# Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady's Hospice and Care Services</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000465</td>
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<tr>
<td>Centre address:</td>
<td>Harold's Cross, Dublin 6w.</td>
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<tr>
<td>Telephone number:</td>
<td>01 406 8700</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:info@olh.ie">info@olh.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Our Lady's Hospice Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Mo Flynn</td>
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<tr>
<td>Lead inspector:</td>
<td>Deirdre Byrne</td>
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<tr>
<td>Support inspector(s):</td>
<td>Liam Strahan</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>100</td>
</tr>
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<td>Number of vacancies on the date of inspection:</td>
<td>10</td>
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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 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 renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 07 October 2014 09:30 08 October 2014 08:00
To: 07 October 2014 18:30 08 October 2014 18:00

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

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Summary of findings from this inspection
Inspectors assessed compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards of Residential Care Settings for Older People in Ireland. As part of the inspection, inspectors met with residents and staff members, observed practices and reviewed documentation such as care plans, accident logs, policies and procedures.

At this inspection, inspectors found the centre had clearly defined lines of authority in place, and there were robust systems to ensure effective operational governance of the centre. Inspectors were satisfied with the ongoing the fitness of the person acting on behalf of the registered provider (the provider) and the person in charge.
Overall, inspectors found a high level of compliance with the Regulations. The staff were familiar with the residents and their health care needs. The residents were afforded choice in how they went about their day, and what services they availed of. Staff treated the residents in a kind, patient and dignified manner, and were knowledgeable of their health care needs. The residents were regularly consulted with about the running of the centre. Care was provided to residents in a timely and effective manner, with medical, pharmaceutical and a range of allied health professionals employed directly by the service.

There were adequate staffing levels and skill mix to meet the assessed needs of residents. There were robust staff recruitment processes in place.

However, the management of nutrition also required improvement. Also, improvements were identified in relation to the management of falls and care planning.

Inspectors assessed compliance with the eight required actions from the previous inspection of October 2013. Seven actions were completed. One was not fully addressed, and related to the premises.

These and all other matters are outlined in the report and Action plan at the end of the report.
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 2013 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:**
Inspectors were satisfied a written statement of purpose was developed for the centre that met the requirements of Regulation 3 and Schedule 1 of the Regulations.

The statement of purpose outlined the aims, mission and ethos of the service. It provided a clear and accurate reflection of facilities and 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:**
Inspectors were satisfied there was a clearly defined management structure that outlined the lines of authority and accountability, with systems in place to review the safety and quality of life of residents.

The centre was overseen by a board of directors with meetings held every two months. The provider was based full time in the centre. There were regular management
meetings between the provider, the person in charge and senior management. Minutes read by inspectors confirmed meetings took place at frequent intervals and a range of issues were discussed regarding the operation of the centre such as residents health, infection control, tissue viability, falls management, staffing levels and risk management.

There were robust systems in place to monitor the quality and safety of care and the quality of life of residents. The deputy director of nursing outlined the auditing system in place. Inspectors reviewed a sample of documented audits, reviews and surveys carried out. In addition, a "nurse metrics" audit was carried out each month. This was an audit of key performance indicators over the four units in the centre, along with other services on the wider campus. A sample of six files per unit were assessed. This included a residents satisfaction survey. A detailed report was compiled and action plan generated where issues identified were addressed. An audits for August 2014 was read. There was evidence of the change and learning from the monitoring carried out. For example, a care plans had not been developed for a newly admitted. It was decided that a nurse would be nominated to a newly admitted resident in the future to ensure all assessments and care plans were developed.

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:
Inspectors were satisfied that a guide to the centre was available to residents and a contract of care agreed with each resident on their admission to the centre.

There was evidence a written contract of care was agreed with residents on their admission to the centre. A sample of contracts were reviewed, they set out the services to be provided and the fees to be charged. A list of services that incurred an additional fee was included in the contract.

There was a residents guide to the centre that met the requirements of the Regulations.

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:**
Inspectors were satisfied that the centre was managed by a suitably qualified and experienced person with accountably and responsibility for the service.

The person in charge was a registered general nurse who had the relevant length of experience required by the Regulations. She demonstrated very good knowledge of the Regulations, and was clearly aware of her requirements therein.

The person in charge participated in ongoing professional development through her involvement on a range of committees involved in practice development in residential and acute care settings. She attended seminars organised by in the area of care of the older person. The person in charge completed a range of training such as dignity, leadership, clinical waste, education and practice. She completed all areas of mandatory training.

The person in charge was based in the centre five days per week and fully engaged in the management of the service. She met with the provider every day, and participated in management meetings and board of directors meetings. There was evidence of regular staff meetings throughout the year, with a range of issues discussed and acted on. The person in charge was familiar with the residents health and social care needs, and residents informed inspectors they were familiar with her.

Satisfactory deputising arrangements were in place. The person in charge was supported in her role by a deputy director of nursing who deputised in her absence. The deputy director of nursing participated fully in the inspection process, and demonstrated ample clinical knowledge and familiarity with the Regulations.

**Judgment:**
Compliant

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**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:**
Inspectors were satisfied that all documents as outlined in Schedules 2, 3 and 4 of the Regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval.

There were policies and procedures in place as required by Schedule 5 of the Regulations. Inspectors found policies were centre specific and comprehensive. There was a system in place to ensure staff had read key policies, with staff sign off sheets read. Inspectors found staff were sufficiently knowledgeable of policies.

There was evidence to confirm the centre was adequately insured against loss or damage to residents property, along with insurance against injury to residents.

Inspector saw evidence that records were maintained in the centre, were up-to-date, secure, but easily retrievable.

**Judgment:**
Compliant

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**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:**
The provider was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days. There were appropriate contingency plans in place to manage any such absence. The deputy director of nursing deputised for the person in charge in her absence.

**Judgment:**
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:
Inspectors found systems were in place to protect residents from being harmed or suffering abuse and measures were in place to ensure a positive approach to behaviours that challenged. However, improvements were identified in relation to financial transactions.

Inspectors reviewed the arrangements in place to safeguard residents' finances. While there was a procedure in place to guide staff and practices to safeguard monies, some gaps were evident in the maintenance of the documentation. For example, some withdrawals carried out on one resident's behalf did not outline the rational and there was no evidence of a receipt.

There was a detailed policy on the protection of vulnerable adults that provided sufficient detail to staff on the steps to follow in the event of an allegation of abuse. Records read confirmed all staff had received training in the protection of vulnerable adults. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place.

The person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. She was aware of the requirement to notify any such allegation to the Authority.

All residents spoken to said that they felt safe and secure in the centre. Residents stated that they attributed this to their unit manager and the staff who said they were caring and trustworthy.

Inspectors found good practices in the management of behaviours that challenged. There was a policy on the management of behaviours that challenged that guided practice. Care plans were developed for residents who had behaviours that challenge, an area of improvement was identified and is outlined under Outcome 11: Health care needs. Evidence based tools were used to where incidents occurred. Staff were knowledge of the residents and informed inspectors how to handle certain situations with residents.
There was evidence that the national policy "Towards of Restraint Free Environment" was promoted. A policy on the use of restrictive practices was read by inspectors and seen to be implemented in practice. An action from the last inspection was addressed and a new risk assessment tool was completed which included the alternatives to restraint available. Care plans were developed for the use of restraint and documented checks carried out when in use. Inspectors were informed bedrails and lap belts were used. There were 37 residents using bedrails and three using exit seeking personal alarms. However, the person in charge regularly reviewed bed rail usage throughout the year.

**Judgment:**
Non Compliant - Minor

**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:**
Inspectors found there were systems in place to protect and promote the health and safety of residents, visitors and staff. However, an area of improvement was identified in relation to the ongoing management of risk.

Inspectors reviewed the risk management policy that met the requirements of the Regulations. A corporate risk register and risk registers for each of the four units in the centre were read inspectors. They contained risk assessments for a range of hazards identified along with control measures to manage them. Individual risk assessments were completed for residents also. However, improvements were required in relation to the assessment of residents who smoked. For example, there was no evidence of risk assessments completed in the sample of resident files reviewed. Furthermore, care plans did not comprehensively outline the controls measures in place.

While actions from the previous inspection had been addressed, inspectors noted an unlocked door into a utility room that stored sharps. A sluice room in another area was unlocked. These matter were brought to the attention of the person in charge who assured the inspector it would be addressed immediately.

There was a monthly safety walk of the centre carried by the provider, person in charge and deputy director of nursing. A daily walk about was carried by staff and any issues identified were brought to the attention of the maintenance officer. A quarterly analysis was carried out of each risk register. A risk officer updated the risk register regular. The risk and quality committee and board of directors reviewed corporate risks. A clinical improvement group met monthly to review all risks at unit level.
There were arrangements in place to manage adverse events involving residents. Inspectors reviewed incidents records and there was evidence that appropriate action was taken to address each incident and they were investigated in a timely manner. There was evidence of the learning or improvement to prevent these incidents from happening again.

Inspectors found many residents were encouraged to be actively mobile. Staff were observed following best practice in the movement of residents. There was regular training in the movement and handling of residents. Records read confirmed all staff had completed training, with ongoing refresher training.

There was safe floor covering and handrails throughout the centre and a passenger lift accessed each floor.

An comprehensive emergency plan was in place. It included the alternative locations should an evacuation be required. Staff had attended training in how to respond to do in the event of an emergency.

There were suitable measures and policies in place to control and prevent infection. An infection, prevention control nurse specialist provided additional assistance. All staff received training in hand washing and appeared to follow best practice. There was access to supplies of gloves and disposable aprons and staff were observed using the alcohol hand gels which were available throughout the centre.

Inspectors were satisfied suitable fire precautions were in place. A fire policy was in place and fire procedures were prominently displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. It was noted that the fire panels were in order and fire exits, which had daily checks, were unobstructed.

Training records read confirmed all staff had attended annual fire safety training. Regular fire drills were conducted, with the most recent in July 2014. Inspectors discussed drills with the maintenance office, who outlined a comprehensive programme of drills, with evidence of action taken if improvements were identified. Staff spoken to were knowledgeable of the procedure to follow in the event of a fire.

**Judgment:**
Non Compliant - Moderate

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

Findings:
Inspectors were satisfied that each resident was protected by policies and procedures for medication management. Actions from the previous inspection were completed.

There were comprehensive policies relating to the prescribing, storing and administration of medicines for residents. There were policies in place on out of date and the disposal of medication. Inspectors reviewed a sample of residents medication prescription and administration sheets and overall good practice was observed. Nursing staff spoken with were knowledge of the best practices to follow.

Inspectors read procedure and observed good practice on the management and storage of medications that required strict controls (MDAs). A register of controlled medications was held, and two nurses checked the balance of the medications at the end of every shift.

There was regular review of residents medication by a medical practitioner, pharmacist and nurse. There was a system in place for monitoring safe medication practices. Inspectors read audits carried out, and any recommendations made were acted on by the person in charge. Inspectors saw records of medication errors that had occurred in the centre. The deputy person in charge had investigated each, and there was evidence appropriate action was taken. Furthermore, the person in charge reviewed medication errors every month. They were looked at by location, category, stage of process and were risk rated.

Inspectors saw training records that confirmed nursing staff completed medication management training.

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:
Inspectors were satisfied that a record of all incidents was maintained and where required were notified within the specified time frame to the Chief Inspector.
The person in charge was aware of the requirement to notify the Chief Inspector of certain incidents. In addition, a quarterly report outlining other incidents in the centre was made to the Chief Inspector.

**Judgment:**
Compliant

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### 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

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

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

**Findings:**
Inspectors found residents received care from nursing staff who were familiar with their health care needs. There was very good access to medical services and a wide range of allied health professionals. However, improvements were identified in relation to the documentation of care plans, and aspects of falls management.

Inspectors found residents health care needs were regularly assessed using evidence based tools and care plans were developed where a need was identified. However, improvements were identified. For example, care plans were not consistently documented for wounds care and oral care. Care plans were regularly reviewed and updated, and while they outlined the interventions or care to be delivered, an area of improvement was identified. For example, care plans reviewed for catheter care and behaviours that challenge did not contain sufficient detail to guide staff. There was evidence residents were consulted with regarding their care.

There was evidence residents were seen by range of allied health professionals. There were occupational therapy and physiotherapy departments based in the centre with a team of staff. Two social workers were based in the centre. The centre had recently recruited a dietician and was in the process of recruiting a speech and language therapist. Inspectors found allied health professional recommendations were incorporated into care plans.

Inspectors found evidence of good practices the management of falls, with an area of improvement identified. There was detailed policy that guided staff. However, it was not fully implemented in practice. For example, there was inconsistent evidence that neurological observations were completed following an unwitnessed fall or suspected head injury. Residents were regularly assessed for risk of falls, and post falls...
assessments were completed after a fall. Inspectors read care plans for residents who had experienced injuries from falls. Care plans were also updated following a fall, and outlined the interventions and strategies to prevent future falls occurring. Inspectors saw that controls measures were in place to protect residents such as hip protectors, crash mats and review by the physiotherapy team.

Inspectors found suitable arrangements in place for wound care. There was a policy in place to guide staff. Where wounds occurred there was a process for charting its healing however, a wound assessment chart used to track the wound of one resident contained one entry, and no other update. Therefore it was not clear if and when the wound healed. Residents were regularly assessed for the risk of developing pressures sores, and care plans were developed where a risk was identified. A tissue viability nurse was based in the centre and provided support and guidance to staff. Inspectors were shown drafts of a new wound care plan and wound management policy.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
The design and layout of the centre was in line with the Statement of Purpose and met residents individual and collective needs, with some improvements identified.

The centre was laid out over one floor, and comprised of four units: Mary Aikenhead, Marymount, St. Benedicts and St. Michael’s. There were five four-bedded rooms located in two units, St. Micheal’s and St. Benedicts. These bedrooms will not meet the criteria of the National Standards. The ten four-bedded rooms were visited by inspectors. They were pleasantly decorated and laid out, with many residents adding their own personal touches such as photos and paintings. All residents had their own wardrobe and locker by their bed for personal items. There was sufficient space around each bed to access residents with a hoist if required. However, there were no en-suite toilets or bathrooms provided in each of the bedrooms. There was one communal bathroom and five communal shower rooms located in each of the two units, which would meet the needs of the residents. These bedrooms were discussed with the person in charge and
provider. Inspectors were informed by the provider there were no formal plans in place to reduce or reconfigure these rooms at present.

There was storage provided for assistive equipment. However, some hoists and wheelchairs were stored in a communal bathroom and wheelchairs were stored in some residents en-suite toilets.

The centre was kept clean, and was well maintained to a good standard of repair. There were three internal courtyards directly accessible to residents. In addition, there was an rose garden and extensive grounds available to more independent residents. The gardens were pleasantly landscaped, with shrubs and plants, and seating areas provided.

An ancillary area with laundry facilities and a self contained apartment for families were accessed by a lift.

Adequate private and communal accommodation provided, with an oratory, a number of sitting areas and smaller rooms for residents to sit in during the day.

All beds had an emergency call facility, and inspectors found they were in good working order.

There was provision of assistive equipment such as hoists and lifts. Servicing reports were read by inspectors confirmed they were serviced and in good working order.

**Judgment:**
Non Compliant - Moderate

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<th>Outcome 13: Complaints procedures</th>
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<td><strong>Theme:</strong> Person-centred care and support</td>
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<th>Outstanding requirement(s) from previous inspection(s):</th>
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<tr>
<td>The action(s) required from the previous inspection were satisfactorily implemented.</td>
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<th>Findings:</th>
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<td>Inspectors were satisfied that the provider and person in charge ensured a proactive approach to the management of complaints.</td>
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There was a detailed complaint’s management policy in place that met the requirements of the Regulations. The complaints procedure was displayed in the centre, which outlined the complaints process. An appeals process was in place, that was fair and objective.
Residents who spoke to inspectors knew the procedure if they wished to make a complaint, and said they would have no problem making a complaint if they needed to. They would report any concerns to the unit manager.

A complaints log was maintained and a sample of records were reviewed. There was evidence that each complaint was appropriately responded to, with details of the investigation carried out, the action taken, and whether the satisfaction of the complainant.

**Judgment:**
Compliant

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**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:**
Inspectors were satisfied residents' received care at end-of-life that met their individual needs, with policies and procedures in place to ensure each resident's end-of-life care needs were met.

A policy was reviewed which provided guidance to staff. Inspectors reviewed residents care plans which contained general information about residents spiritual and religious wishes. There was a system in place to document residents wishes within the comprehensive assessment. This was discussed with the person in charge and provider described the systems in place to illicit residents wishes. This included the admission stage, ongoing discussion and interaction with residents.

The centre was part of the campus for Our Lady's Hospice. There were palliative care services available directly to the centre. Staff had completed a range of training and courses in end-of-life care and palliative care practice.

A visitor's room was available for relatives and friends for privacy if required. A single bedroom was available to residents approaching end-of-life if this was requested or required. A self contained apartment was located in the centre for families and loved ones who wished to stay close by a resident approaching end-of-life.

An oratory was available if families wished to use it. Staff and residents would be informed of any residents passing.

**Judgment:**
**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:**  
Inspectors found residents were provided with food and drink in quantities adequate to their needs. However, the system of ensuring meals were in accordance with residents assessed needs required improvement.

Inspectors found the process in place to ensure residents received correctly prescribed diets required improvement. A list of residents special dietary requirements was read by inspectors. However, the information read in unit was not accurate and did not clearly outline the residents prescribed diet. For example, there was conflicting and incorrect information regarding the type of consistency diet for residents. In addition, there was no evidence of when residents were professionally assessed. This may put residents at risk. This was discussed with the nurse on the unit and the person in charge who assured inspectors the matter would be addressed.

Inspectors later met the chef and reviewed records of residents dietary requirements. However, the information was not accurate. For example, the information for the unit outlined above did not reflect the information read earlier by inspectors and modified consistency diets changed each day.

There was a policy on the management of residents nutritional and dietary needs. However, it was not comprehensive enough to guide practice. For example, it did not clearly outline the types of consistency diets for residents. Furthermore, training had not been provided to staff on modified consistency diets or dysphagia.

Prior to the inspection, unsolicited information was received by the Authority regarding mealtimes and assistance provided to residents. The provider had been requested to submit detailed reports to the Authority. These matters were also followed up carefully by during the inspection. Inspectors spent time with residents in two dining rooms during the lunchtime meal. They found residents were discreetly and respectfully assisted with their meals where required. A nurse supervised the mealtime experience. Additional assistance was also provided by volunteers who had been provided with training. This was discussed with the volunteer coordinator who outlined the training provided. A menu was displayed on each table that outlined the choice of meal for the day. Tables were pleasantly set.
There were systems in place to ensure residents did not experience poor nutrition with regular assessments of residents using a malnutrition universal score test (MUST) assessment tool. Inspectors saw care plans were developed to guide practice, along with monthly weights of each resident. However, as outlined in the paragraph above an area of improvement was identified. Where residents were at risk the person in charge carried out increased monitoring, with more frequent weights, food balance sheets and referral to the GP and dietician.

A dietician had recently reviewed the menu and recommendations would be shared with the chef when completed.

Inspectors saw residents being offered a variety of snacks and fresh water, fruit juices and hot drinks during the day.

**Judgment:**
Non Compliant - Moderate

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**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):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied residents were consulted with and participated in the organisation of the centre. The residents privacy and dignity was respected and there were opportunities to participate in activities appropriate to individual interests and preferences.

There were systems in place to ensure residents were consulted with about how the centre was planned and ran and to facilitate participation in the organisation of the centre. A residents’ committee met regularly and the minutes of the last meeting held in May 2014 were read. Residents told inspectors they had attended the meetings in the past.

Voting rights were respected, and a polling booth was set up by the local council at each election or referendum. The details were outlined by the deputy director of nursing, who ensured residents details were provided to the council.

Religious and spiritual needs of residents were respected. Residents of all denominations
were facilitated. An oratory was available in the centre, and mass was held daily for residents of the Roman Catholic faith. An interdenominational prayer room was available.

There were no restrictions on visits except where requested by residents. There were arrangements in place for residents to receive visitors and a private, quiet areas and rooms were available.

There were was a large volunteer group who visited the centre on a daily basis. The volunteer service was managed by three coordinators. The volunteer played a vital role in the centre, they provided company, supported residents at meals and where required support for the residents to attend appointments or events in the community.

The residents had access to their own telephone and there was access to a centre phone. There were televisions provided and available in each bedroom and communal area. The newspapers were available each day including weekends.

Overall, residents received care in a dignified way that respected their privacy at all times. Inspectors observed staff chatting and sitting with residents. The residents seemed comfortable and happy in their surroundings, and were observed reading the paper, sitting in the communal area and garden or receiving visitors. Inspectors spoke to a number of resident who expressed their satisfaction with the centre.

There were adequate facilities for recreation with a number of sitting areas for residents to choose to sit in, including a large living areas in each unit.

Inspectors were satisfied residents had opportunities to participate in activities that were meaningful and purposeful and in accordance with their interests. Each resident had a social assessment developed that outlined interests, hobbies and likes. A social care plan was also completed also that ensured activities were appropriate to their needs, likes and preferences. The occupational therapy department, and the volunteers coordinated activities in the centre. A timetable of activities was seen by inspectors. A range of activities was provided such as baking classes, exercise, physiotherapy, gardening, and art classes. A mans shed had been established for male residents, and a six week programme took place for a group of residents. One resident told inspectors about a bird table he had made in the group.

Inspectors were satisfied that residents communication needs were highlighted in their care plans and reflected in practice. Interventions and supports were put in place for residents who required additional assistance. For example, one resident informed inspectors she was provided with assistive aids to use the television, mobile phone and call bell. The occupation health department had put these measures in place for the resident. The resident told inspectors how these simple devices had brought significant independence to their lives.

**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:**
Inspectors were satisfied that residents had adequate space for their personal belongings and their clothes were suitably laundered and returned to them.

There was a policy on residents' personal property and possessions. Inspectors were informed that residents had a list of their personal possessions on file. This documentation was not reviewed at this time.

Residents were encouraged to personalise their bedrooms. Many of the bedrooms were decorated with pictures and photographs.

There were adequate laundry systems in place to ensure residents own clothes were returned to them. Residents were facilitated to use laundry facilities internally or an external service provider. Inspectors spoke to residents who confirmed they were satisfied with the way in which their clothes were cared for.

**Judgment:**
Compliant

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**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):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Inspectors were satisfied that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents on the day of inspection.

There was a wide range of education and training available to staff in a broad range of areas. All staff had completed up to date training in mandatory areas. Inspector saw staff had completed training in other areas such as hand hygiene, waste management, end-of-life and food hygiene.

Inspectors found there were adequate staffing levels and skill mix on the days of inspection. A two week roster was read that accurately outlined the staff on duty.

There was a recruitment policy that met the requirement of the Regulations. Inspectors reviewed a sample of staff files and found recruitment practices were in line with the Regulations. This had been an action at the previous inspection and completed.

There were agency staff employed in the centre. A service level agreement was in place, that outlined staff documentation was in line with the requirements of the Regulations.

Inspectors reviewed a sample of files and found that nursing staff had up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2014. There were over one hundred volunteers actively involved in the centre. Appropriate supervision, training and support systems were in place. Inspectors met with one of the three volunteer coordinators who oversaw the service. Documentation for a sample of volunteers read was in line with the Regulations.

Judgment:
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:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

**Centre name:** Our Lady's Hospice and Care Services

**Centre ID:** OSV-0000465

**Date of inspection:** 07/10/2014

**Date of response:** 20/11/2014

### 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 07: Safeguarding and Safety

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The documentation of transactions from residents accounts required review.

**Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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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:
We are satisfied that procedures regarding transactions are robust and comply with regulations.
Of the two withdrawals pertaining to one resident at the time of inspection—
documentation has been located in the patient’s 2012 file of accounts and not the current file which was made available to the inspector.

Proposed Timescale: 31/10/2014

Outcome 08: 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:
Areas of risk as outlined in the inspection report had not been identified and risk assessed.

There was no evidence that residents were assessed for the dangers of smoking and controls in place were not adequate.

Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
To ensure 100% compliance to smoking policy in place and subsequent risk assessment and care documentation-a quarterly audit will be carried out commencing in December 2014(A)
Corrective action has been taken for Resident smokers who were found not to have the appropriate documentation in place at time of the Inspection. All outstanding risk assessments and control measures were actioned immediately following October inspection (B). Reference to smoking policy added to Index of Risk policy. As part of safety walkabouts by DDON ,dashboard now includes residents who smoke(C) Nurse metrics will also monitor compliance as part of ongoing documentation audit(D)

Overall risk will continue as a standing agenda item on our Quality &Risk committee (ongoing)

Proposed Timescale: A-Complete/B-Complete/C-Complete/D-December 2014

Proposed Timescale: 31/12/2014

Outcome 11: Health and Social Care Needs
Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care plans were not consistently completed for identified needs for example, wounds and oral care.

Some care plans lacked detail to guide practice for example, catheter care and behaviours that challenge.

Improvements were identified in the management of falls.

Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
Corrective action has taken place to address shortfalls in care plans identified by Inspector(A) Success criteria for individual care plans will be monitored by Nurse Metrics(bi-monthly) and overseen by the Quality & Risk Committee commencing in December 2014

Champion groups led by senior nurses are currently reviewing and updating our documentation and provision of guidance for staff based on international evidence. There is a role our programme underway of pre-planned care plans inclusive of Catheter Care, End of Life, Oral Care, Behaviours that Challenge, Tissue Viability, Symptom Management which commenced in June 2014 and is due for completion in February 2015. (B)

Phase two will expand a suite of care plans and continue throughout 2015

In line with Falls policy it has been restated to staff that all un witnessed falls or suspected head injury should have neurological observation completed and ongoing monitoring as prescribed by the medical team. All incident forms submitted to DDON and the Risk department will monitor adherence as a secondary form of assurance(C)

Proposed Timescale: (A)-Complete/(B) February 2015 /(C)-/Complete

Proposed Timescale: 28/02/2015

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:
The ten multi-occupancy bedrooms do not meet the requirements of the National Standards.

There was inadequate storage provided for equipment.

Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
The centre was built in two phases in 2006 and 2008. The issue of multi-occupancy rooms was raised by the Provider with the Heath Information and Quality Authority's (the Authority) inspectors during the first registration inspection and we were advised that there was no requirement to change these rooms given the medical/nursing requirements of the residents occupying them. Indeed we implemented a programme of interior re-design to create more individual space and privacy in recognition of the regulations. The conversion of these rooms into single occupancy would have significant implications in terms of capacity, model of care and funding. In particular our strategically important supportive palliative care capacity would be significantly reduced with the consequent impact on our acute hospital partners and specialist in-patient beds.

Wheelchairs stored in resident’s en-suites are individually prescribed and adapted to meet the specific needs of the user. Residents prefer this easy access when their individual chair is required throughout the day and when not in use. On a previous inspection it was agreed with Inspectors that hoists would be stored in assisted bathrooms with a lock. It is not time efficient nor are there sufficient resources to move wheelchairs to/from storage areas located off the immediate ward area several times a day.

Proposed Timescale: 24th November 2014-for discussion at Board of Directors meeting.

Proposed Timescale: 24/11/2014

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system in place to ensure residents receive the correct consistency diet required improvement.

There was inconsistent evidence of an up-to-date professional assessment for residents
on a modified consistency diet.

The management of nutrition policy required revision to include procedures on modified consistency diets.

Staff required additional education in the area of modified consistency diets.

**Action Required:**
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietician staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

**Please state the actions you have taken or are planning to take:**
In the absence of Dietetic input from the HSE the Board of Directors have contracted services of a Dietician who commenced working with the organisation in October 2014(A)

A proposed plan of policy on procedure, education and synergy with clinical and catering services has been agreed and is underway

1. Up-to-date professional assessment for residents on a modified consistency diet.(B)
   - A recruitment plan is underway to engage the expertise of a Speech and Language Therapist (SLT) approved by the board for a six month period. All residents with dysphagia requiring modified consistency diets will be reviewed and care plans updated.
   - The dietician will review the nutritional content of the modified consistency diets in partnership with the catering department to ensure that they are nutritionally adequate.

2. The management of nutrition policy will be updated to include procedures on modified consistency diets. (C)

3. Roll out of staff education in the area of modified consistency diets( D)
   - The dietician has already commenced staff education at ward and catering level and posters and information have been disseminated.
   - The dietician and SLT will roll out a programme of staff education in the area of modified consistency diets to ward staff, catering services and members of the MDT in AGH. Education will be conducted in partnership with the practice development team as relevant.

**Proposed Timescale:**
- Complete (B)/November-December 2014
- January 2015 (D) / February 2015

**Proposed Timescale:** 28/02/2015