room.

Avondhu unit with 15 beds is on the third floor. It has five single bedrooms and five double bedrooms; each bedroom has a wash-hand basin and access to toilets and showers facilities close to the bedrooms. There is a sitting room, a small dining room and a small quiet room/visitor's room available for residents use. This is a secure unit.

St Camillus unit is located at the rear of the main hospital and consists of a basement and three floors. Communal accommodation is on the ground floor with two large sitting rooms, a smaller quiet sitting room and a bright very large dining room. Resident private accommodation is provided on the first and second floors. The first floor has eight double bedrooms and the second floor has five double bedrooms.

Art therapy and cookery classes take place in the basement which also includes a hair salon, smoking room and toilets.

Date centre was first established:			1953	
Number of residents on the date of inspection:			47	
Number of vacancies on the date of inspection:			8	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents	10	29	7	1
Gender of residents			**Male (✓)**	**Female (✓)**
			22	25

Management structure

The Registered Provider is the Health Service Executive represented by Operations Manager, Gretta Crowley.

The Person in Charge is the Director of Nursing Julia Kelleher, who currently reports to the Operations Manager.

The Person in Charge is supported in her role by an acting Assistant Director of Nursing (ADON), Mary Staunton. There are three Clinical Nurse Manager's 2 (CNM2), one Clinical Nurse Manager 1 (CNM1) and a team of nursing staff and multi-task attendants who in turn report to the Person in Charge.

There are three members of administration staff who look after residents' finances and undertake general administrative duties and one runs a shop part time for residents.

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

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

Inspectors met with residents, relatives, and staff members over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge. The Fit Person self-assessment document which was completed by the person in charge was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

The person in charge and the provider demonstrated 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*.

The person in charge is a very experienced nurse and manager and has been in her current role for 10 years. The person in charge was fully involved in the day-to-day running of the centre and met with staff and residents on a daily basis and was found to be greatly committed to improving the service for residents.

The registered provider is new to her current role as operations manager and the role of registered provider to the centre, having only taken over the role this year and was making herself familiar with the centre and the issues it presented.

Twenty three completed questionnaires were received from relatives and residents prior to the inspection and a number of residents and relatives were interviewed in private; many more were spoken to throughout the inspection. The feedback received from them was generally very positive and indicated that they were satisfied with the care provided but some would like to see improvements in the facilities for privacy and space in the centre and some relatives would like separate male and female units.

Inspectors observed that residents appeared to be well cared for, which was further reflected in residents' comments and that their daily personal care needs were well met. The involvement of relatives was actively invited and facilitated by an open visiting policy. The residents' committee provided a voice to residents in the operation of the centre.

Inspectors found that the premises posed significant challenges to the provision of residential care services, in particular current size and layout of some communal rooms, the toilet and bathroom facilities in one unit required urgent attention as did the décor

and flooring. Upgrading of the premises was also required to meet current requirements for fire safety and to meet the regulations.

A number of improvements were required to comply with 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.* These are dealt with in detail in the Action Plan at the end of this report.

These improvements included:

- provision of mandatory training
- provision of fire certification
- further risk assessments on the stairs and smoking area
- review of the skill-mix
- upgrades to the premises
- medication administration
- provision of adequate dining, storage and visiting facilities
- staff required evidence of three references in the staff records.

Section 50 (1) (b) of the Health Act 2007
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. Statement of purpose and quality management

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

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

Inspection findings

A recently updated statement of purpose and function which described the service and facilities provided in the centre was viewed by the inspectors. It identified the staffing structures and numbers of staff in whole time equivalents. It also detailed many other aspects of the service and met all the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older people) Regulations 2009 (as amended).

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

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

Inspection findings

There is an active residents committee in place which allows residents to raise issues and bring forward their experiences and suggestions of the care; this will be discussed further in outcome 11.

The person in charge was in the centre every day and constantly monitored the quality of care the residents received and spoke to all residents daily to establish their experience of the services.

The majority of the nursing staff had undertaken clinical audit training and there was evidence of consistent review of the quality and safety of care. On each unit there was evidence of regular audits taking place which included audits on falls, medication management, flu vaccinations, care planning, and occurrence of urinary tract infections and of chest infections. The clinical nurse managers completed audits on each others units and were able to describe the learning from this which led to changes and improvements made to practice as a result.

The inspectors identified that the whole area of clinical risk audit and review of the quality and safety of care was of a high standard throughout the centre.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

There was a policy for the management of complaints and HSE information leaflets were available regarding 'your service, your say'. Relatives interviewed all stated they would have no difficulty in brining any issue to the staff. They outlined that each member of staff were approachable and easy to talk with.

Inspectors saw that complaints from residents and relatives were logged in a complaints log which outlined the complaint, action taken and outcome. The person in charge informed inspectors that all complaints were discussed with staff to ensure that learning and changes to practice are implemented as a result of complaints as is appropriate.

Although there was a complaints procedure clearly displayed on all units and in the main reception areas it did not clearly identify the nominated complaints officer or the independent appeals process as is required by legislation.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

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

Inspection findings

The inspector met the social worker who has responsibility for elder abuse in that area. He is based on site and provides training for all staff in all elder abuse prevention detection and reporting mechanisms. He informed the inspector that his latest round of training with staff is very interactive and based around scenarios that arise and how best these are responded to. Inspectors viewed records maintained of staffs' attendance at elder abuse training. Staff interviewed informed the inspector that they had viewed the Health Service Executive (HSE) DVD on elder abuse and held discussions in order to increase their awareness and understand clearly their responsibilities. Staff were aware of what to do if an allegation of abuse was made to them and clearly told the inspectors there was a policy of no tolerance to any form of abuse in the centre.

There had been two allegations of abuse in the centre which the person in charge had followed the HSE trust in care document and had involved the elder abuse social worker in the investigation of both cases and had reported and notified the authority in accordance with the regulations. The inspectors were satisfied that the full policy and procedure had been adhered to and the incidences were being fully investigated and satisfactory measures were being implemented to prevent reoccurrences.

Residents' finances were safeguarded by the policy on the management of residents' accounts and personal property. Inspectors saw a record of all money and valuables kept in the safe for safekeeping for residents, along with a list of all withdrawals or lodgements which were signed and properly receipted. All financial records are subject to regular internal and external audits and inspectors saw evidence of this.

The insurance report was reviewed and found to meet regulatory requirements for the protection of residents' property.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

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

Inspection findings

The fire policies and procedures viewed by the inspector were centre-specific. The fire safety plan was viewed by inspectors and found to be very comprehensive. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the building. Fire training was provided to staff on

various dates in 2011 and 2010. Inspectors viewed records that showed that staff had attended training which had taken place seven times in 2011 and fire drills form part of this training. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire and spoke of the emergency list of staff they could call in the event of a fire or any other emergency.

Inspectors examined the fire safety register with details of all services carried out which showed that fire fighting, fire safety equipment and fire alarms had been serviced in July and August 2011. All fire door exits were seen to be unobstructed. The structure and age of the premises posed significant problems in ensuring it met the requirements for fire safety. A comprehensive independent fire audit was undertaken in the centre in the summer of 2011 which identified that extensive work was required particularly in relation to St Camillus unit to ensure it was compliant with the legislative requirements. A copy of this report was not finalised but is to be forwarded onto the Authority when it is made available to the provider and the person in charge. Therefore there was no written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

The residents' smoking area was in the basement in St Camillus unit which was a low traffic area; although it contained a nurse call-bell and there was a fire extinguisher in the vicinity the inspectors were concerned for the safety of the residents using the smoking room. There was little staff supervision as most of the residents were independent and went up and down to the smoking area unaccompanied. The inspectors felt the risk increased in the evening time when there are already reduced staffing levels.

The centre-specific heath and safety statement was seen by the inspectors and had been reviewed in January 2011 and is reviewed annually. The risk management policy was viewed by the inspectors which contained numerous safe working practice sheets and hazard identification sheets with control measures. The inspectors saw a comprehensive assessment completed by the person in charge of aspects of safety in the centre which was sent to the provider for review. A number of areas were identified as posing a risk to residents including the floor covering in St Camillus unit, further risk assessments are required to be completed on stairways for residents use in both units and on smoking areas for residents use.

There was a comprehensive emergency plan in place.

The person in charge has contracts in place for the regular servicing of all equipment and the inspectors viewed records of all equipment serviced in 2011 and 2010.

Clinical risk assessments are undertaken, including falls risk assessment, nutritional assessments, pressure sore prevention, and assessments for dependency, continence, moving and handling and restraint. The person in charge has identified areas where each resident may be at risk of injury and precautions in place to control the risk.

Inspectors observed staff abiding by best practice in infection control with regular hand washing, and the appropriate use of personal protective equipment such as gloves and aprons. Hand sanitisers were also present at the entrance to the buildings and throughout staff and resident areas.

Although there was a moving and handling training course being undertaken in the centre on the first day of inspection, training records showed that not all staff had received updated training in moving and handling with one staff member having last received this mandatory training in June 2008. The centres policy is to have moving and handling training on a two-yearly basis to ensure the safety of the staff and protection of the residents. The person in charge informed the inspectors that outstanding staff were booked into the next two training dates available in 2011.

Outcome 6
Each resident is protected by the designated centres' policies and procedures for medication management.

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

Inspection findings

Medication policies viewed by inspectors were centre specific, comprehensive, current and referenced to best practice.

Medications were prescribed, stored, and disposed of appropriately in line with An Bord Altranais Guidance to Nurses and Midwives on Medication Management (2007), the auditing of medication management had commenced with the nurse manager from each unit auditing the practice of nurses in other units.

The staff on one unit have undertaken an audit on the use of laxatives and has substantially reduced the use of laxatives by introducing alternatives such as linseed into resident's diets. This is to be rolled out to other units.

Resident's medications were reviewed on a three monthly basis as required by regulations. The local pharmacist is involved in reviewing medications and providing advice and education to staff on all aspects of medication management.

The medication prescription sheet contained all the required information and included residents' photographs. The inspectors observed a nurse undertaking a medication round and administering the medications. The medications were being administered from the medication signing sheet that came from the pharmacy and not from the original medication prescription sheet which was stored in a different folder which was not consulted during the medication round. This practice is not in line with An Bord Altranais Guidelines 2007 on medication management and could lead to medication errors.

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. Nurses were checking the quantity of medications at the start of each shift. The nurses displayed a good knowledge of medications.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

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

Inspection findings

Inspectors observed that residents appeared to be well cared for, which was further reflected in residents' and relatives comments that their daily personal care needs were well met.

Residents, where possible, were encouraged to keep as independent as possible and inspectors observed many residents moving freely around the units, in the corridors and on the grounds of the hospital.

The medical team for Mount Alvernia comprises of five consultant psychiatrists, who have two medical registrars, and two senior house doctors (SHOs) from the general practitioners (GP) training rotation scheme, which rotate every six months. This psychiatric team visit the centre on a regular basis. Two local general practitioners' (GP) provide day-to-day medical care with out-of-hours medical services also provided. Residents received a full review of all their medical care in which bloods were taken frequently and medication was reviewed on a three-monthly basis or sooner if required. These reviews were recorded on their drug

cards and in their medical notes which were seen to be comprehensive with timely and thorough reviews, investigations with results, follow-up appointments and intervention documented.

All admissions to Mount Alvernia come through the consultant psychiatrists at St Stephen's Hospital Cork following an admission assessment. The clinical director based at St Stephens Hospital has clinical responsibility at Mount Alvernia, the inspectors spoke with him during the inspection.

Residents have access to dietician and physiotherapy through referral to the local acute hospital. Speech and language therapy is provided on site. The chiropodist visits every four to six weeks and this service is provided by the hospital. The hairdresser visits regularly and a large well laid out hairdressing room is available in the main hospital.

Inspectors viewed a number of residents' nursing records. The staff had recently updated their assessment and care planning documentation and they were implementing new documentation for all. Residents were assessed using a comprehensive activity of daily living assessment tool and other assessment tools including risk of pressure sore formation, falls, and nutrition; these assessments formed the basis for person-centred care plans. Reassessments were completed on a three-monthly basis or sooner if required. Social histories and residents likes and dislikes all formed part of their care plans.

The inspectors reviewed the skin assessments, wound care assessment and recording charts in use in the centre and found they were comprehensive. Staff spoken to, were knowledgeable about the preventative and treatment measures.

The inspectors were satisfied to note that staff were working towards a restraint-free environment. There was a policy on restraint and staff were familiar with that. The staff informed the inspectors that there had been a reduction in the use of bedrails in the centre and they were using other measures such as low-low beds and safety mattresses to prevent injuries in the case of residents assessed as falls risk. Audits of bedrail usage have been conducted which confirmed the reduction in their usage. Records of the residents being restrained were viewed by the inspectors and an assessment for the need for restraint had been completed, but some of these assessments were found not to be reviewed on a regular basis and a couple were found not to have been completed fully. Further training on the use of restraint is required to ensure staff give care in accordance with best practice guidelines.

An activity programme is available and coordinated by the nurses on each unit. Gentle exercise, relaxation, and bingo, newspaper reading, sing songs and reminiscence therapy are included on the programmes. The inspectors observed an exercise session with a large number of residents in St Camillus unit partaking in the session and sing along with others enjoying watching it. Inspectors saw the obvious enjoyment and participation of the residents and staff. Residents and staff also told inspectors that they look forward to the exercise sessions.

Residents generally spoke highly of the organised activities and told inspectors they had a choice to participate or not depending on how they felt on the day. A variety of one-to-one activities had also been put in place to facilitate the residents who were unable to or do not wish to attend the organised activity sessions in the day room. Trips out happen regularly with residents going to town shopping or out on trips to places of interest.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

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

Inspection findings

The centre had policies and procedures for end-of-life care which were centre-specific. On the first day of inspection a resident had died in the centre. The relatives' had been facilitated to stay over the weekend and overnight with their relative. Beds, meals, drinks and snacks were provided to families as required.

Staff told inspectors that they have access to services of the palliative care team and the local hospice for advice and support to enable them to provide care to residents at end stage of life in the centre when necessary. A number of staff have attended end of life training and other nursing staff had completed the palliative care course.

There is a chaplain attached to the centre that holds mass there on a weekly basis and provides pastoral care to the residents and attends the centre on a regular basis for anointing of the sick. There is a beautiful church in the main building which provides a place for residents to pray or for quiet time and reflection. There were no residents of other religious denominations, but when there is they are visited by their ministers on request.

The centre has its own mortuary in the grounds of the hospital.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

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

Inspection findings

Residents received a nutritious and varied diet with choice of two meats or fish each day for dinner. Residents are asked on a daily basis what they would like. Special dietary needs are also provided for. The catering staff were aware of the likes and dislikes of residents and inspectors saw the list that went to the kitchen identifying preference and type of diet consistency required for each resident.

There were a good percentage of residents with diabetes, and a good choice of diabetic food was provided. All residents spoken to stated that they enjoyed the food and had plenty of choice offered.

Residents had access to fresh drinking water, jugs of water, were seen placed in the sitting room and dining room. Drinks were available in bedrooms.

The risk of weight loss was well managed. Residents had their weight recorded and the malnutrition universal screening tool (MUST) was being used to record all residents' body mass index on a three-monthly basis or sooner if required. The community speech and language therapists were based on the hospital site.

Many residents were independent in eating and drinking and were seen to enjoy their lunch and meals in two bright, relaxed dining rooms. In the Avondhu unit there is one long table; in St Camillus unit the dining room is very large, spacious and bright, all tables were set with table clothes, condiments and appropriate cutlery. On the day of inspection the quality of meals was seen to be of a good standard, which was confirmed by inspectors' sampling of the food. Inspectors saw staff assisting residents where necessary with their meals in a respectful manner whilst maintaining residents' independence wherever possible.

Improvements were required to the dining experience in the Avondhu unit as the dining room was small and had only one table, so the majority of the residents had their meals on tables in front of their chairs in the day room where they spent their day. The inspectors observed the residents having lunch and found that it was difficult for them to converse with other residents and found the dining experience did not allow residents to socialise and relax at a dining table over meals. Having meals in the day room did not allow the resident the choice of moving to another area for meals.

Birthdays and family occasions are celebrated as they arise.

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

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

Inspection findings

Contracts of care had recently been implemented for all residents and were seen in their notes on each unit. The contracts were comprehensive, were agreed within a month of new admissions and they stipulated the fee to be paid and what was included and excluded from that fee.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

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

Inspection findings

Inspectors observed residents' privacy being respected by the appropriate use of screens around each bed when any personal care was being delivered. Staff were seen to knock on the doors of residents' rooms and wait for a reply before they entered.

There is an active residents committee in place in each unit. The inspectors viewed minutes of previous resident committee meetings and saw actions taken and issues addressed as a result of the meetings; a number of these were in relation to food and choice which had all been resolved. Residents commented on how good the committee was for them to raise issues and bring forward suggestions.

There are suggestion boxes available for residents' comments and suggestions and the person in charge and CNM2 talk to the residents and relatives daily and look for any issues or areas that require addressing.

There is an open visiting policy in operation and this was confirmed by residents and relatives. Residents and relatives commended staff on how welcoming they were to all visitors but a number of visitors identified not having privacy for visiting was an issue for them. Some were not aware that there was a visitors' room available in the Avondu unit for their use.

The person in charge informed inspectors that residents were encouraged to go out on organised outings and overnight stays where possible and a number of residents told inspectors that they had done so. There is an annual summer holiday organised from the centre to Ballybunnion for one week and this year nine residents and three staff went on the holiday, which residents and staff who spoke to the inspectors informed them that they all really enjoyed.

Plenty of newspapers were seen throughout the units and televisions were placed at appropriate positions in the day rooms.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings

Inspectors saw, and residents confirmed, that they were encouraged to personalise their rooms. Residents' bedrooms were comfortable and many were much personalised with residents' own pictures and photos. Plenty of storage space including hanging space was provided for clothing and belongings and lockable storage space was also provided.

The system in place for managing residents' clothing was effective. Following residents' agreement all clothing was discreetly marked on admission. This helped to ensure clothing from the laundry was returned to the correct resident. Residents stated that they were happy with the way their clothing and personal belongings were managed in the centre.

The laundry was managed in a systematic way with each unit colour-coded. Dedicated laundry staff ensured that residents clothing were returned in a good condition to each resident.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings

The person in charge is actively involved in the day-to-day organisation and management of the service. She displayed a clear understanding of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and showed an acute awareness of the challenges facing the hospital in line with *the National Quality Standards for Residential Care Settings for Older People in Ireland.* She was instrumental in the implementation of the standards in the centre.

The person in charge is a registered psychiatric nurse, registered general nurse and a registered midwife who has undertaken many post registration courses including a degree in nursing, a diploma in health service management, and various other courses to keep her knowledge base up-to-date. She has been the person in charge of the centre for 10 years and demonstrated authority, accountability and responsibility for the provision of the service.

The person in charge works full time and is supported in her role by an assistant director of nursing who covers for the person in charge in her absence and the three clinical nurse manager 2 (CNM2), and clinical nurse manager 1 (CNM1) and senior staff nurses take charge of the centre at the weekends and on night time. There is a senior rota and it was clear who was in charge of the centre at all times, including weekends, evenings and nights.

Outcome 14
There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

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

Inspection findings

Residents and relatives spoke positively regarding staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity.

HSE and centre-specific, evidence-based recruitment policies and procedures were reviewed by inspectors and found to be comprehensive.

A number of staff were interviewed regarding their recruitment, induction, and ongoing professional development. Review of staff records showed that staff were recruited and inducted in accordance with best practice.

Staffing records viewed by inspectors showed that staff had mandatory training in fire drill and evacuation, hand hygiene, and training in elder abuse and protection. As identified in outcome three a number of staff required update moving and handling training. All staff have undertaken non violent crisis intervention training. Many of the nursing staff are trained in blood taking procedures.

Further areas of training provided included:
- wound care
- dementia training
- audit training
- palliative care
- catheterisation
- continence promotion
- nutritional training on dysphasia
- care planning and documentation
- leading empowered organisation (LEO)
- Further Education and Training Awards Council (FETAC) Level 5 (eight Modules)
- Hazard Analysis Critical Control Point (HACCP)

- preceptorship training
- basic life support.

All staff reported a great level of support and encouragement from the person in charge and the ADON to attend training and keep their knowledge base up-to-date. Inspectors saw completed staff appraisals in staff files which also identified training requirements.

Inspectors saw, and staff confirmed, that the staff facilities were available with lockers, changing area, staff toilet, shower and staff dining room.

Overall the staffing levels and skill-mix were based on the number and dependency levels of the residents and the current staffing levels were adequate to meet the needs of the residents. The inspectors felt that staffing levels required ongoing review to ensure they meet the assessed needs of residents at night time, taking into consideration the size and layout of the centre, particularly in St Camillus unit which is over four floors and has only two staff available to provide care for up to 25 residents. The dependency levels of the residents in St Camillus unit is currently generally low, if this was to increase staff levels would require review.

Although inspectors saw that there were a number of comprehensive staff files, and that the person in charge was working towards attaining all the information required, a few of personnel files did not evidence of medical fitness to work at the centre and did not have three written references as required by legislation.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

The centre was found generally to be homely with a large level of communal space in one unit but a lack of communal space in other units. The large windows made the building bright and allowed residents to see out to the large gardens, lovely views of the countryside and views of Mallow racecourse.

Residents told inspectors that they were encouraged to personalise their rooms with pictures of family and friends and individual possessions and many rooms were seen by the inspectors to be very personalised.

The kitchen was clean and very well organised. Catering staff interviewed had all received food handling training, and records of training reviewed by inspectors were found to be up-to-date. The kitchen was well stocked with ample food supplies. Home baking was evident with freshly baked scones and cakes.

There was appropriate assistive equipment available to meet the needs of residents such as electric beds, pressure-relieving mattresses, wheelchairs and walking frames. There was also a sufficient number of hoists which were seen to be used correctly by staff. Inspectors observed residents moving independently around the corridors using their individual mobility aids. Hoists and other equipment were all maintained and service records seen by inspectors were found to be up-to-date.

There is a maintenance person/grounds man employed who responds to all the day-to-day maintenance of the building, grounds and equipment. The waste management system was well managed and secure. Staff demonstrated awareness of the correct bags to use for domestic and clinical waste. Inspectors viewed an up-to-date contract which was in place for the removal of waste.

There was a call-bell system in place beside residents' beds in the day rooms, dining and smoke room, inspectors heard and saw the call-bell activated and a staff member responded promptly to it.

There were many challenges posed by the structure of the building and the physical environment to ensure that resident's needs were met on a daily basis and during end-of-life care.

Inspectors identified a number of issues with the premises which are outlined below:

- there were a number of areas in the centre that required painting and redecoration
- the floor covering in St Camillus unit required replacement as discussed in outcome 3
- lack of dining space was covered under outcome 9
- lack of storage space for equipment particularly in the Clyda unit
- many of toilet and shower facilities required upgrading in St Camillus unit
- premises requires upgrading to meet the requirements of fire safety legislation.

7. Records and documentation to kept at a designated centre

Outcome 16

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

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

Resident's guide

Substantial compliance ☒ Improvements required* ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required* ☐

General records (Schedule 4)

Substantial compliance ☒ Improvements required* ☐

Operating policies and procedures (Schedule 5)

Substantial compliance ☒ Improvements required* ☐

Directory of residents

Substantial compliance ☒ Improvements required* ☐

Staffing records

Substantial compliance ☐ Improvements required* ☒

Staff files required evidence of three written references.

Medical records

Substantial compliance ☒ Improvements required* ☐

Insurance cover

Substantial compliance ☒ Improvements required* ☐

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings

The inspectors saw that there was a comprehensive log of all accidents and incidents that took place in the centre.

The person in charge had notified the Social Service Inspectorate of incidents as required by Article 36 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Notifications were reviewed prior to and throughout the inspection and the inspectors were satisfied with the outcomes and measures that were put in place.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings

There has been no change to the person in charge but the provider and the person in charge was aware of the obligation to inform the Chief Inspector if there is any actual or proposed absence.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge, the assistant director of nursing and the three clinical nurse managers to report on the inspectors' findings, which highlighted both good practice and where improvements were needed. A shorter feed back was given to the provider earlier as she was unable to attend the feedback meeting.

Acknowledgements

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

Report compiled by:

Caroline Connelly
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

3 November 2011

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:	Mount Alvernia
Centre ID:	0723
Date of inspection:	20 September 2011 and 21 September 2011
Date of response:	19 October 2011

Requirements

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

Outcome 3: Complaints procedures

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

The system of complaints management does not meet the criteria as set out in Schedule 5 in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) in that it did not identified clearly the complaints officer or the independent appeals process.

Action required:

Make available a nominated person in the designated centre to deal with all complaints. Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Reference:

Health Act 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Providers response: The nominated person to investigate all complaints locally is Julia Kelleher the complaints officer. The independant review of complaints are carried out by Sinead Byrne General Manager Consumer Affairs Administration block Kilkcreene hospital Kilkenny HSE South Tel 057-9357617 or email;sineadj.byrne@hse.ie. This has been inserted in all policies throughout the hospital and staff have been informed of the changes to the policy.	11 October 2011

Outcome 5: Health and safety and risk management

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

There were no risk assessments completed on stairways for residents use in both units and on smoking areas for residents use, particularly the smoking room in the basement of St Camillus unit, actions were not set out to manage these risks.

The floor covering in St Camillus unit on the top floor was worn and torn and was a trip hazard in places.

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Action required:

Provide safe floor covering.

Reference:

Health Act 2007
Regulation 31: Risk Management Procedures
Standard 29: Management Systems

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

Provider's response: Risk assessments have been carried out in both stairways in the main hospital and in St Camillus and a second hand rail has been recommended. Risk assessment has been carried out in the smoking room in St Camillus and a CCTV has been recommended with staff checking the monitor in the nurses office every 15 minutes and then signing the check list. Risk assessment has been carried out in the smoking room in the main hospital. Here the staff have to accompany residents to and from to the smoking room. We have now put a check list in place in the smoking room whereby staff check residents and sign off the check list every 10 minutes. A fire extinguisher is also being provided there and a cctv monitor in the ward. Each resident using the smoking room will have an individual risk assessment undertaken on their ability to use the smoking area's safely and will only use the smoking room unaccompanied if assessed as safe to do so.	12 January 2012 Completed 15 November 2011

3. The provider has failed to comply with a regulatory requirement in the following respect: Written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with was not available for the centre for registration purposes.	
Action required: Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.	
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: An inspection of the premises by a suitably qualified person with experience in fire safety, design and management has been completed for Mount Alvernia. The cost of rectifying any high risk issues identified has been quantified. The funding required to meet	The target for completion of this process will be the end of the

these essential works has been identified by HSE management. Contracts will be awarded to carry out the required works. On completion of the works the centre will again be inspected and then certified as required by HIQA by a suitably qualified person. The completion of these works may require the temporary relocation of some clients to facilitate the works.	first quarter or mid-second quarter 2012.

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

Training records showed that not all staff had received updated training in moving and handling.

Action required:

Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice

Reference:

Health Act 2007
Regulation 17: Training and Staff Development
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have arranged for the staff that are not up to date in moving and handling training to attend training and all the training will be complete by the 14 December 2011	14 December 2011

Outcome 6: Medication management

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

The medications were being administered from the medication signing sheet that came from the pharmacy and not from the original medication prescription sheet which was stored in a different folder which was not consulted during the medication round. This practice is not in line with An Bord Altranais Guidelines 2007 on medication management and could lead to medication errors.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference: Health Act 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management Standard 15: Medication Monitoring and Review	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff that have not used the original prescription sheet for dispensing medication have been informed that this is not the appropiate way to dispense medication and as outlined in the policy document .They are following the correct procedure now and since the 11 October 2011	11 October 2011

Outcome 7: Health and social care needs

6. The provider has failed or is failing to comply with a regulatory requirement in the following respect: Training on restraint was required to ensure staff provided care in accordance with contemporary evidence-based practice.	
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Reference: Health Act 2007 Regulation 25: Medical Records Regulation 17: Training and Staff Development Standard 24: Training and Supervision Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Two staff have attended train the trainer on restraint and are implementing the training locally. The first two sessions were held on 19 October 2011 and on the 2 November 2011. Completion date for all training 12 December 2011	12 December 2011

Outcome 9: Food and nutrition

7. The provider is failing to comply with a regulatory requirement in the following respect: There was not enough dining space for residents in the Avondhu unit to enjoy their meal at a dining table and residents were having their meals at their chairs in the day room and by their bedsides.
Action required: Provide adequate dining space separate to the residents' private accommodation.
Action required: Submit to the Chief Inspector a plan of how dining space will be provided to all residents in the future.
Reference: Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Providers Response: We will assess the viability of converting a bedroom to extend the dining room in the context of the overall requirements to meet the standards.	First quarter 2012

Outcome 14: Suitable staffing

8. The provider has failed or is failing to comply with a regulatory requirement in the following respect: Not all staff personnel files had evidence of medicals and three written references and therefore do not meet all the criteria set out in Schedule 2 in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).
Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform and have three written references.

Please state the actions you have taken or are planning to take with time scales	Time scale
Providers response: Recruitment procedures are being put in place to insure no staff member is employed without medical certification that they are mentally and physically fit to do theirjob and that they have three refefences	31 January 2012

Outcome 15: Safe and suitable premises

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

Inspectors identified a number of issues with the premises which are outlined below:

- premises requiring upgrading to meet the requirements of fire safety legislation
- there were a number of areas in the centre that required painting and redecoration
- there was a lack of storage space for equipment particularly in the Clyda unit
- many of the toilet and shower facilities required upgrading in St Camillus unit.

Action required:

Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

Make available to the Chief Inspector an action plan outlining future planning regarding compliance of the physical environment with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Action required:

Keep all parts of the designated centre clean and suitably decorated.

Action required:

Provide suitable storage facilities.

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	

We are undertaking a detailed costing exercise to determine the investment required to bring the centre up to the standards required. In the event that funding is secured to undertake these works our expectation is that works will be completed on a floor by floor basis and this will necessitate the requirement to move patients from one floor to another to enable the works to be carried out. We will assess the viability of transferring the hair salon in Clyda ward to the ground floor and converting the salon room to an equipment room. We will also access the visibility of carrying out an action plan of decorating and upgrading the premises, toilets, bathrooms sinks and watertaps as listed in the context of the overall requirements to meet standards.	First quarter 2012

Any comments the provider may wish to make:

Provider's response:

None received.

Provider's name: Gretta Crowley, Operations Manager

Date: 26 October 2011