

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Mary's Hospital
Centre ID:	OSV-0000495
Centre address:	Shercock Road, Castleblayney, Monaghan.
Telephone number:	042 975 3600
Email address:	margaret.mcnally@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Rose Mooney
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	46
Number of vacancies on the date of inspection:	24

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 October 2015 10:00	01 October 2015 17:30
02 October 2015 09:00	02 October 2015 17:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This inspection was announced and took place over two days. The inspection was completed in response to an application made by the provider for renewal of registration. The last inspection of the centre was completed on 21 March 2014. An extensive refurbishment of all resident accommodation was found to be completed to a good standard on this inspection and in line with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People)

Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The layout and design of the newly refurbished premises is traditional in style and optimises opportunities for residents to live in a comfortable and accessible environment.

The inspector found that the centre was clean, decorated and finished to a very good standard. The layout and variety of internal and external areas was found to provide a comfortable, pleasant and interesting environment for residents. Bedrooms were spacious and bright with assistive equipment fitted including ceiling hoists. The centre comprises of three independently operating households situated around an amenity-rich central communal area. One household is a dementia specific area with thirteen long-term care beds and eight dementia respite-care beds. The respite programme was suspended while the refurbishment project was in progress and planning was underway to recommence this service.

Drumlin house was not occupied on the days of inspection and was fully fitted and furnished in preparation for temporary relocation of residents from another designated centre managed by the provider to facilitate refurbishment of their accommodation. All proposals presented prior to and during the inspection in relation to this refurbishment project were examined, and will be verified and followed up following an action plan response, and by an inspection when registered and occupied by the residents.

On the days of this inspection, the inspector spoke with residents and staff members and reviewed documentation including policies, risk management, audits and staff training records in addition to the Authority's pre-inspection questionnaires completed by residents and their relatives. The action plan from the last inspection was satisfactorily completed. The collective feedback from residents both on the days of inspection and from resident and relative feedback in pre-inspection questionnaires was complimentary in relation to the staff, care provided, the service and the quality of life gains for residents living in the newly refurbished premises.

The inspector found that residents had good access to nursing, medical and allied healthcare, and there were measures in place to protect residents from being harmed or suffering abuse. Residents had opportunities to participate in meaningful activities, appropriate to their interests and capacities. From an examination of the staff duty rota and communication with residents and staff, the inspector found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents.

Compliance with the requirements of the regulations was found in 15 of the 18 outcomes assessed. Minor improvements were required in three outcomes to bring the centre into full compliance with the legislation. Areas requiring improvement included timely investigation of a complaint, provision of appropriate documentation of revised emergency evacuation procedures to take account of designated exits not in use and implementation of some procedures for staff supervision.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in

Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a written statement of purpose available that accurately describes the service provided in the centre and is clearly demonstrated in practice.

A copy of the centre's statement of purpose and function dated 01 September 2015 was forwarded to the Authority. This document was reviewed and the inspector found that it contained all of the information as required by schedule 1 of the Regulations and was revised to include the details of the designated centre following completion of the refurbishment project.

The statement of purpose and function accurately described the range of needs that the designated centre meets and the services provided.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a clearly defined organisational structure in place. Accountable and responsive management practices were demonstrated by inspection findings. Lines of accountability and authority were evident. The inspector observed that meetings were held at multiple staff levels and were minuted. Risk management was on an item on all meeting agendas. The provider nominee attends the centre on a regular basis.

The inspector found that there were sufficient resources to meet the needs of residents in terms of facilities, equipment, staffing, staff training and professional development to ensure effective delivery of care in accordance with the centre's statement of purpose on the days of inspection.

The inspector found that there was a culture of quality monitoring and improvement with systems in place to ensure that the service provided was safe and appropriate to meet resident needs, consistent and regularly monitored. Weekly statistics were collated by the person in charge on key clinical areas including resident falls, infection, medication use, incidents of residents with pain, incidents of challenging behaviour, wounds, restraint use among others. A comprehensive auditing schedule was in place with evidence of robust analysis and tracking of actions taken to resolve deficits to satisfactory completion. Clinical and environmental audits were completed by the clinical nurse managers in each house and forwarded to the person in charge for collation and action planning. The data was presented and discussed at weekly management meetings between the person in charge and clinical nurse managers from each house. The person in charge told the inspector that this approach facilitated comprehensive risk management review, shared learning and consistency among the team. An annual quality and safety report was available for review on this inspection.

There was evidence of consultation with residents demonstrated by meaningful actions taken in response to resident feedback on their environment and how they wanted it to be. The inspector saw that many of the quality improvements were focused on residents and aimed to enhance their quality of life, comfort and safety in the centre.

Judgment:

Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. 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.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Each resident had a contract of care that described the terms and conditions of their care and welfare in the centre. The inspector reviewed a sample of residents' contracts and found them to be dated and signed by residents themselves in some cases or their next of kin. The contracts included specified fee details and any additional fees.

A resident's guide was available with a copy accessible in each house which advised of the services provided. Large white boards and notice boards in each house and on communal corridors advised residents of the recreational activities available to promote their independent choice regarding their participation and other useful information that may be of interest to them. There was a good standard of signage throughout the centre which enhanced accessibility. Each resident's photograph was displayed by their bedroom door and the centre was organised into four individual units each differently designed in a domestic style and called after local areas to promote the independence of residents in locating their accommodation and communal areas in the centre.

Residents' bedrooms were fitted with WiFi access.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge has responsibility for two designated centres. She is also the nominated person in charge of Oriel House designated centre located within close proximity to St Mary's Community Nursing Unit. The person in charge demonstrated that she had authority and accountability for the service provided and was adequately involved in the governance, operational management and administration of the centre. She is a registered nurse and has a postgraduate qualification in gerontological nursing. She has the required experience in caring for dependant people and management of a residential care facility. She has been person in charge of the centre since 2012 and prior to that was in a deputising role. The training records confirmed that the person in charge had maintained her professional knowledge and development up to date by attendance at various courses and training sessions.

The person in charge had sufficient systems in place in particular relating to information governance evidenced by regular departmental staff meetings, clinical quality and safety monitoring systems and information required was easily accessed and well organised.

Residents spoken with knew who the person in charge was. Pre-inspection relative and resident questionnaires forwarded to the Authority before the inspection referenced residents and relatives stating they could approach the person in charge if they had a query and that she was accessible to them. At times where the person in charge was otherwise engaged, residents and relatives confirmed that she would always get in contact with them to follow-up their queries.

Judgment:

Compliant

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.***

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found that 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) were maintained and available for review.

All of the written operational policies as required by Schedule 5 of the Regulations were available and up to date. The admissions discharge and transfer policy dated 01 July 2014 was available and reviewed by the inspector and reflected practice in the centre.

The directory of residents was complete as required by Schedule 4 of the Regulations and maintained in an electronic format.

Records to be maintained in respect of each resident as described by the regulations were secure and in place.

Judgment:

Compliant

Outcome 06: Absence of the Person in charge
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.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There were suitable deputising arrangements in place should the person in charge be absent and the Provider was aware of his responsibility to notify the Chief Inspector of the absence. To date the person in charge had not been absent for a period of more than 28 days.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The front door to the centre was monitored by closed circuit television (CCTV) and by a receptionist during office hours. A policy document informed use of this surveillance equipment and notice of use was displayed.

Completion of a visitors' book was required and monitored. The main entrance doors were locked after 17:00hrs and access was controlled by staff in the centre thereafter who could view persons requesting entry on a receiving monitor located in each of the houses. A member of security staff checked the centre each night and completed a checking template.

The inspector found that there were satisfactory arrangements in place to safeguard residents on this inspection. The inspector confirmed that all staff had attended training on prevention, recognition and management of elder abuse from review of the training

records. Staff spoken with by the inspector were informed and knowledgeable regarding actions to take in the event of a resident disclosing an incident of abuse. A policy was in place which informed the management of allegations of abuse. The policy referenced contact numbers for referral of incidents including the elder abuse officer, local garda and professional bodies. A member of staff had completed a train the trainer course in recognition, prevention and responding to elder abuse. This staff member provided training for staff and there was evidence of on-going staff refresher training for 2015. Vetting procedures were completed for all staff employed in the centre including volunteers.

The inspector reviewed the management and investigation of allegations made against peers and some staff. There were no incidents regarding protection of vulnerable persons under investigation on the days of inspection. The inspector found evidence that any incidents of staff interactions with residents of a less than adequate standard were fully investigated and residents were appropriately safeguarded while investigation was in progress. However, one investigation reviewed was not subject to timely closure. There was also evidence of dissatisfaction in relation to timely investigation highlighted by a resident's relative in the form of a complaint and is detailed in outcome 13. The inspector observed staff - resident interactions on the days of inspection and found that all staff interactions were perceptive, healthy, warm and responsive to residents' needs, including residents with challenging behaviour and dementia. Call bells were observed to be answered promptly by staff on the days of inspection.

Resident finances were reviewed as part of this registration renewal inspection process. A procedure was in place to inform a designated person on managing residents' finances including personal money for residents' own day-to-day use. Residents were able to access their money when they wished. Residents had access to a lockable facility in their bedrooms for securing their personal valuables if they wished.

The person in charge informed the inspector that some of the residents currently residing in the centre exhibited intermittent behaviour that challenged which was proactively managed by staff with positive supportive diversional techniques where possible. A policy document was in place to inform management of behaviour that challenges as exhibited by residents. This advisory documentation focused on promoting a positive approach to managing challenging behaviour whilst supporting the resident concerned. This was evidenced in practice in the centre and was particularly evident in the dementia specific house. The inspector found from review of training records that all staff had attended training on management of challenging behaviour. There was also evidence on this inspection of comprehensive assessment of residents who potentially posed a risk to themselves or others with appropriate monitoring safeguards in place on the days of inspection.

A resident restraint register was maintained in the centre as part of the clinical risk register documentation. Residents using bedrails had assessments completed and there was evidence of a proactive approach to minimising bedrail use with adequate monitoring and review. Where bed rails were used a risk assessment supported necessity and instances where residents themselves wished to have bed rails in place at night time. No residents were prescribed for chemical restraint. These findings reflected satisfactory implementation of the National restraint guidelines. Most beds in the centre

were low-level in design to assist and promote resident safety and a restraint free environment. An up-to-date policy document was available to inform restraint use in the centre.

Judgment:

Compliant

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

Theme:

Safe care and support

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

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

Findings:

The inspector found the health and safety of residents, visitors and staff is promoted and protected. There was a risk management policy referencing incident identification, reporting and investigation.

The inspector reviewed the centre's safety statement and saw that the safety statement was up to date for 2015. A risk register was maintained informing environmental, chemical and clinical risk mitigation. The identification and assessment of risks with controls to prevent potential adverse incidents to residents, visitors and staff was complete. The risk register was demonstrated to be a working document, reviewed on a monthly basis by the management team including the person in charge, deputy person in charge and clinical nurse managers from each house. All resident accident and incidents were recorded and fully investigated with evidence of learning from this process. There was also evidence that the risk register was updated with the outcomes of investigations of serious resident accidents and incidents. The inspector did not observe any new unidentified or unassessed risks on this inspection in areas accessible to residents. Health and safety and risk management was a standing agenda item on meetings at all levels.

The centre had access to a full time maintenance person and where deficits had been identified appropriate timely remedial action had been taken.

Fire safety had been reviewed for all areas of the designated centre with completion of the refurbishment project. Fire doors and exits were unobstructed on the days of inspection and preventative checking procedures were in place. Servicing of the fire panel, alarm, emergency lighting, directional signage and smoke/heat sensor equipment including carbon monoxide sensors had been completed and documentation reviewed confirmed they were in working order. Equipment including fire extinguishers and blankets were available at various points throughout the centre including smoking areas. Risk assessments were completed for residents who smoked. Fire evacuation drills were

completed reflecting day and night-time resources and conditions to ensure residents could be safely evacuated in an emergency. Personal evacuation plans were in place which recorded each resident's evacuation needs in terms of staff and equipment. Emergency plans for safe refuge for residents were in place to support the emergency policy. Fire safety training was completed by all staff, as confirmed by the staff training records and staff spoken with by the inspector regarding emergency procedures in the event of a fire. However, a designated fire exit door was out of use in two houses as assessed unsafe due to pending handrail installation. While there was alternative means of emergency exit, revised arrangements were not documented in the emergency plan.

Hand hygiene facilities were located throughout the premises and staff were observed completing hand hygiene procedures as appropriate. Environmental cleaning procedures, schedules and evaluation of staffing requirements were satisfactorily completed. The inspector observed that the daily cleaning schedule included a deep-clean of residents' rooms. The staff training records reviewed by the inspector referenced that all staff had attended training in Infection control including hand hygiene. Staff spoken with were knowledgeable regarding environmental cleaning in line with best practice. An infection control policy and manual advised on procedures for management of communicable infection and infection outbreak as required. Personal protective equipment (PPE) was available for use as required.

Judgment:

Substantially Compliant

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that the centre had implemented a medication management system where the policy and procedures promoted resident safety and were resident focused. An up-to-date medication management policy was available to advise staff on management of residents' medications.

Residents' medications were stored in secure units in their bedrooms to promote ownership and to reduce the associated risks with medication trolley transportation, security and infection control. This practice also reduced potential for medication error and interruption of the nurse administering medications as all medications were administered in residents' bedrooms. All medications were prescribed and medication documentation was complete.

The centre's pharmacist was known to residents. There was evidence of auditing procedures completed by the pharmacist and support given by them to staff with medication management including training. In addition medication auditing procedures were completed by the clinical nurse managers at each house level. These audits demonstrated comprehensive reviews of practice with actions identified to address any deficits found. A procedure was in place for management of adverse medication incidents. The staff training records referenced that all staff nurses were required to complete medication updates on an annual basis.

There were procedures in place for managing return of unused and out of date medicines. Controlled medications under the Misuse of Drugs legislation were stored securely in a designated facility and stock checking procedures were undertaken as required by staff.

Judgment:

Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The provider and person in charge were aware of their legal requirements regarding notifications to the Chief Inspector including serious injury to residents.

To date and to the knowledge of the inspector, all relevant incidents had been notified to the Chief Inspector as required.

Quarterly notification requirements were forwarded as required including details of restraint use.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

There were forty six residents in the centre on the days of this inspection. Twenty eight residents were assessed as having maximum dependency needs, eleven had high dependency needs, three had medium and four had low dependency needs. Fifteen residents had a diagnosis of dementia/alzheimers disease.

Most of the staff team caring for residents in the dementia specific unit had completed 'best practice in dementia care' training. The clinical nurse manager had completed dementia care mapping. The inspector was told that residents with dementia were supported with activities around the functions of living that were meaningful and specific to each resident's interests and capability.

The inspector found on this inspection that residents' healthcare and support needs were met. Arrangements were in place and staffing practices were adequate to meet residents' assessed health and social care needs. Residents' care needs were assessed using accredited risk assessment tools in each case. The inspector observed that all residents care needs were identified in a care plan that informed appropriate interventions to be taken by staff to address needs. Training in care planning was provided for registered nurses and was on-going. Daily progress notes were completed and were linked to care plans. Care plan development and subsequent review was undertaken though documented consultation with residents and or their next of kin to ensure the care and support provided reflected the assessed needs and wishes of residents.

The inspector observed that residents had timely access to allied health professionals including their general practitioner and psychiatry of older age medical services. There were many examples of appropriate resident referral to and consultation by physiotherapy, dietetic, speech and language therapy, occupational therapy and optical specialists in response to acute events or as part of on-going healthcare and assessment.

A dietician attended the centre as required and assessed residents identified as being at risk of unintentional weight loss and set out recommendations to supplement their intake as appropriate. There were no residents with unintentional weight loss on this inspection. The dietician was also involved in developing diet plans to support residents

on intentional weight loss programmes. Residents' weights were closely monitored and assessed to identify and intervene in changes at an early stage. This area of care is discussed further in Outcome 15.

Judgment:

Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

An extensive refurbishment project was found to be satisfactorily completed on this inspection and involved upgrading of all resident accommodation in the designated centre. The inspector found that the layout and design of the centre meets its stated purpose. The centre is now organised into three resident areas as follows;

- Dromore House accommodates 25 residents with continuing and palliative care needs in ten twin and five single bedrooms,

- Lorgan House is a thirteen bed dementia extended care and eight bed dementia respite unit. The accommodation is designed to facilitate separation of the eight residents on respite from residents in long term accommodation if necessary. Otherwise the house in totality consists of nine twin bedrooms and three single bedrooms.

- Drumlin House has accommodation for 24 residents with continuing and palliative care needs in nine twin and six single bedrooms. This house was fully fitted and furnished to receive residents and staff from Oriel House designated centre on a temporary basis while refurbishment of that premises was taking place.

All bedrooms have an en suite fitted with a shower, toilet and hand basin. Each house functions as a self contained household with sitting, dining, kitchenette and storage facilities. Each house has sluicing facilities, a number of sitting areas and an enclosed garden with raised flowerbeds. Each house has an assisted bathroom and wheelchair accessible toilets.

Drumlin house has an additional end of life room to ensure residents in twin rooms in any of the houses can be accommodated in a single room to meet their end of life needs. This is discussed further in outcome 14.

The central communal area in the designated centre is designed in a 'shopping street' style and includes the reception area to the centre. A comfortable seating area arranged

around an ornate fireplace is located inside the front entrance. Entrance doors to each of the houses are in a domestic front door style. Other communal amenities include a licensed bar, coffee shop and a second-hand clothes and accessories shop. A large communal room is used for weekly mass and other events. A smaller oratory is available to residents and is also used for end of life religious services.

Seated areas are placed at intervals along the centre's long wide corridors. All areas of the premises is built on ground floor level and was found to be accessible, safe, hygienic, spacious and finished to a good standard to meet the assessed individual and collective needs of residents including residents with dementia care needs in a comfortable and homely way.

Furniture and fittings including wall pictures were selected to foster a sense of homeliness, comfort, familiarity and freedom within the environment.

The inspector found that the location of the Lorgan unit, its design and layout is specific to its stated purpose and adheres to evidence-based principles on dementia care and design including secure outdoor walks and garden areas that are safe, accessible and provide multi-sensory stimulation. Many features were included to enhance the quality of the garden as an occupational, therapeutic and restful environment. The fitting, layout and floor space requirements as set out in the criteria for existing designated centres in the National Quality Standards for Residential Care Settings for Older People in Ireland and legislation were met. Resident areas in the centre were painted in various pastel shades complimented by traditional colour schemes in curtaining and table covers.

Bedrooms were spacious and equipped to assure the comfort and privacy needs of the residents. Accordion bed screens were in place to mitigate the clinical effect of bed screen curtains. There was a call bell system in place at each resident's bed. All windows had opening restrictors fitted and were at an adequate height for opening and viewing. Specialised glass was fitted in lower level panes to the front of the centre to ensure residents' privacy by obstructing visibility from the outside into the rooms. There was suitable lighting provided in each bedroom to meet the needs of the residents in addition to signal and night lighting. The en suite facilities in each bedroom were suitably adapted to meet the comfort and safety needs of residents. Mirrors and lighting were provided over each wash basin. The en suites and bathrooms were tiled throughout, maintained in a clean condition and were ventilated mechanically. Grab support rails in contrasting colours were provided alongside all toilets and showers in line with dementia care principles. Ceiling hoists were fitted in all bedrooms and in assistive bathrooms. Sloped pathways had handrails in place on both sides.

Toilets were located in close proximity to communal rooms for residents' convenience. Testing indicated that the temperature of the hot water did not pose a burn or scald risk to residents. An under floor heating system is in place which is thermostatically controlled.

Kitchenettes in each house had a number of safety features fitted including a convection hob to ensure residents could safely access this area.

Judgment:

Compliant

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A policy document was available to inform procedures and practices in relation to complaints management. The complaints procedure was in line with the requirements of the Regulations and included an appeals process. The procedure was on display in the centre and included in the residents' guide document. A comment box was placed in a area long the main corridor in the designated centre. This document is also made available to prospective residents for their information.

There was evidence that residents were listened to and any expressions of dissatisfaction were acted upon. A complaints log was maintained in the centre and recorded verbal and written complaints. All complaints were investigated and actions to be taken as stated where appropriate. Outcomes of complaint investigations were communicated to complainants in writing. However, the inspector observed that some improvement is required in completing the investigation process of complaints. The inspector was informed that there were no active complaints under investigation at the time of this inspection.

Residents spoken with by the inspector on the days of this inspection and feedback received by the Authority in pre-inspection resident and relative questionnaires supported a finding that residents or/and their relatives knew who to approach if they were dissatisfied with any aspect of the service and expressed confidence that they would be listened to and their concern would be addressed.

Advocacy services were available and a detail of same was included in the residents' guide which the inspector saw in some residents' bedrooms for their reference.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

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.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A policy document was in place to inform care of residents at the final stage of their lives in addition to procedures relating to last offices, post mortem, verification and certification of death and management of property of the deceased.

Most residents had made their end of life wishes known to staff and this information was documented in their care plans. The remaining residents had not made decisions regarding their end of life plans however; there were systems in place for recording same when they became available.

Community palliative services attend the centre to support residents with pain and symptom management on referral of residents by staff. Most staff had completed 'what matters to me' training in respect to end of life care of residents.

An end of life room was provided as part of the refurbishment project as discussed in outcome 12. Families were facilitated to stay overnight in the centre with residents who were in receipt of end of life care. Residents and their families were offered use of the centre's oratory for removal and funeral services. Residents had access to religious clergy to meet their faith needs.

An annual remembrance service was held to remember residents who had deceased during the year.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that residents were provided with a nutritious and varied diet to meet their nutritional needs in dining areas in each of the houses. The food was prepared off-site and transported to a central kitchen where it was distributed to the houses in heated transport trolleys. The food was plated at each house level by staff giving residents an option on portion size and to change their menu choice if they wished. Food temperatures were checked at various intervals through the transportation process.

The centre has policies in place to inform management of the nutritional and hydration needs of residents. The policies included evidence based practice and procedures to advise staff on nutrition assessment and hydration, protected mealtimes and guidance for assisted meals, administration of subcutaneous fluids/hypodermoclysis and recording of fluid balance intake-output. An accredited nutritional risk assessment tool was used to assess residents' needs. Residents' weights were regularly assessed, documented and closely monitored with corrective actions implemented where risk was identified. There were no residents with unintentional weight loss in the centre on the days of inspection. Fresh fruit and/or fruit dishes were provided as desert options on the days of inspection.

Staff had attended training on the malnutrition universal screening tool (MUST). Training was also available to staff on food care, high protein/high calorie diet content, basic food hygiene and dysphagia. A dietician was available to assess residents' needs if required.

Residents with swallowing difficulties were appropriately referred and assessed by the speech and language therapy (SALT) service.

There was documentary evidence that the dietician and SALT recommendations were referenced and implemented. Residents with swallowing difficulties who required assistance were assisted discretely and sensitively on a one to one basis by staff who maintained eye contact on the resident to ensure their safety with eating.

Each table in the dining room was dressed with a traditional style tablecloth. A selection of condiments was available for use by residents to suit their tastes. The inspector saw that there was a choice of hot meal options offered on a daily basis to residents. The menu was displayed. Residents spoken with by the inspector and residents who completed the Authority's pre-inspection questionnaires expressed their satisfaction with

and enjoyment of the food provided. Residents had a choice of fluids to drink with their meals, jugs of fresh water in their bedrooms and were offered hot and cold beverages and snacks throughout the day prepared in the kitchenettes in the houses.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

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

Findings:

The inspector found that residents received care in a dignified way that respected their privacy at all times during the days of inspection. The inspector observed staff knocking on residents' bedroom doors and closing doors to bedrooms and toilets during personal care activities. This practice was enhanced by the placing of a notice on closed doors advising that resident care was in progress. The inspector observed that staff interactions with residents were respectful, courteous and supportive.

The inspector noted a commitment by management to involve residents and their families in the running of the centre. Residents were consulted and their views were valued and used to inform the design and layout of the centre's refurbishment project. A residents' forum is convened on a monthly basis. Issues raised were discussed at the senior management meetings. Feedback on residents' satisfaction with the service was obtained through six monthly surveying and by use of comment card processes. There was a policy of open visiting in the centre with protected mealtimes in line with the residents' wishes. Pre-inspection relatives' questionnaire feedback confirmed that they were always made welcome when visiting in the centre. There was a variety of communal areas for residents to meet their visitors in private if they wished.

Residents were facilitated to participate in activities in the communal areas within the designated centre. A schedule of activities taking place in the various communal areas was displayed to facilitate residents to choose which activity most interested them. Activity provision was facilitated throughout all days of the week including weekends. Activities were led by staff who had completed courses in an accredited sensory based programme to meet the recreational needs of residents with cognitive impairment and dementia. The inspector observed that residents were occupied pursuing their interests

on the days of inspection.

There were systems in place and a policy available to manage temporary absence and discharge of residents.

Residents were encouraged to personalise their bedrooms and the provider and person in charge welcomed their wishes to bring items of furniture from home as their preference to the centre furniture for their use in their bedrooms if they wished. Mass was celebrated for residents each Wednesday.

Judgment:

Compliant

***Outcome 17: Residents' clothing and personal property and possessions
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.***

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector observed that residents could maintain control over their personal possessions and clothing. Residents could maintain control over their belongings and they had access to a lockable space to store their valuables. The inspector observed that residents could also lock their bedroom doors if they wished.

Residents clothing was tagged at laundry level to prevent loss of their clothing. There was no complaints logged referencing care of residents' clothing. The centre's laundry facility was viewed by the inspector and arrangements and procedures were satisfactory to ensure residents' clothing was satisfactorily laundered. Designated laundry staff were responsible for this area. The on-site laundry was used for laundering residents' personal clothing only and all other laundry was laundered in an off-site facility. Residents spoken with by the inspector expressed satisfaction with the laundry service and residents' clothing worn on the days of inspection was observed by the inspector to be well cared for and in good condition.

An up-to-date property and possession list was available for each resident and was reviewed on a six monthly basis to take account of new clothes or if clothing was discarded. These records included details of personal items and assistive equipment.

Judgment:

Compliant

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

The inspector reviewed staff training records, observed practices and spoke with staff and found that all staff working in the centre had completed mandatory training in fire safety, elder abuse prevention, recognition and management and safe moving and handling procedures. In addition to mandatory training requirements, the inspector saw that staff were facilitated to attend additional training for their professional development to support and refresh knowledge and skills to ensure residents assessed needs were met with contemporary evidence based care. The centre was approved for student nurse placement as part of their training. The inspector observed that the student nurses on placement were closely supervised by staff and a student nurse spoken with by the inspector described the placement as a good learning environment.

There was evidence to support ongoing staffing level review with revised staffing numbers in response to the changing needs of residents. The person in charge and provider completed ongoing review of staffing levels and skill mix to ensure residents' needs were met. Care of residents in each house was led and supervised by a clinical nurse manager. Staff appraisal was not in place and the person in charge advised that she had recognised same and was in the process of developing a competency assessment framework to ensure staff had the skills and knowledge to meet residents' needs. Recruitment policies and procedures were in place to inform practice.

A sample of staff employment files and the files maintained for two volunteers were reviewed by the inspector and were found to be complete as required by Schedule 1 of the regulations. All staff including volunteers were appropriately vetted. Volunteers' roles were clearly stated. The inspector found that all staff spoken with were well-informed and knowledgeable regarding residents' needs and the interventions required to meet their needs. Arrangements were in place for all staff to transfer with the residents from Oriel House to St Mary's Community Nursing Unit to ensure continuity of care and adequate staffing levels and skill mix to meet their assessed needs.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St. Mary's Hospital
Centre ID:	OSV-0000495
Date of inspection:	01/10/2015
Date of response:	03/11/2015

Requirements

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

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

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

A designated fire exit door was out of use in two houses and assessed as unsafe pending handrail installation. While there was alternative means of emergency exit, revised arrangements were not documented in the emergency fire plan.

1. Action Required:

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

¹ 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:

As from 01/10/2015 the person in charge has the procedures to follow in the event of a fire prominently displayed in the centre. Handrails to be installed at fire exit doors in 2 houses – 20/11/2015.

Proposed Timescale: 20/11/2015

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

Some improvement is required in completing the investigation process of complaints.

2. Action Required:

Under Regulation 34(1)(d) you are required to: Investigate all complaints promptly.

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

The registered provider will ensure that complaints are investigated in a timely and promptly period.

Proposed Timescale: 31/10/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

While in process, staff appraisal or competency assessment procedures were not implemented as part of staff supervision in the centre.

3. Action Required:

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

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

The person in charge will meet annually with each member of staff to review their training and other additional training they require, which they need for their role. This will commence in Jan 2016.

Proposed Timescale: 31/12/2016