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**St. Mary's Hospital, Shercock
Road, Castleblayney, Monaghan.**

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Authors	Connolly Gargan, Catherine Rose
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**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:	ORG-0000495
Centre address:	Shercock Road, Castleblayney, Monaghan.
Telephone number:	042 974 0014
Email address:	cathal.hand@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Cathal Hand
Person in charge:	Margaret McNally
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	56
Number of vacancies on the date of inspection:	14

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 judgements 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.

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 2009 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 monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
21 March 2014 12:00	21 March 2014 17:00
25 March 2014 09:00	25 March 2014 15:00
18 June 2014 09:00	18 June 2014 12:00

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

Outcome 01: Statement of Purpose
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 16: Residents Rights, Dignity and Consultation
Outcome 17: Residents clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This inspection was an announced inspection for the purpose of monitoring on-going compliance with the regulations and standards on the first two days of inspection and to review the completed refurbishment of Lorgan unit prior to residents moving into it on the third day of inspection. Progress with completion of the action plan developed from findings during inspection of the centre by the Authority in November 2013 was evaluated. The inspector found that actions required were all satisfactorily addressed with the exception of the existing layout and design of the currently occupied resident accommodation. The provider has capped admissions at a maximum occupancy of 56 residents while the centre refurbishment project is underway. The premises are currently undergoing substantial refurbishment to meet 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 refurbishment of the Lorgan unit constitutes the first phase of an extensive refurbishment project involving the full centre premises. Aspects of the remaining units do not comply with the requirements of the regulations or recommendations of

the Standards in terms of residents' accommodation, space, ratio of sinks available and multi-occupancy rooms. An inspection of the newly refurbished Lorgan unit was completed on the 18 June 2014 by the Authority prior to residents moving into this accommodation. These premises will provide accommodation for thirteen residents with a confirmed diagnosis of dementia in one single en-suite and six en-suite twin bedrooms. 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. The Lorgan unit 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 with dementia care needs in a comfortable and homely way.

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 day-time staff duty rota, 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.

Medication management required improvement and is the subject of an action plan with this report. Nurses were involved in transcription of residents' medications which the inspector was told was to assure legibility and to reduce risk of error hence a control was in place whereby this practice was confined to clinical nurse manager grade only. However, the inspector observed that the signatures of the transcribing nurse and a second person to check the entry was not documented on each prescription.

Other areas that required minor improvement included risk management, detail in the statement of purpose document, installation of a handrail on a sloped pathway to improve safety for vulnerable pedestrians and a bed screen did not extend the full distance around a resident's bed in one area currently accommodated by residents.

The action plan at the end of this report identifies areas where improvements are required to comply 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.

Section 41(1)(c) 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), Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 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:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

A revised statement of purpose and function dated June 2014 was forwarded to the Authority to take account of changes made as a result of completion of phase one of the Lorgan unit refurbishment project. However, the document was missing some required information including;

- Total staffing complement, in whole time equivalents for the centre with nursing and management staff given by grade.
- The organisational structure did not include all staff, for example, staff nurses, carers, administration, catering, cleaning and others.
- Registration number and conditions of registration as detailed on the centre's registration certificate.
- The maximum overall number of residents who will be accommodated with age range of residents for whom it is intended that accommodation should be provided.
- Not all resident accommodation room size details were included for each unit in addition to communal areas outside the units e.g. new hairdressing salon/coffee dock and bar.

A copy of the revised statement of purpose containing missing required information should be forwarded to the Chief Inspector and made available to residents.

Judgement:

Non Compliant - Moderate

Outcome 06: 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.

Theme:

Safe Care and Support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Measures were in place to protect residents being harmed or suffering abuse are in place. A policy was in place dated May 2014 which adequately informed management of allegations of abuse. It 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. She provided training for staff and there was evidence of on-going staff refresher training for 2014. 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. Residents spoken with told the inspector that they felt safe and that staff were kind and patient with them. The front door to the centre was monitored by closed circuit television and by a receptionist who requested the inspector to complete the visitors' book. The main entrance doors were locked after 17:00hrs and access was controlled by staff thereafter. A member of security staff was on duty in the centre each night.

Judgement:

Compliant

Outcome 07: 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:

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. However, the risk management policy/procedure informing practice was due for review in November 2012. The missing person policy was up to date at the time of inspection but did not reference procedures if a resident went missing during the night when staffing levels were reduced. However in practice preventative procedures were robust in that all residents had a missing person profile completed which included use of good quality photographs. There was identification following assessment of residents who were at increased risk of leaving the centre unaccompanied, the inspector viewed the controls in place which were satisfactory. All staff had participated in missing person drills which were convened regularly. In addition, a missing person pack was readily available to expedite timely location of the missing resident. The pack included torches, high visibility vests and a folder containing each resident's profile information.

The policy informing management of behaviour that challenges also required some additional information to inform identification of triggers and de-escalation techniques. However, while the policy required improvement, in practice this area was well managed. The inspector observed that training on managing behaviour that challenges

and training in dementia care was provided for staff as part of their professional development. In addition, there was a proactive approach to reducing use of psychotropic medication. For example, the inspector was told that psychotropic preparations were reduced to use by two residents in low doses. A weekly report was produced by each unit manager to include information including incidents of challenging behaviour, restraint and use of psychotropic medication. A policy on management of self-harm and violence and aggression including assault were available.

A risk register was in place in each area, information which identified hazards were risk assessed with controls documented to mitigate these risks. The inspector reviewed the risk assessment documentation in place to ensure building work taking place on-site did not negatively impact on the safety and well-being of residents and others. This documentation was found to identify all risks posed and included adequate controls. On the 18 June 2014, the inspector reviewed the completed Lorgan unit prior to occupation by residents. Documentation was in place that identified potential hazards and was analysed with stated controls in place. The inspector also observed that learning from hazards posed by the existing residents' accommodation was applied where possible at the planning and design stages of the refurbishment project for Lorgan. Subsequently, many risks were eradicated through building design modifications. For example, security of hazardous areas such as the sluice and clinical room, external grounds for use by residents including sloped pathways, privacy assurance included the installation of window glass that obstructed visibility in without reducing visibility out in low level windows, installation of ceiling anchored hoists in all residents' accommodation and push-bar final fire exit doors among others.

A fire management policy was available dated May 2014, local specific arrangements put in place as a result of risk assessment were included in the fire policy for that area, for example, a fire extinguisher that posed a risk to vulnerable residents was stored inside the cleaners' room on Lorgan unit. In addition this control was displayed on the door of the cleaners' room. Staff knowledge of fire alert equipment was the subject of an action plan developed from findings during the last inspection of the centre on the 06 November 2013. The inspector observed that a simplified algorithm was displayed by break-glass units to inform staff and others on activation procedures if required. This control was recorded as a safety measure to ensure mitigation of risk in the event of fire. The inspector reviewed fire safety arrangements in the centre. Weekly checking of the fire alarm, equipment and fire exit doors was in place. Personal emergency evacuation plans were available for each resident detailing their equipment and staff requirements in the event of an evacuation been required. Staff spoken with were knowledgeable about the procedure they should take in the event of a fire. Staff refresher fire safety training was in progress for 2014. All staff participated in a fire drill on a twice annually basis. The inspector observed that staff had been given the opportunity to participate in a full simulated fire incident and evacuation practice in April 2014, facilitated and aided by management of the centre and the local fire brigade. While this exercise afforded staff the experience of a realistic emergency, it was used to test the fire safety arrangements in the newly refurbished Lorgan unit and to identify areas for improvement. As a result, an external fire evacuation route pathway was widened to ensure safe evacuation of residents to the designated assembly area.

The absence of a call-bell to alert staff in one area, crowded communal areas and lack

of appropriate supervision by staff was identified as areas requiring review in the action plan from the inspection in November 2013. The inspector found that each of these areas had been addressed and satisfactorily completed. A temporary call-bell system was installed in the sensory room in the Kavanagh unit. Daily documented checking was in place to ensure it was in working order in the event of residents needing to use it. It was also recorded in the risk register as a control promoting the safety of residents using this room. The layout of communal areas used for residents in addition to the implementation of structured staff supervision of these areas. These arrangements had been strengthened by the identification of staff designated the role of supervision on the duty rota.

The inspector examined the records of accidents and incidents some of which incurred notification to the Authority as required due to injury sustained to residents. Copies of internal investigation completed including mitigation of risk procedures were forwarded to the Authority as requested and were found to be comprehensive and references actions taken to mitigate any risk of re-occurrence and promote residents' safety.

Judgement:

Non Compliant - Minor

Outcome 08: Medication Management

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

Theme:

Safe Care and Support

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector observed administration of medication to residents on the Ashbury Unit which was not observed to follow best practice procedures as outlined in the centre's policy document. Medication management was informed by a policy document dated January 2013. This policy included information on medication prescribing, administering, recording and safekeeping but required review to reference medication disposal procedures. Nurses were involved in transcription of residents' medications which the inspector was told was to assure legibility and to reduce risk of error hence a control was in place whereby this practice was confined to clinical nurse manager grade only. The inspector observed that the signatures of the transcribing nurse and a second person to check the entry was not documented on each prescription.

All discontinued medications were signed and dated by the residents' GP. Some 'as required' (PRN) medications did not have a maximum dose over 24 hours stated on the prescription record. Instruction for 'crushing' of some residents' medications was detailed as an instruction on the front of the prescription and administration document. This did not clearly inform staff administering medications regarding which individual medications could/were to be crushed or if combining any of the crushed medications was contraindicated.

An assessment tool was in use to assess and inform administration of 'as required' medication to residents with symptoms of pain.

The finding of a medication tablet on the floor was the subject of an action plan from the last inspection in November 2013. The person in charge was required to conduct an internal investigation into this incident. This was forwarded to the authority and procedures to mitigate risk of re-occurrence were satisfactory. All medications were found to be stored and secured in line with legislative and professional guidelines. Observation of medication administration practices on this inspection involved confirmation by staff that swallowing of medications administered to residents was complete in each case.

Medications that were controlled under the Misuse of Drugs (Safe Custody) Regulations, 1982 were stored securely in a double locked cupboard and stock levels were recorded at the end of each shift in a register by two members of staff.

Changes in the newly refurbished unit included installation of secure boxes anchored inside wardrobes to be used for storage of each individual resident's medications. While the medication policy informs procedures for managing medication self-administration, the inspector was told that each resident will be assessed in that regard. However, this revision of medication storage was primarily to foster a 'household' model of care where residents were afforded a sense of control and ownership over their medications empowered by assessed level of staff support in each case.

Judgement:

Non Compliant - Moderate

Outcome 10: Reviewing and improving the quality and safety of care

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

Theme:

Effective Care and Support

Outstanding requirement(s) from previous inspection:

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

Findings:

There was evidence of a system in place to review, monitor and improve the quality and safety of care and the quality of life of residents. The inspector found evidence that the quality of care and experiences of the residents were monitored and developed on an ongoing basis. Residents received respectful care and discussions with staff demonstrated their commitment to ensuring care was safe and that residents enjoyed a meaningful and fulfilling life in the centre. Clinical audits to review incidence of wounds including pressure related skin damage, weight loss, complaints, medication errors, challenging behaviour falls, and whether residents remained in bed, incidence of communicable infection and others was collated on a weekly basis by the person in charge. This information was analysed at the end of each month and findings were sent to the clinical nurse manager in each unit. A monthly meeting convened by the person in charge with clinical nurse managers from each unit to address audit findings. The inspector saw where there were actions to be taken informed by audits documented as

outcomes of these meetings. However, some improvement was required to reference risk assessment procedures to facilitate prioritisation of areas of greatest risk to residents. Timescales and person with allocated responsibility to lead completion of actions was not stated in each case.

Environmental audits including a health and safety audit was completed and was seen by the inspector. There was evidence that prioritisation of high risk deficits identified on analysis of the information collated was done but details of the risk assessment completed was not clear to inform details of risk mitigation. The inspector noted, twenty seven hazards had been found in one unit with evidence of progression to resolution and prioritisation of deficits that could potentially impact on residents' safety and quality of life in the centre. A major refurbishment project is underway of which phase one was completed and reviewed by the inspector on the 18 June prior to occupation by residents. The inspector saw evidence of consistent and on-going inclusion of residents and their families in the process including site visits, feedback and consultation. A resident satisfaction survey is completed every six months which seeks residents' feedback on satisfaction with care, catering, staff and environment. There was evidence that information received in satisfaction survey feedback was utilised to inform aspects of the centre refurbishment project. The provider and person in charge were in the process of compiling a report to detail audits completed and subsequent improvements in the quality and safety of care and the quality of life that are manifest in positive outcomes for residents.

Judgement:

Compliant

Outcome 11: Health and Social Care Needs

Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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:

No actions were required from the previous inspection.

Findings:

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

The inspector reviewed care of residents with exhibiting intermittent episodes of

challenging behaviour. While the policy informing this area of care required some improvement as discussed in Outcome 7 of this report, in practice care of these residents was satisfactory. The inspector saw where a resident exhibiting episodes of challenging behaviour had a care plan in place describing management strategies for this behaviour including details advising of triggers and effective de-escalation procedures.

The inspector reviewed a sample of care plans developed to meet residents assessed needs. The format of nursing documentation was revised following the registration inspection of the centre in 2011. The inspector observed that residents' needs were clearly identified and documented. Residents' needs were identified by means of accredited assessment tools and care plans were in place to inform care practices. Progress notes were linked to care plans. Reassessment of need was completed every three months or more often if required. Residents' weights were monitored to ensure their health and well-being and to identify significant weight loss or gain at an early stage. Where there was evidence of weight loss, a proactive programme was commenced including monitoring procedures, recording of intake and review by a dietician who attended the centre on a weekly basis as a matter of routine. The dietician reviews all residents on a monthly basis.

Residents had access to a recreational programme reflecting their interests and capabilities. Some residents went out with family and/or friends on a regular basis. All members of the staff team caring for residents with a diagnosis of dementia had completed training in dementia care and sensory therapy. 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 with a focus on retaining and fostering their feelings of self-worth and usefulness. As a quality improvement initiative all staff working with residents in the dementia care unit were empowered through training and in-service education to meet the care and recreational needs of each person on a 1:1 basis.

Judgement:

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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Care and Support

Outstanding requirement(s) from previous inspection:

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The centre comprised four separate units accommodating residents. The refurbishment

of the Lorgan unit constitutes the first phase of an extensive refurbishment project involving the full centre premises. An action plan developed from findings during the last inspection in November 2013 referenced the finding that aspects of the design and layout did not meet residents' needs in respect of adequacy of shared spaces, hand hygiene facilities in twin rooms, ventilation in a clinical room and damaged flooring in a bath/shower room. The inspector found that this action plan was partially completed. A bath/shower room floor on Drumlin unit was repaired and a window in the clinical room was replaced to allow for sufficient ventilation. The remaining units do not comply with the requirements of the regulations or recommendations of the Standards in terms of residents' accommodation, space, ratio of sinks available and multi-occupancy rooms. The Authority was forwarded a copy of plans detailing how the premises would be brought into compliance on a phased basis. Completion of phase one with refurbishment of the Lorgan unit within set timescales has enabled planning to commence for phase two to commence in October 2014.

An inspection of the newly refurbished Lorgan unit was completed on the 18 June 2014 by the Authority prior to residents moving into this accommodation. These premises will provide accommodation for thirteen residents with a confirmed diagnosis of dementia in one single en-suite and six twin en-suite bedrooms. 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. The Lorgan unit 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 with dementia care needs in a comfortable and homely way.

The fitting, layout and floor space requirements as set out in criteria for existing designated centres in the National Quality Standards for Residential Care Settings for Older People in Ireland and legislation were met. The unit was painted in pastel shades and each room was painted in a different colour. Furniture and fittings including wall pictures were selected to foster a sense of homeliness, comfort, familiarity and freedom within the environment. A number of the rooms were fully furnished on the day of the inspection.

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 meet privacy needs 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, level access showers were available in each en-suite. Mirrors and lighting were provided over each wash basin. The bathrooms were tiled, maintained in a clean condition and were ventilated mechanically. Grab support rails were provided alongside all toilets and showers.

The corridors in the Lorgan unit were wide and spacious with handrails in a contrasting

colour on both sides to facilitate safe walking areas. All doors facilitated access and egress for wheelchairs and beds in the event of an emergency.

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

The centre contained a sitting room, a kitchenette with open access to a spacious dining room. The kitchenette had a number of safety features fitted to ensure residents could safely access this area including a convection hob. The sitting room is spacious and furnished in a domestic style including a large dresser. A hairdressing salon was also newly constructed and was located immediately outside the Lorgan unit as it will form part of the services all residents in the centre can access along a central point to resemble a shopping street.

Hand gel dispensers were available throughout the centre in addition to hand wash sinks which were in line with infection control best practice standards.

A clinical room, storage rooms, and cleaners' rooms were also available. The unit had two sluice rooms equipped with stainless steel sinks, a wash-hand basin and storage areas for bedpans. A bed pan washer was provided.

Laundry storage areas were located on corridors to enhance accessibility.

The centre building and a number of public areas within the centre were monitored by CCTV surveillance. Use of CCTV is supported by a policy and notice of use of CCTV is displayed. While access to the centre is monitored and controlled. An additional access control is in place to the Lorgan unit. Access to Lorgan unit is controlled by the staff there, who had access to a closed circuit viewing unit of the front door of the unit as the nurses station is not located in the body of the unit.

The external enclosed garden can be accessed at a number of points from the Lorgan unit. Many features were included to enhance the quality of the garden as an occupational, therapeutic and restful environment. The inspector observed raised planting beds, a water-feature where water bubbled up through stones, meandering paths, trellis shading and seating. Not all plants and shrubbery was in place however, the inspector was told that they would be selected with an aim of stimulating the senses. Plants already in place included bright pink scented roses.

There were sloped pathways in place to one side of the building; handrails were in place on both sides of the pathways with the exception of one which had a handrail on one side only.

Judgement:

Non Compliant - Moderate

Outcome 16: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each residents 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.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection:

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

Findings:

Window blinds had not been pulled down between each ward which meant that residents, visitors and staff could see directly into each unit was observed on the last inspection of the centre in November 2013 and was the subject of an action plan following that inspection. The inspector observed that all these window blinds were closed on this inspection. Dignity and respect was included as a standing agenda item on all team meetings. A member of the Regional Nursing and Midwifery Professional Development Unit spoke at the clinical nurse managers' team meeting on 18 February 2014. Following same, the contents of the presentation was shared with unit staff by each clinical nurse manager at the unit team meetings. Training in this area was being organised at the time of this inspection.

The inspector observed that residents' privacy needs were met and respected by all staff throughout the days of inspection. Residents' personal needs were discretely managed by staff. However, the inspector noted that a bed screen did not extend the full distance around a resident's bed in one area.

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. The refurbishment plans were displayed along the main corridor in the centre for residents' information. A residents' forum was convened every four to six weeks. The inspector reviewed the minutes of same and noted that food and recreational activities were discussed. As a result the catering manager attended the next meeting and themed days were organised as part of the social programme. For example, a tea party was organised in March 2014 and a fish and chip day was organised on the 04 April 2014. Residents with communication needs had care plans in place to inform staff on the interventions to be implemented to address areas of need, for example, a resident who had diminished sight was provided with a communication tool, staff took additional time to orientate them to their surroundings and increased attention was given to supporting them to engage in meaningful recreational activities. The inspector observed that signage in the new Lorgan unit was in text and pictorial format on signage with contrasting background colours to the colour on walls to enhance visibility. Bathroom and toilet fittings and handrails in circulating areas were in a contrasting colour also. Wall colours in bedrooms were soft to promote rest.

Judgement:

Non Compliant - Minor

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:

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

Findings:

Lack of adequate space for residents' clothing was the subject of an action plan following the last inspection in November 2014. The inspector found that this issue was satisfactorily resolved. All residents had adequate storage space in each unit of the centre. While storage of residents' clothing was in wardrobes that were restrictive due to their size, residents were provided with four drawer units, clothing was stored neatly in three drawers and toiletries was stored in the fourth drawer which could be locked by the resident if they wished or the contents posed a risk of ingestion. Storage for residents' property and possessions in the newly refurbished Lorgan unit was of a good standard with provision of large double wardrobes which were partially shelved, in addition to spacious drawer units that also served as lockers.

An up-to-date property and possession list was available and was reviewed on a six monthly to take account of new clothes or if clothing was discarded. Residents clothing was appropriately labelled to reduce the risk of loss or misplacement. Residents' clothing was observed to be clean and in good condition and residents spoken with confirmed that their clothing was well looked after by staff.

Judgement:

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.

Theme:

Workforce

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector found that there was appropriate staff numbers and skill mix to meet the assessed needs of residents, given the size and layout of the designated centre. All staff

working in the centre were included on the staff rota which detailed hours of duty for each staff member. A nurse was on duty at all times in each unit in the absence of a clinical nurse manager who was designated as the lead member of each unit team. Staff were appropriately supervised and the inspector observed that clinical nurse managers involved themselves in care delivery. A formalised arrangement was in place where each clinical nurse manager was supernumerary to calculation of staffing level requirements to meet the assessed needs of residents. Clinical nurse managers had protected management days indicated on the staff rota where they were involved in the administration of the unit and quality assurance in their area of responsibility. The inspector found that staff had up-to-date mandatory training and access to ongoing internal and external education and training to inform their practice in meeting the needs of residents. A lack of knowledge on setting pressure relieving mattress pump pressures was found on the last inspection in November 2013 and was the subject of an action plan following same. Staff training had been completed on use of specialist equipment including pressure relieving mattress pumps. This training was documented on the staff training records. The inspector found staff to be well informed and confident in their role. They were well supported by senior staff including the person in charge.

Judgement:

Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

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:	ORG-0000495
Date of inspection:	21/03/2014
Date of response:	06/11/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure 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 2009 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

Theme:

Leadership, Governance and Management

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

The statement of purpose document was missing some required information including;

- Total staffing complement, in whole time equivalents for the centre with nursing and management staff given by grade.
- The organisational structure did not include all staff, for example, staff nurses, carers, administration, catering, cleaning and others.
- Registration number and conditions of registration as detailed on the centre's registration certificate.
- The maximum overall number of residents who will be accommodated with age range of residents for whom it is intended that accommodation should be provided.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

- Not all resident accommodation room size details were included for each unit in addition to communal areas outside the units e.g. new hairdressing salon/coffee dock and bar.

Action Required:

Under Regulation 5 (1) (c) you are required to: Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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

The Statement of Purpose has been updated and contains each of the aspects that were identified as missing.

Proposed Timescale: Completed

Proposed Timescale:

Theme:

Leadership, Governance and Management

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

A copy of the revised statement of purpose containing missing required information should be forwarded to the Chief Inspector and made available to residents.

Action Required:

Under Regulation 5 (2) you are required to: Make a copy of the Statement of purpose available to the Chief Inspector.

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

The updated Statement of Purpose is available to all of the Residents in the Centre. A copy has been provided to the Authority and the Chief Inspector with this Action Plan.

Proposed Timescale: Completed.

Proposed Timescale:

Outcome 07: Health and Safety and Risk Management

Theme:

Safe Care and Support

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

The risk management policy/procedure informing practice was overdue for review since November 2012. The missing person policy was up to date at the time of inspection but did not reference procedures if a resident went missing during the night. The policy informing management of behaviour that challenges also required some additional information to inform identification of triggers and de-escalation techniques.

Action Required:

Under Regulation 31 (2) (c) you are required to: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

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

The Risk Management Policy for the Centre has been reviewed and updated. A copy is available to view in the Centre and a copy is attached with this Action Plan.

A separate policy has been written for the Management of Self Harm and a copy of this policy is also available to view and attached with this Action Plan.

The Missing Persons Policy has been updated to include the necessary procedures if a Resident goes missing during the night. A copy is available to view in the Centre and a copy is attached with this Action Plan.

The policy on the Management of Challenging Behaviour is currently under review. It will be finalised and signed off by the Management Team at its next meeting. At that point a copy of the updated policy will be available to view in the Centre and a copy will be forwarded to the Authority.

Proposed Timescale: Completed for Risk Management, Management of Self Harm and Missing Persons policies. The policy on the Management of Challenging Behaviour will be completed by Friday 1st August and a copy forwarded to the Authority.

Proposed Timescale:

Outcome 08: Medication Management

Theme:

Safe Care and Support

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

The signatures of the transcribing nurse and a second person to check the entry was not documented on each prescription.

Some 'as required' (PRN) medications did not have a maximum dose over 24 hours stated on the prescription record.

Instruction for 'crushing' of some residents' medications was detailed as an instruction on the front of the prescription and administration document. This did not clearly inform staff administering medications regarding which individual medications could/were to be crushed or if combining any of the crushed medications was contraindicated.

Action Required:

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

The signatures of the transcribing nurse and a second person to check the entry is now

documented on each prescription. This is available to view on inspection.
All 'as required' PRN medications now have a maximum dose over a 24 hour period stated on the prescription record. This is available to view on inspection.
Where a prescription contains a medication that needs to be 'crushed', this is clearly indicated on the prescription. Each prescription also documents if combining any of the 'crushed' medications is contraindicated. This will be documented by the prescriber in the Special Considerations section on the prescription. A copy is available to view on inspection.

Proposed Timescale: Completed

Proposed Timescale:

Theme:

Safe Care and Support

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

The medication management policy included information on medication prescribing, administering, recording and safekeeping but required review to reference medication disposal procedures.

Action Required:

Under Regulation 33 (2) you are required to: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

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

The Medication Management Policy has been updated to include clear and specific reference to medication disposal procedures. . A copy is available to view in the Centre and a copy is attached with this Action Plan.

Proposed Timescale: Completed.

Proposed Timescale:

Outcome 12: Safe and Suitable Premises

Theme:

Effective Care and Support

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

Aspects of the design and layout of three units of resident accommodation did not meet residents' needs in terms of adequacy of shared spaces, hand hygiene facilities in twin rooms and multi-occupancy rooms.

Action Required:

Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and

needs of the residents.

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

With the ongoing capital works that are underway in the Centre, one of the three Units referenced with regard to design and layout issues has now been closed since the date of the last inspection. Before the end of 2014, the remaining two Units will also be closed, on completion of Phase 2 of the Capital Programme. In the interim period the Registered Provider and Person in Charge will ensure that available space, storage and hygiene facilities are maximised in the remaining multi-occupancy rooms.

Proposed Timescale: The closure of all three Units will be achieved by January 2015.

Proposed Timescale:

Theme:

Effective Care and Support

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

A sloped pathway had a handrail on one side only.

Action Required:

Under Regulation 19 (3) (o) you are required to: Provide and maintain external grounds which are suitable for, and safe for use by residents.

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

A second handrail will be put in place on the opposite side of this sloped pathway.

Proposed Timescale: 15/08/2014

Outcome 16: Residents Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

A bed screen did not extend the full distance around a resident's bed in one area.

Action Required:

Under Regulation 10 (c) you are required to: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

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

The bed screen referred to above was replaced on the day of the Inspection by a bed screen that does extend the full distance around the Resident's bed.

Proposed Timescale: Completed.

Proposed Timescale:

