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Peamount Hospital inspection report, 9 November 2011

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Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Peamount Hospital
Centre ID:	0468
Centre address:	Newcastle
	Co Dublin
Telephone number:	01 6010300
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Type of centre:	☐ **Private** ☒ **Voluntary** ☐ **Public**
Registered providers:	Peamount Hospital Incorporated
Person in charge:	Joan Guinan Menton
Date of inspection:	9 November 2011
Time inspection took place:	**Start:** 10:00 hrs **Completion:** 15:15 hrs
Lead inspector:	Sheila Doyle
Support inspector:	N/A
Type of inspection:	☒ Announced ☐ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

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

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

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Peamount Hospital is set on a 500 acre site in Newcastle, Co. Dublin. Residential and respite care for older people is provided in two units, St. Ciaran's and St. Patrick's. Care is provided for 50 residents and there were 48 residents on the day of inspection. One resident was on respite care and some residents had dementia related conditions.

Each unit has a similar layout.

St. Patrick's Unit has accommodation for 25 male and female residents. There is a ramped entrance leading to a foyer which is located centrally. A treatment room and nurses' office are located in the front hall. Directly off the foyer is the dining room which is a bright pleasant room with round tables and seating. A balcony area has been added off the dining room for use as a smoking area. The kitchen area is located to the rear of the dining room. There is a short corridor beside the dining room with a small storage area for laundry and dry stores. A washing machine and dryer is available for small personal items of residents' clothing. A sluice room is located here with a macerator and locked cupboards for the storage of chemicals. Next door is a small staff room and beside that a staff changing room with toilet, wash-hand basin and lockers.

To the right of the main entrance is the ladies bedroom accommodation with 14 beds arranged in one single, one twin, one triple and two four-bedded bays. Midway between the bays there is a sitting area. A short corridor leads off the three-bedded bay to a storage room.

To the left of the main entrance is the male bedroom accommodation which again is divided into two four-bedded bays and one two-bedded bay, a single room is also available. At the end of the bedroom accommodation is a sitting room and a short corridor leading to a small store.

There are two assisted showers, with toilets and wash-hand basins, two assisted bathrooms, with toilets and wash-hand basins and two additional assisted toilets.

St. Ciaran's Unit also has accommodation for 25 residents, is of a similar layout and offers the same facilities. In addition, a small enclosed garden is available for residents of this unit.

Location

Peamount Hospital is located on a 500 acre site on the Newcastle road, Co Dublin. The centre is accessible by bus and car and is set in a landscaped site available for residents use. Ample parking is available throughout the grounds.

Date centre was first established:	1912. Older person services since 1996
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	2

Dependency level of current residents	Max	High	Medium	Low
Number of residents	20	10	11	7

Management structure

The Provider is Peamount Hospital Incorporated which is governed by a voluntary board of directors. The person nominated on behalf of the Provider is the Chief Executive Officer (CEO) who is supported by a Director of Human Resources, a Director of Finance, a Director of Rehabilitation and a Director of Nursing. The Director of Nursing (DON) is currently on leave and the Assistant Director of Nursing (ADON) is deputising for her and is the Person in Charge. She is supported in her role by a Quality and Education Officer and a Clinical Nurse Specialist (CNS). There is a Clinical Nurse Manager 2 (CNM2) and a Clinical Nurse Manager 1 (CNM1) in both units. Unit staff report directly to the CNM on duty who in turn reports to the Director of Nursing. There is a night sister on duty for the Peamount hospital complex.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	6	6	4	2	*	**

*Administration and other staff were employed for the Peamount hospital complex and included a full range of service providers such as peripatetic personnel, maintenance, medical, finance and HR personnel.
** a physiotherapist, two occupational therapists (OT), two activity coordinators.

Background

This was an announced inspection and the second inspection to be carried out by the Authority. The purpose of this inspection was to carry out a fit person interview with the newly appointed person in charge and to review progress on the actions from the Registration inspection of September 2010.

At the 2010 inspection, while areas for improvement were identified, overall the inspectors found that the provider and person in charge met 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*. They had established strong management processes to ensure the delivery of services to residents in a consistent and safe manner and were aware that the present building would not meet the standards and had developed a five year plan to address this.

The provider and the person in charge promoted the safety of residents. A risk management process was in place for all areas of the centre. Fire precautions such as fire drills, and servicing of equipment were in place. In addition, an emergency response plan was in place with regular drills held.

The health needs of residents were met. Residents had access to on site medical cover from a consultant geriatrician and his team and a range of other health services and evidence-based nursing care was provided. Care plans were in place and the documentation was regularly reviewed.

The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day. The dining experience was pleasant, and an ethos of respect and dignity for both residents and staff was evident. However, there were not enough staff on duty in the evening to facilitate residents' choice if they wished to stay up later and as a result many residents were in bed by 7.00 pm.

Significant improvements were required to the structure of the premises in order to comply with the Regulations. Inspectors were also concerned that not all staff had undertaken mandatory training on a number of topics including fire training and prevention of elder abuse training.

Other areas identified for improvement included the statement of purpose, the Residents' Guide and the provision of lockable storage space for residents.

This inspection report can be found at www.hiqa.ie

Summary of findings from this inspection

A fit person interview was carried out with the new person in charge who was appointed in November 2011. The inspector noted that she was very familiar with the residents and staff and very aware of her responsibilities under the Regulations.

Overall, the inspector found that improvements had been made since the previous inspection. Six of the eight actions previously identified had been completed and the two remaining actions were partially completed. The two recommendations had also been completed.

Improvements were noted in care plans, the provision of mandatory training and staffing levels. The statement of purpose and Residents' Guide had been amended and residents' finances were now safeguarded.

Improvements were noted in the premises but the layout still did not meet the requirements of the Regulations. Further work was also required on staff files.

These issues are addressed in the Action Plan at the end of this report.

The inspector also noted on going development work on end-of-life care and medication management and these are discussed briefly in the report.

Actions reviewed on inspection:

1. Action required from previous inspection:

Provide premises suitable for the purposes of achieving the aims and objectives set out in the statement of purpose and that meets the requirements of the Regulations and the Standards.

Provide suitable and sufficient storage space to meet the needs of residents.

Provide personal lockable storage space for each resident.

Provide sufficient storage space for equipment.

Provide a sufficient number of toilets for residents' use.

This action was partially completed.

The current premises were not suitable for the purposes of achieving the aims and objectives set out in the statement of purpose and do not meet the requirements of the Regulations and the Standards.

The beds were arranged in bays with insufficient space for residents. Personal storage space for the residents was insufficient and additional wardrobe space had to be provided in the seating area. This additional space was located too far away from residents' beds to be of any real benefit to them. There was insufficient storage space for equipment and some equipment was seen stored behind screens in the sitting area and in unoccupied bays.

A five year strategy plan (2008 - 2013) was in place which outlined plans to redevelop and purpose build accommodation for residents within this timeframe and subject to resources. In addition, an extensive brief had been developed to cost this project, which provided for single en suite accommodation, with adequate personal and communal space, bathroom facilities and storage areas for equipment. In addition, the new accommodation would provide the necessary staff changing and showering facilities. The inspector read copies of emails confirming ongoing negotiations and planning. In addition more detailed projected costings had been drawn up and these too were shown to the inspector.

However, despite the unsuitability of the premises staff had continued to made efforts to make the centre more homely and the inspector noted several improvements since the previous inspection. The bay areas were personalised with residents' belongings and photographs. Additional shelving had been installed to provide more display areas for residents' personal items.

Two additional assisted toilets had been installed in each unit and both residents and staff commented on how beneficial this was.

Each resident was provided with a locked press of sufficient size which was secured to the wall near their beds. One resident jokingly told the inspector how important this was and how he kept all his "IOUs" locked away in it.

A sluice room was available in each unit with a macerator and locked cupboards for the storage of chemicals. A single room was developed in each unit and was used as needed for end-of-life care or management of specific infections.

Additional screening to ensure privacy was installed between the bay areas and the inspector saw that these were used in addition to the screens around the beds when personal care was being attended to. In addition it was noted that these gave a more homely feel to the bay areas.

2. Action required from previous inspection:

Arrange for all staff to attend the mandatory training.

This action was completed.

The inspector read the training records and noted that a training matrix was in place to identify when staff were due to attend training.

Mandatory training was provided for staff within the whole complex and so frequent sessions were available.

Moving and handling training was carried out on a monthly basis and all staff had attended within the required timeframe.

Training on the prevention, detection and response to abuse was carried out twice monthly and all staff had attended. The inspector noted that staff members on night duty were accommodated to attend. Staff spoken with confirmed that the training was completed and they were knowledgeable about the procedures to follow.

Fire training was held on a two-monthly basis. The inspector read the training records which confirmed that all staff had attended the training. The inspector also noted that staff who were due to attend a refresher course were scheduled in the training calendar to attend the next session.

3. Action required from previous inspection:

Update staff files to include all information required under the Regulations.

This action was partially completed.

Additional references had been obtained and the inspector saw the recruitment policy was being updated to meet the requirements of the Regulations. A tracking system was in place to track the information obtained for inclusion in the staff

personnel files. The HR manager discussed with the inspector ongoing progress in this area and the inspector read a sample of letters sent to staff outlining the additional information required.

However evidence of Garda Síochána vetting was not available on all staff files as required by the Regulations. It was available on files of all staff recruited since 2007. Overall, evidence of Garda Síochána vetting existed for 94% of staff working in the residential units.

4. Action required from previous inspection:

Ensure that at all times the numbers and skill-mix of staff are appropriate to the assessed needs of residents.

This action was completed.

This related to the staffing numbers available from 8.30 pm when there were only two staff members on duty in each of the units and inspectors saw that most of the residents were returned to bed at 7.00 pm as a result. Inspectors were concerned that the reduction in the number of available staff from early evening meant that residents returned to bed as part of staff routine and not by choice.

Following negotiations with staff, a four month trial of a new staffing roster had been implemented. This allowed for one additional staff member to be on duty in each unit until 9.30 pm. This ensured more flexibility and choice for residents at evening time. The inspector read the rosters and spoke to staff who confirmed that this was so. Residents also stated that this was so.

The new rostering trial was continuing and the intention was to seek feedback from staff, residents and nursing administration as to the benefits or otherwise to all concerned before completion.

The inspector also noted that staff had developed a questionnaire for residents with a plan to distribute it in the near future. This was to seek residents' opinions on what their preferences were for this time of the evening. It also included questions on whether there was any particular activity they would like to undertake in the evenings.

5. Action required from previous inspection:

Put in place a secure, robust and transparent system to safeguard residents' finances.

This action is completed.

Each resident had been provided with a locked press to safety store their own monies. A billing system had been introduced for residents who wanted to purchase their own newspapers. This was then handled through the central finance

department. The CNM confirmed that nursing staff no longer manage any money for residents at unit level.

6. Action required from previous inspection:

Revise the statement of purpose to include a statement as to the matters listed in Schedule 1 of the Regulations.

This action was completed.

The statement of purpose was updated to meet the requirements of the Regulations. It was currently being amended to reflect the change in person in charge.

7. Action required from previous inspection:

Amend the Residents' Guide to include all the information required by the Regulations.

This action was completed.

The Residents' Guide was updated to meet the requirements of the Regulations.

8. Action required from previous inspection:

Keep the residents care plans, including the assessment of the activities of daily living, under formal review, no less frequently than at three-monthly intervals, with involvement of the resident.

This action was completed.

New care plan documentation was introduced. The inspector read a sample in both units and noted that at a minimum, three-monthly reviews were carried out and signed by staff and residents or relatives.

In addition the care plans were now being audited on a three-monthly basis. A named nurse had responsibility for a given number of residents. This allowed the results of the audit to be used to identify if an individual nurse required more training and support in order to complete the documentation to a satisfactory standard. The inspector saw where additional supports had been put in place for some nursing staff, and improvements in the documentation were noted in the following audit as a result.

Best practice recommendations from previous inspection:

Provide suitable signage to enhance the privacy, dignity and independence of residents and visitors.

This recommendation was completed.

Additional signage was provided on the approach to both units, to ensure residents and visitors could easily identify the units in advance of entering them.

Best practice recommendations from previous inspection:

Continue to develop the programme of activities to include appropriate and meaningful activities at the weekend.

This recommendation was completed.

The inspector saw the activity programme which was displayed in both units. She also spoke with the activity coordinator and staff who confirmed that the programme now covered the seven days. Various activities were scheduled for the weekend and were organised either by the activity coordinator or unit staff.

Other issues identified at inspection:

End of Life Care
The inspector saw where the centre had been involved in developing and piloting the Hospice Friendly Hospital (HfH) programme and standards. They were now introducing the HfH quality standards for end-of-life care into their practice.

A review of deaths in the centre was carried out particularly concentrating on the last 48 hours of life. Base line audits were completed and current deficits identified. These included the need for the provision of a single room should that be the residents' wishes. It also identified the need for better communication between the residents/families and the staff. Additional documentation and training was also required.

The inspector noted that many of these issues had been addressed. A single room was set aside and was currently being redecorated. Additional equipment had been purchased including an altar which was designed by the HfH for use in hospitals when a resident was at end of life or following their death. The inspector saw that it housed religious artefacts. The family handover bag had also been introduced to facilitate the discreet and dignified return of personal possessions of a deceased resident to family members. In order to facilitate a more dignified and respectful removal of a deceased person from the unit to the mortuary, specific trolley drapes had also been purchased.

A staff member was providing ongoing training for staff on the use of syringe drivers to aid in the management of pain. Support and advice was provided by the local palliative care tem. The person in charge told the inspector that they are currently developing a bereavement policy.

Report compiled by:

Sheila Doyle

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

10 November 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
14 September 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report *

Centre:	Peamount Hospital
Centre ID:	0468
Date of inspection:	9 November 2011
Date of response:	23 November 2011

Requirements

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

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

The current premises were not suitable for the purposes of achieving the aims and objectives set out in the statement of purpose and do not meet the requirements of the Regulations and the Standards. The beds were arranged in bays with insufficient space for residents.

Personal storage space for the residents was insufficient and additional wardrobe space had to be provided in the seating area.

There was insufficient storage space for equipment and some equipment had to be stored behind screens in the sitting area and in unoccupied bays.

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

Action required: Provide premises suitable for the purposes of achieving the aims and objectives set out in the statement of purpose and that meets the requirements of the Regulations and the Standards.	
Action required: Provide suitable and sufficient storage space to meet the needs of residents.	
Action required: Provide sufficient storage space for equipment.	
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:**
Provider's response: A five year strategy plan (2008 - 2013) is in place which outlines plans to redevelop and purpose-build accommodation for residents within this timeframe and subject to resources. In addition, an extensive brief has been developed to cost this project, which will provide for single en suite accommodation, with adequate personal and communal space, bathroom facilities and storage areas for equipment. In addition, the new accommodation would provide the necessary staff changing and showering facilities. There are on going negotiations and planning to progress this plan. In addition more detailed projected costings had been drawn up.	2014

2. The provider has failed to comply with a regulatory requirement in the following respect: Some staff files did not meet the requirements of the Regulations e.g. some were missing the third reference whilst others did not have evidence of Garda Síochána vetting.
Action required: Put in place recruitment procedures to ensure that full and satisfactory information in respect of the matters set out in Schedule 2 is available.

Reference: Health Act, 2007 Regulation 18: Recruitment Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Recruitment and Selection policy and procedures will be amended to comply with the requirements of the Regulations in regard to seeking third references for all staff currently working in the residential units identified. The Hospital is currently awaiting direction from the Health Service Executive on the most appropriate approach to dealing with the outstanding Garda Síochána vetting requirements.	

Any comments the provider may wish to make:

Provider's response:

Peamount acknowledges the professional and courteous manner in which the inspection was carried out. All staff involved in the inspection found it a positive experience and feel encouraged and motivated to continue to improve the standard of care to our residents.

Provider's name: Peamount Hospital Incorporated
Date: 23 November 2011