<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Leopardstown Park Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000667</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Foxrock, Dublin 18.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 295 5055</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@lph.ie">info@lph.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Leopardstown Park Hospital</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Ann Marie O’Grady</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Deirdre Byrne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Angela Ring; Gearoid Harrahill</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>168</td>
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<tr>
<td>Number of vacancies on the date of inspection:</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.
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 un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 25 August 2015 08:00  
To: 25 August 2015 18:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
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**Summary of findings from this inspection**

This inspection took place to assess ongoing 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 2009. Inspectors also followed up on areas of non compliance identified at the previous inspection which took place on the 4 and 5 February 2014. At this and previous inspections it was reported there were significant deficits in the design and layout of the centre, that do not meet the requirements of the Regulations and the Standards and significantly compromise residents’ rights to privacy and dignity. These deficits include four large open plan nightingale units where up to 15 residents share a room. These deficits in the layout and design of the units were highlighted and discussed with the provider nominee and person in charge at a number of
meeting's, the provider submitted interim and long term plans to the Authority to address the deficits, however these works have yet to be commenced.

As part of this inspection, inspectors met with residents, family and staff members, observed practices and reviewed documentation such as care plans, accident logs, policies and procedures. Inspectors found the structural deficits outlined in the previous inspection report’s had not improved or changed. Inspectors spent time in three of the four units mentioned above. The design and layout of the units did not meet the individual and collective needs of the residents. While senior management and staff were aware of the deficits and had taken some measures to reduce the impact of the layout on residents, negative outcomes for the resident’s were observed. These related to lack of privacy, insufficient space for personal possessions, risk of infection control and insufficient storage for clothing. The layout of the units were not conducive to residents making individual choices on how they wished to spend their day. The structural deficits are outlined in more detail in this report.

Inspector’s found that there were good governance structures in place, mealtime’s were satisfactory and staff interacted with residents in a kind, dignified and respectful manner. The staff were knowledgeable of the health care needs of residents. There was good access to the services of medical, pharmaceutical a wide range of allied health professionals. Inspectors found there were adequate staffing levels and skill mix to meet the assessed needs of residents. An internal programme of training was in place, with staff trained in various fields of expertise to a high level.

A number of other improvements were identified, and these primarily related to the documentation of care planning and an aspect of policy review. The seven actions from the previous inspection were reviewed, six had not been addressed. These and all other matters are outlined in the report and Action plan at the end of the report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 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 in the centre, with systems in place to review the quality and safety of life of residents.

There were satisfactory governance arrangements in place. The provider nominee was full time in the role, based in the designated centre and worked closely with the person in charge. Regular meetings were held with the Board of the Hospital where all areas of clinical governance were discussed.

There were systems in place to monitor the quality and safety of care. The provider and person in charge had the support of a person tasked with the role. A quality and safety manager outlined the systems in place to review several areas of health and quality of care through a collation of key performance indicators each month. This formed part of a regular review of quality of healthcare provided of residents. The indicators included incidence of falls, use of restraint, medication errors, wounds, episodes of behaviour that challenge and infection control. A detailed analysis and a comparison with the previous audits were carried out and there was evidence of action taken and improvement brought about. For example, a recent falls audit found falls in the centre were in line with European statistics. Furthermore recommendations were made, action plans formulated and a committee met to review falls monthly. The result being, an overall low level of falls in the centre, with infrequent serious injuries occurring.

The provider was aware of the requirement to prepare an annual report on the overall review of the safety and quality of care of residents. A report for 2013 was read by inspectors, and 2014 was in progress, the provider acknowledged that further improvements were required in this area to ensure that the report was prepared in consultation with residents and their families as identified in the Regulations. In the interim, the person in charge had a system in place of providing feedback to staff,
residents and relatives where a newsletter was prepared and made available to all with a range of information for residents and the results of audits carried out in the centre.

**Judgment:**
Substantially Compliant

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**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.

She was familiar with the residents' health and social care needs, and was observed interacting with resident's during the inspection. The person in charge was a registered nurse who had the relevant length of experience required by the Regulations. She demonstrated adequate knowledge of the Regulations, and was aware of her requirements therein. The person in charge held regular meetings with staff. The minutes of these were read by inspectors and outlined a range of issues discussed.

The person in charge participated in ongoing professional development by attending courses on a range of topics. She had completed a Master in Leadership and Management in 2013. In addition, she also completed training in mandatory areas. Satisfactory deputising arrangements were in place, the person in charge was supported in her role by an assistant director of nursing (ADON).

**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 found the records, policies and procedures required by the Regulations were in place. An area of improvement was identified in relation to the review of policies and procedures.

All records reviewed as part of the inspection were maintained in a manner to ensure accuracy and ease of retrieval. A sample of policies and procedures required by Regulations were reviewed, generally the policies were up-to-date and guided practice. However, some improvements were required. For example, the policy on the protection of vulnerable adults would not fully guide practice as outlined (see outcome 7 for more details), the restraint policy did not reflect the national policy "Towards a Restraint Free Environment". In addition, the end-of-life policy did not fully reflect the practices and services provided in the centre (see outcome 14).

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors were satisfied that systems were in place to protect residents being harmed or suffering abuse were in place; measures in place to ensure a positive approach to behaviours that challenged and restrictive practices were in accordance with the Regulations.

The centre was guided by policies on the protection of vulnerable adults in place. However, policies read required updating to reflect the National Health Service Executive policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse". This is
discussed under outcome 5.

There was regular staff training in the protection of vulnerable adults. Records read confirmed staff completed training. A small number of staff required refresher training, and dates had been scheduled for this. 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. An allegation of abuse had been notified prior to the inspection, this was discussed with the person in charge during the inspection who outlined the procedures taken and it was evident that appropriate action had been taken.

Inspectors spoke to a number of residents who said that they felt safe and secure in the centre. Families also spoken to said they felt their loved ones were safe and attributed this to the staff who said they were caring and trustworthy.

The systems in place for safeguarding residents’ money were not reviewed during this inspection.

Inspectors read a policy on the management of behaviours that challenged that guided practice. A sample of files of residents who presented with behaviours that challenged was reviewed. Care plans were developed to support staff. However, as outlined in Outcome 11, they did not fully guide practice. Inspectors found evidenced based tools were utilised to monitor behaviours where required and staff were familiar with the residents and understood their behaviours, what triggered them and the least restrictive interventions to follow.

There was a policy on the use of restraint. However, it required review as it did not incorporate or reflect the national policy "Towards of Restraint Free Environment", see outcome 5. It was evident that the policy on the use restrictive practices was implemented in practice. There was regular review of the use restrictive practices, risk assessments were completed every three months and overseen by a multi-disciplinary team. The team included the medical officer, pharmacist, speech and language therapist, occupational therapist, dietician and a nurse. A record of each residents assessments by the team were maintained in residents files.

A relatively small number of restrictive practices were used were in the form of mechanical (bedrails, wandering tags) and chemical restraint. The person in charge and provider ensured the least restrictive form of restraint was used, and a range of alternatives were considered before its used. For example, in two units inspected, three residents required bedrails, each resident had a care plan developed and half hourly monitoring checks were carried out. The use of alternatives was actively encouraged and "low low" beds and wedges were available.

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

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found the provider had ensured there were systems in place to protect and promote the health and safety of residents, visitors and staff. An area of improvement regarding the identification of risk was required.

As identified in the summary, the layout of the open plan wards posed a potential risk to infection control as there were inadequate means of isolation should a potential outbreak occur. Given the deficits, inspectors found that provider and person in charge were aware of the risks and had implemented systems to control and prevention of infectious diseases; this included the appointment of a full time infection control nurse. There was mandatory infection control training provided to all staff and they was access to supplies of gloves and disposable aprons. Staff were observed hand washing and using the alcohol hand gels which were available throughout the centre. A policy was seen by inspectors, which oversaw infection control procedures in the centre which were kept updated. The person in charge outlined the infection control programme to inspectors. However, despite the measures taken to promote good practice in infection control, inspectors found that the layout of the nightingale wards posed significant risk to residents in prevention of spread of infection.

A safety statement was seen by inspectors. There were health and safety policies as required by Regulations. A risk management policy was in place and it met the requirements of the Regulations. Overall, it was implemented throughout the centre, however, areas of risk had not been identified, for example, cylinders of oxygen were not securely stored in two units of the centre and easily accessible to residents and visitors which could pose a risk.

Inspectors read the risk register, which outlined each identified risks description, controls, impact/likelihood risk rating. The risk identified above was not included. There are arrangements in place to review health and safety procedures in the centre. A health and safety officer for the centre outlined his role to inspectors. When a hazard is identified in the centre a a risk management event forms is completed. These forms are categorised and followed up with the relevant maintenance staff in the centre. The health and safety officer is also the department head of the cleaning and housekeeping team.

A health and safety committee meeting was held bimonthly. It is attended by all heads of department. A sample of minutes read confirmed a range of matters were discussed
for example, general health and safety, fire procedures, equipment maintenance. The committee reported to an integrated Quality and Safety (IQS) Committee which were forward the reports from each meeting. Minutes of the IQS committee read confirmed a range of risk based issues were discussed including, infection and hygiene incidents, HIQA and notifiable incidents.

There were arrangements in place to manage adverse events involving residents. There was evidence of learning and improvement to prevent these incidents from happening again. For example, the management of falls, with evidence of prevention of falls and serious injuries in the centre.

Inspectors saw residents were encouraged to be as mobile as best as possible, and were seen being escorted around the centre. A physiotherapy department was located in the centre. Residents spoke about the exercise classes in the physiotherapy unit and how they encouraged to walk and keep active. Staff were observed following best practice in the movement of residents who required assistance. There was safe floor covering and handrails throughout the centre. There was regular training provided to staff in the movement and handling of residents.

An emergency plan was reviewed by inspectors. It outlined the procedures to follow in the event of fire, flood, loss of power or heat and any other possible emergency. The plan outlined the location of alternative accommodation if an evacuation was required.

Inspectors were satisfied that suitable fire precautions were in place. There were fire orders displayed throughout the centre. Inspectors saw fire procedures also outlined the responsibilities of the nurse in charge and the member of a fire safety response team. Staff spoken with were familiar with the procedures. There were weekly fire alarm tests carried out. Records of regular fire drills were read by inspectors, with up to three drills per unit per year carried out. The records included the length of drills and outcome. The health and safety officer carried out regular checks of the fire alarm.

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 unobstructed. There were regular fire safety checks which included fire exits.

Judgment:
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 09: Medication Management</th>
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<tbody>
<tr>
<td>Each resident is protected by the designated centre’s policies and procedures for medication management.</td>
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</table>

| Theme: |
| Safe care and support |

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

**Findings:**
Inspectors found each resident was protected by the designated centres’ policies and procedures for medication management. An area of improvement was required regarding the practices in the administration of medications.

A comprehensive policy was read by inspectors that guided practice. Inspectors read completed prescription and administration records and overall they were in line with best practice guidelines. However, an area of improvement was identified. For example, the times recorded on the medication administered sheets did not consistently reflect the prescription times. This was discussed with the person in charge during the inspection who assured inspectors action would be taken to address it.

There was written evidence that residents medications were reviewed every three-months reviews. In addition to the medical officer, there were four nurse prescribers available to support in prescribing medications where required. A pharmacy service based in the centre provided support and training to staff. The pharmacist was also involved in the review of residents medications.

Inspectors read reports of medication errors that had occurred, which also included details of the investigation carried, actions that were taken and evidence of sharing of information with staff for learning purposes.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked the balance of a sample of medication and found it to be correct.

Staff nurses involved in the administration of medications had undertaken training updates in best practice, and weekly medication audits were completed to identify areas for improvement.

**Judgment:**
Substantially Compliant

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**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 a record of all incidents occurring in the designated centre were maintained and notified where required to the Chief Inspector.

The person in charge was familiar with the incidents that required notification in three working days, along with a report of specified incidents to be made every three months. There was a system to record, report and review all incidents.

Judgment:
Compliant

**Outcome 11: Health and Social Care Needs**

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

Theme:
Effective care and support

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

Findings:
Overall, inspectors found residents were regularly assessed for a range of health care needs with care plans developed where a risk was identified. However, the documentation of care plans and consultation with residents required improvement. These had been actions at the previous inspections and were not fully addressed.

A sample of residents' care plans were reviewed during the inspection. The care plans were in an electronic format. Overall, care plans were developed where a need was identified. However, the documentation of plans required improvement as the plans did not consistently guide staff practice or reflect the good practices carried out by staff. Some care plans contained generic statements obtained from the electronic system plan, for example behaviours that challenge and falls care plans. Some care plans were not updated following a change in the residents circumstances, for example, risk of pressure sore development. The specific wishes or preferences of residents were not consistently described such as end of life care.

The health care assistants did not have access to the electronic care plans and had no input into their documentation. There was some evidence that care plans were updated by staff however, a formal review did not take place, for example updates stated "continue care plan". There was lack of evidence that residents and their families were consulted with regarding their care.
There were good practices in the management of residents' nutritional needs, the management of falls and the arrangements in place for wound care. There were regular review of residents' health care needs using evidence based assessments tools. These were completed every three months. Where an identified need arose, care plans were developed. The staff were knowledgeable of residents care needs and had also received training to enhance their practices and keep them up to date with best practice. There was evidence of referral to the relevant health professionals. Inspectors saw electronic nursing notes provided information on the treatment and condition of the residents.

There was regular access to a full time medical officer who was based in the centre, and there was evidence of regular review of residents' medical needs. A second medical officer provided additional support. The residents also had a choice of retaining their own GP.

Appropriate arrangements were in place for on call out of hours and at weekends. There was a range of allied health professional services available in house for example, physiotherapy, occupational therapy, dietician, speech and language therapy, social work and pharmacy service were provided. Where recommendations were made by these professionals, they were recorded and residents' care plans were updated.

**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:**
Inspectors were not satisfied that the physical environment in Leopardstown Park Hospital meets the residents’ needs and the requirements of the Regulations. There are significant improvements required to the premises in order to comply 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 2009. As stated in the summary, the provider was fully aware of the deficits in the centre and had submitted a strategic plan prior to the registration.
inspection in February 2014 that outlined a long term plan to address the deficits in the premises. However, to date these plans have not been acted on.

During this inspection, inspectors focused on four units: Tibradden, Kilgobbin, Kiltiernan and Enniskerry. There are 15 residents living together in one room in these units, which are divided into open bays. There are two to three single bedrooms also located in the units.

The structural deficits in relation to these units are as follows:

- the units were institutional in nature, with up to 15 residents sharing a room
- there was insufficient space around the beds to ensure privacy and dignity for example, personal and intimate care is carried out by residents bedsides, with only a screen dividing the bed, and in most cases the main corridor of the room went by their bed
- there was insufficient room to receive visitors or for residents to sit out by their beds at the same time
- there was an infection control risk as beds were in close proximity together. For example, there were gaps of just three feet (1 metre) between some of the beds. This increased the risk of cross contamination
- Beds were very close together and as a result there was no means of maintaining a private space for each resident to block out noise and malodours
- there was limited storage space for residents to store clothes, for example, wardrobes were not large enough to store all residents clothes. Staff reported they sent excess clothes home as they did not all fit in wardrobes
- there was limited space for residents to personalise the small space around their beds, most residents had one small locker to store personal belongings and display personal items
- the single bedrooms do not meet the minimum size requirements of the Standards.
- there was inadequate quiet-private space for residents to meet visitors
- there was lack of sufficient communal space provided for residents and corridors in the units were used as sitting areas
- there was inadequate storage space for equipment which was stored along corridors and in bathrooms communal which posed a potential risk.
- there was one open plan shower and toilet with no door provided. This is discussed in more detail in outcome 16

The centre was in a clean condition and was maintained to a good standard internally
and externally. It was pleasantly decorated in parts with photos of residents and staff throughout the years. There was direct access to a number of secure gardens from the centre, including an enclosed sensory garden. Appropriate assistive equipment was provided to meet residents’ needs such as hoists, seating, specialised beds and mattresses. Inspectors found that sluice and kitchen facilities were satisfactory and met the requirements in the Authority's Standards.

Judgment:
Non Compliant - Major

**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 found the provider ensured residents received care at their end-of-life care from an emotional, social and spiritual perspective, improvements regarding the policy and care planning are detailed in outcomes 5 and 11.

In addition, as identified throughout this report, the layout of the large open plan units did not promote residents rights to privacy, in particular at end of life care. Where residents indicate a preference as to their location at end-of-life, and efforts were made to facilitate this, there were only two to three single rooms in the four units inspected. Staff said residents may be accommodated in these rooms but only if there were vacancies at that time. Therefore, residents preferences for a single room at end of life care could not always be facilitated.

A policy on end-of-life provided guidance to staff, although many of the good practices carried out and services in the centre were not fully reflected. For example, the post death arrangements available in the centre. Inspectors reviewed a sample of end-of-life care plans. An action from the previous inspection was complete and care plans were developed for residents who required them. However, residents wishes were not consistently incorporated into the care plans.

The were strong links with the local palliative care team. In addition, two nurses were trained to provided care and support in palliative care. Inspectors spoke to staff who said they provided guidance and direction when residents were approaching this stage in their lives. The staff in the centre were also provided training in palliative care and end-of-life.
A chapel and private room was available to residents at any time and religious services took place on a regular basis. Inspectors were advised that family members could stay overnight in the event that their loved one was dying and refreshments were provided.

**Judgment:**
Non Compliant - Moderate

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**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 were satisfied that resident's were provided wholesome and varied food and drink adequate to their needs, and assistance was offered in a discrete and sensitive manner.

The person in charge ensured processes were in place to ensure residents nutritional and hydration needs were met. There was of regular weight monitoring, and nutritional assessments completed for all residents. There was access to the medical officer and referrals made to the speech and language therapist and dietician who were based in the centre. Inspectors read care plans for residents who had difficulty maintaining weight or had specific nutritional needs. Where a risk was identified for example, a reduction in weight or poor intake, additional measures were taken such as dietary monitoring records and fluid balance charts.

Inspectors spent time with residents in a number of dining rooms at lunch time. The residents who required support during their meal were discreetly and respectfully assisted by staff, who sat beside them and chatted quietly. A menu was displayed on each table, it outlined with the choice of meal for the day. There was also choice at mealtimes for residents on a modified consistency diet. Some residents said they asked for other dishes not on the menu and it was always provided. One resident told inspectors that she preferred fish and this was provided on her request. The meals served at came out in hot trollies from the main catering kitchen, and were service by care staff. A nurse was present during the meal and those on a modified consistency diet received their meals as prescribed. The meal served at lunchtime looked and smelled wholesome.

Inspectors visited the kitchen and found it was well laid out and stocked with a good supply of food. Each day a menu plan was completed by each unit in the centre for the
kitchen staff. It reflected the residents special dietary requirements and choice of food. The catering manager regularly met the residents and monitored feedback on their likes and dislikes. Meals would be changed to reflect any comments.

There was a four week rolling menu which was reviewed by the catering manager with input from the dietician. A nutrition committee was also in the process of being set up by that would include the catering team and dietician. Inspectors saw residents being offered a variety of snacks including fruit and hot drinks during the day.

**Judgment:**
Compliant

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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 reviewed this outcome specifically in terms of the residents living in the four multi-occupancy units Tibradden, Kilgobbin, Kiltiernan and Enniskerry. Overall, residents in the four units were not fully afforded privacy or supported in how they chose to go about their day.

Inspectors commenced the inspection in the units at approximately 8am. Inspectors observed staff starting their days work and where residents were sleeping they were not disturbed. However, the design and layout of the unit, along with staff practices, meant residents could not choose how they started their day. For example, the lights were on in the entire unit, the room was not sound proofed and noise could easily heard from a breakfast trolley, staff helping residents and general conversations from the nurses station. In addition, some residents beds were opposite the toilet area and along corridor in the room. The screen was the only barrier between each bed and these areas.

The privacy of residents living in the four units required improvement. As reported in outcome 12, some beds in each unit were a metre apart. Due to such close proximity, there was lack of space for a chair and for both residents to sit out of their bed at the same time. Inspectors found that when residents required personal or intimate care, screens were pulled around their beds. However, odours and noise from these areas
could not be prevented, which also impacted on these residents dignity.

The large bathroom areas in two of the units were inspected. The design and layout of the bathrooms would not ensure residents privacy and dignity was respected. These bathroom areas consisted of an open plan shower and toilet area with two toilet/shower rooms off it. However, a lockable door was not provided in the open plan area, with only a moveable screens for privacy. Furthermore, staff or residents had to pass through the area to access another two toilets. Equipment was also stored in the area, making the area inaccessible. See outcome 12.

The provider and person in charge had ensured residents had a range of choice in how they spent their day. An activities programme was displayed in each of the units of the designated centre. While activities extended through the week, inspectors found there was a lower level of interesting things for residents to do at the weekends. This was discussed with the person in charge who assured inspectors it would be reviewed. An activities coordinator provided one to one time with residents and facilitated a number of group activities in the centre. The programme included exercise classes, newspaper readings, movie nights, and art classes. One resident told inspectors about the computer classes she attended. A number of other residents talked about the exercise class they enjoyed going to. These were held by the physiotherapy department. There was an OT programme that included sensory exercises, catering and gardening classes. Residents appeared relaxed and at ease in the sitting areas of the units.

Judgment:
Non Compliant - Moderate

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 found that adequate provision had been made for the management of residents' personal possessions. While this outcome was compliant, improvements regarding storage were identified and actioned in outcome 12.

While storage for residents clothing was provided, the wardrobe space in the four multi-occupancy units were not adequate as size was limited. This is reported in more detail in outcome 12.
Residents told inspectors they were satisfied with the laundry service provided. A list of residents’ personal property was maintained on the care plans.

Inspectors did not inspect the laundry at this inspection, however, the previous inspection reported to be well organised and maintained in a clean condition.

**Judgment:**
Compliant

**Outcome 18: Suitable Staffing**
*There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.*

**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied the provider had ensured a recruitment policy was in place and staff records were in accordance with the Regulations, there was a training programme for staff and a adequate number and skill mix of staff was on duty. Staff were observed to interact in a warm, respectful manner with residents.

Inspectors observed a good relationship between the residents and staff in the centre. Care and assistance was seen to be provided to residents in a friendly, respectful and discreet manner. The staff were familiar with the residents and their needs and preferences well, and some residents had photos of them with staff placed among their family photos.

The staffing level and skill mix in the centre was sufficient to meet the assessed needs of the residents. All staff spoken to had a good knowledge of policies and procedures surrounding fire and emergency, protection of vulnerable adults, infection control and manual handling.

Inspectors reviewed a sample of personnel files for nurses and healthcare assistants. The documentation was as per Schedule 2 of the regulations. A recruitment policy was read that clearly outlined the procedures of assessing and screening potential staff. Agency nursing staff were used and a detailed service level agreement was in place. The agreement confirmed the documentation and information required by the Regulations.
was in place for example, the registration, An Garda Síochána vetting, qualifications, and references.

Staff training was up-to-date with a clear means of identifying where gaps existed in the mandatory training for individuals. A detailed training programme was seen by inspectors. Records of training confirmed all staff completed training and where refresher training was required, a schedule of dates was in place for specific staff. All staff irrespective of grade completed training on elder abuse, manual handling, fire, infection control and CPR. The culture of learning and development was also evident by senior management encouraging a number of staff to pursue further third level education.

**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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Leopardstown Park Hospital</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000667</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>25/08/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>15/09/2015</td>
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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 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policies on protection, restraint and end-of-life policies required review to reflect practices in the centre and the most recent national policy.

1. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them.

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

Please state the actions you have taken or are planning to take:
Leopardstown Park Hospital Policy on Restraint was reviewed in October 2014 and incorporated the HSE Draft Policy on the use of Physical Restraints in Residential Care Units (2008). Using a interdisciplinary perspective, the Restraint policy will be further reviewed to incorporate the DOH document: “Towards a Restraint Free Environment”.

We are currently competing the “What matters to me workshop” and “Journey of change” with the Hospice Friendly Hospital Programme and following same the interdisciplinary team will review the End of life Policy to incorporate any recommended changes to improve how we provide care to our Residents during this emotive time.

The Adult Protection Policy will be reviewed by the interdisciplinary team to reflect the responsibilities of each individual staff member relating to Adult protection. It will also be updated to incorporate the action currently being taken to deal with incidences of potential and actual abusive action.

Proposed Timescale: 08/12/2015

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 not been identified in the centre, for example, oxygen cylinders were not stored in a secure location and accessible to residents.

2. 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:
There is a robust risk management policy in place which includes hazard identification. A risk assessment in relation to oxygen storage has been completed by the Health and Safety manager in conjunction with the Quality and Patient Safety Manager. All oxygen cylinders are now stored away from the ward area and are secured upright in situ with chains.

Proposed Timescale: 09/09/2015
### Outcome 09: Medication Management

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were gaps in the documentation of the prescribed times that medications were to be administered to residents.

**3. Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
This issue has been discussed at the Medication Management meeting and following consultation with the ICT Manager, a decision has been made to change the documented times of the medical officers prescribing kardex to align with nursing administration kardex.

**Proposed Timescale:** 20/10/2015

### Outcome 11: Health and Social Care Needs

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no formal review of residents care plans every four months.

There was inconsistent evidence of residents and families being consulted with about their care plan.

**4. Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

**Please state the actions you have taken or are planning to take:**
The electronic care planning system at the Hospital is programmed to alert after a period of 3 months to ensure that all care plans are reviewed in the 4 month timeframe. The metrics system is also being utilised to ensure care plans are activated to address individual care requirements. There is also a monthly care plan audit carried out by the Quality and Patient Safety Manager who also then consults with individual CNMs if concerns are raised. A meeting has been held with the CNM1s and CNM2s to identify...
any contributing factors and to ensure that at time of review to revise the care plan accordingly.
All existing Residents an /or Relatives in 2014 were contacted to determine their wishes in relation to their participation in care planning. All of these responses were documented and filed. The residents and their families where appropriate are going to be contacted individually by the CNMs of each unit to determine if they want to be consulted and if so, an appointment will be made to discuss and record their wishes.

Proposed Timescale: 27/10/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans did not consistently outline the interventions to address residents specific needs.

5. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
The metrics system is currently being utilised to ensure residents specific needs are addressed. We envisage that where needs are identified through the screening assessments a corresponding appropriate individualised care plan will be recorded. This process has already commenced and further meetings are scheduled to disseminate this information and ensure compliance.

Proposed Timescale: 09/11/2015

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 design and layout of the four multi-occupancy units named Kilgobbin, Tibradden, Kiltiernan and Enniskerry do not meet residents' needs and do not comply with the Regulations and Standards.

6. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.
Please state the actions you have taken or are planning to take:
The Hospital has a comprehensive plan in relation to works that we intend to carry out to address issues of privacy and dignity with the 4 nightingale wards. The Hospital has secured the services of an estates project manager from HSE who has been working to cost and detail the design of the proposed works to address the issues raised. The Hospital is at the stage of being ready to appoint a design team to commence the building project. A funding submission has been submitted to the HSE who in turn have submitted this to the Department of Health. It is our understanding that currently this lies with the Department of Public Expenditure and Reform for consideration. The announcement of the HSE capital plan for the next period is expected shortly and we would be confident of securing funding to support this development. The Hospital in developing its plans held a “Dignity and Design” workshop with residents and staff to look at how best dignity and privacy might be considered in any design process. Timescales have been identified for the works, subject to securing funding, which would indicate full refurbishment of the designated wards being completed by Q2 2017

**Proposed Timescale:** 30/06/2017

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The four nightingale units were not designed or laid out to meet the residents needs, up to 15 beds were in close proximity together and as a result there was an increased risk of infections, noise and odours in the units.

There was insufficient private and communal space for residents in the units.

There were insufficient number of toilets and showers in the four units to meet the needs of residents.

There was inadequate storage provided to safely store all equipment in the four units.

There was inadequate space and suitable storage facilities for residents personal possessions in the four units.

**7. 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:
All individuals personal hygiene needs are met fully based on care needs assessment and person centred care. Review of requirements for storage is ongoing, monitored and addressed where appropriate. To address individual’s needs for the future we will incorporate the appropriate aspects above in future facilities.
Proposed Timescale: 30/06/2017

### Outcome 14: End of Life Care

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents preferences for a single room at end of life care could not always be facilitated.

**8. Action Required:**
Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

**Please state the actions you have taken or are planning to take:**
A comprehensive plan is in place to reconfigure the 4 nightingale units as previously indicated allowing Residents to reside in Double rooms. When a Resident is approaching end of life, arrangements are made if indicated by the Resident and their family for them to move to a single room to allow privacy and dignity at this difficult time.

Proposed Timescale: Reconfiguration of nightingale wards: 30th June 2017

Proposed Timescale: 30/06/2017

### 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:**
As reported in outcome 16, residents in the four units did not fully choose how they commenced their day.

**9. Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**
An interdisciplinary team meeting has been convened to discuss and attempt to address this issue in a meaningful way during the intervening period prior to the planned
reconfiguration of the nightingale wards. This will identify if any changes in practice can be actioned to allow a more personalised approach to care. This will then be outlined in an individualised care plan and reviewed no less than three monthly.

**Proposed Timescale:** 27/10/2015

**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The design and layout of the four units meant residents could not fully undertake personal activities in private.

The layout of the bathrooms in the four units did not ensure residents privacy was respected.

10. **Action Required:**
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
The Hospital engineer is reviewing the layout of the bathrooms in the four units identified to identify if any improvements can be made within the present infrastructure.

**Proposed Timescale:** 30/03/2016