Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Marymount University Hospital & Hospice
Centre ID:	OSV-0000582
Centre address:	Curraheen Road, Curraheen, Cork.
Telephone number:	021 450 1201
Email address:	info@marymount.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Marymount University Hospital & Hospice
Provider Nominee:	Sarah McCloskey
Lead inspector:	Mairead Harrington
Support inspector(s):	Mary O'Mahony
Type of inspection	Unannounced
Number of residents on the date of inspection:	61
Number of vacancies on the date of inspection:	2

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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
24 January 2017 09:00	24 January 2017 18:30
25 January 2017 08:45	25 January 2017 17:15

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

Marymount University Hospital and Hospice provides respite, intermediate palliative care and residential continuing care services for the older person. The designated centre is a long standing service that commenced operating from its current site in 2011.The centre is a purpose built facility, situated on the outskirts of Cork city. The centre is registered to accommodate 63 residents. There were 61 residents living in the centre on the days of inspection. Residents' bedrooms are located over three floors and can be accessed by both stairs and lift.

This monitoring inspection was unannounced and took place over two days. The purpose of the inspection was to inform a report on the standard of service delivered by the centre. The findings of the inspection are set out under eleven outcome statements. These outcomes set out what is expected in a designated centre and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the

National Standards for Residential Care Settings for Older People in Ireland, 2016. As part of the process inspectors met with members of management, residents, relatives and staff members. Staff were observed in their practice of care and the conduct of their daily duties. Documentation was reviewed that included care plans, medical records, accident logs, policies, procedures and staff files.

The centre was last inspected in October 2015. A copy of that report can be found on www.hiqa.ie. Most of the actions identified on that inspection had since been addressed. An annual quality review had been completed. Care planning and assessment had been reviewed. Environmental risks had been assessed and appropriate controls were in place. Policies and procedures had also been revised, where required. Members of management were available during the inspection and all demonstrated an understanding of the standards and regulatory requirements relevant to their roles. Management and staff demonstrated commitment to a culture of improvement and the provision of person-centred care to residents. There was evidence of individual resident's needs being met and that the staff supported residents to maintain their independence where possible. The collective feedback from residents and relatives was positive and complimentary of the service, particularly the staff. Staff with responsibilities for social and physical activation provided a regular schedule of opportunities. On the days of inspection, residents were seen to engage in, and enjoy, these sessions. Effective and appropriate communication and interaction between staff and residents was noted throughout the inspection.

Overall the inspection returned positive findings on the safety and wellbeing of residents in the centre. A high standard of evidence-based care was in place. The facilities and accommodation were purpose built to a high standard and the design and layout of the premises was in keeping with the needs of the resident profile. Areas for improvement that were identified included staffing resources, audit implementation, regular delivery of mandatory training and the maintenance of documentation on staff files and care plans. These issues are further detailed in the body 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 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Marymount University Hospital and Hospice operated as a company limited by guarantee. An organisational structure was in place that clearly identified roles and responsibilities. Governance was by a voluntary board of directors. The delivery of service was overseen by sub-committees with responsibility for quality, risk management and audit. Separate operational committees operated in these areas and also on infection control and health and safety. The chief executive acted as representative of the service provider. Care was directed through the person in charge who reported to the chief executive. Relevant business plans and related strategies were in place. Regular management meetings took place and systems of communication and accountability were in evidence.

Management systems were in place to monitor the provision of service with a view to ensuring safety and consistency. There was a committee with responsibility for quality, risk management and audit. This committee convened regularly to review the audit schedule and actions were identified to develop learning from this review. Minutes of these meetings were available for reference including action plans and outcomes. The centre maintained a corporate and operational risk register. Effective systems were in place to identify, record, report and learn from incidents and accidents. An annual quality review had been completed that fulfilled the requirements of the regulations and reflected consultation with residents and their families. A review of the training matrix indicated that resources were dedicated on a consistent basis to the continuous professional development of staff. However, management confirmed that the maintenance of a full complement of staff was inconsistent. Several functional roles had remained unfilled for extended periods of time; in relation to practice development and infection control, for example. The lack of continuity in these roles impacted on the effective implementation of quality management systems. Staff and management confirmed that, while these appointments were now filled, the roles were not yet fully

developed in relation to audit responsibilities. A review of the audit programme confirmed that the completion of scheduled audits, in relation to infection control for example, was inconsistent. As identified in other areas of the report, the timely delivery of refresher training in mandatory areas was also affected by delays in filling these appointments.

Judgment:
Non Compliant - Moderate

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

Findings:
The issues identified on previous inspection had been addressed and a daily record of nursing notes was now regularly maintained on care plans reviewed. Schedule 2 records were generally well maintained. However, as reference at Outcome 18, there were some gaps in the employment history of one staff member and references were incomplete on the file of another. Resident records checked were complete and contained information as detailed in Schedule 3, including care plans, assessments, medical notes and nursing records. However, in some instances consent forms had not been signed. Only documentation relevant to the outcomes being assessed were examined in the course of this inspection.

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

Findings:
Appropriate safeguarding measures such as a relevant policy and training programme were in place. Policies and procedures on abuse had been reviewed and referenced current national policy and legislation. Improvements had been implemented since the previous inspection and a screening process was in place to ensure that complaints and allegations were correctly differentiated. An inspector reviewed the system of managing allegations. The processes of both record keeping, and reporting, were in keeping with policy and related protocols. Staff spoken with understood their duty of care and how to recognise different kinds of abuse. They also understood, in the event of such an allegation or incident, the procedure for reporting the information. The inspector met with the designated officer, who had received relevant training and demonstrated a clear understanding of their role. A training matrix was available and a regular training programme was in place. However, as identified on previous inspection, several staff members were overdue refresher training in relation to safeguarding.

There were policies in place on the management of responsive behaviours and the use of restraint. Staff spoken with demonstrated an understanding of the skills and knowledge required to respond appropriately, and care for residents, that might present with such behaviours. A behaviour assessment tool was in place that had been revised in keeping with a recommendation from the previous inspection. Management confirmed that this tool was kept under review. Records indicated that appropriate consultation processes were in place around the use of restraints, such as bedrails. Documentation recorded multidisciplinary input, including that of a physiotherapist, the medical director and nurse. A register was in place to record the regular monitoring of a bedrail or lap-belt when in use. An inspector reviewed practice in relation to the management of residents' valuables and personal monies that was in keeping with the related policy and protocol. Systems of accountability included the double-signing of transactions and an external audit process.

Judgment:
Non Compliant - Moderate

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:
Action had been taken to address the issues identified on previous inspection. A centre-wide water temperature assessment had been undertaken and tap outlets were being monitored regularly.

The centre had a maintenance department and dedicated resources with responsibility for the maintenance of premises and equipment. A regular schedule of maintenance was in place. The centre operated a comprehensive risk register. An inspector reviewed the recorded risks which were relevant to the centre and included related controls and reviews in keeping with requirements. A record of incidents and accidents was maintained and this information was collated on a quarterly basis for review. Learning from this process was circulated through alerts and also communicated at staff meetings. Action had been taken since the previous inspection to assess the use of balconies that were accessible from residents' rooms. The risk assessment tool in relation to the use of bedrails had also been revised. A risk assessment was in place for the use of communal balconies for residents who smoke. Ash trays were provided and fire blankets were readily accessible in these areas. A health and safety statement was in place dated 22 November 2016. A risk management policy was in place. However, it did not fully reference the risk areas of abuse and missing persons as required by Regulation 26; this omission was addressed in the course of the inspection.

Staff spoken with by inspectors demonstrated their understanding of what to do in the event of a fire in the centre. A fire safety check list was maintained for each ward on every floor that recorded the required daily and weekly checks on exits and alarm panels, for example. Regular fire drills took place. A fire evacuation plan and procedure was displayed clearly on each ward and on the door of each resident's room. Fire safety equipment was serviced regularly in keeping with requirements. However, refresher training in fire safety and manual handling was overdue for some members of staff.

Management in the centre had measures in place to manage infection control risks. A clinical nurse manager had been appointed with responsibility for the monitoring and review of infection control practice. Access to hazardous areas such as sluice rooms and kitchenettes was restricted. Staff were seen to utilise personal protective equipment appropriately. Hand-hygiene dispensers were in place throughout the centre and seen to be regularly used. Household staff were seen to implement appropriate protocols around cleaning, such as segregation of laundry and colour-coded equipment. Committees in relation to both risk management and infection control convened regularly to review related issues.

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:
Action had been completed following the previous inspection and pro re nata (PRN) medicines were now clearly documented. Centre-specific policies were in place on the management of medicines that appropriately referenced directions in relation to the ordering, prescribing and storing of medicines; this included protocols on the handling and disposal of out-of-date medicine.

An on-site pharmacy facility supported the centre in its requirements around stock control, audit, training and review. Secure facilities were available for the storage of medicines including lockable trolleys for administration rounds. Controlled drugs were stored and managed in keeping with requirements and records were maintained of stock checks at the beginning and end of each shift that were double-signed by suitably qualified staff members. Where medicines were refrigerated, the temperature was being recorded and monitored. Dates of opening were recorded on medicines, such as eye-drops. A clinical nurse manager confirmed that a system was in place to record medication errors for review and learning. Where residents were self-administering, appropriate assessments had been undertaken.

Medicine prescription sheets were current and contained the necessary biographical information of the resident, including a photograph for reference. Medicine administration sheets contained the signature of the nurse administering the medicine and also provided an area to record instances where a resident might refuse the medicine.

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:
An inspector reviewed the incident log which was well maintained and clearly recorded all the relevant information around the circumstances and impact of incidents. Quarterly returns were provided in accordance with the regulations. Incidents requiring formal

notification were also submitted in keeping with statutory timeframes. However, in one instance the timeframe for submission of a notification, in relation to an infectious outbreak, had not been in keeping with requirements.

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

Findings:
Action had been taken to address those areas for improvement identified on the previous inspection. Comprehensive plans of care were now in place for all residents, both on respite and in continuing care. Risk assessments were carried out in keeping with a relevant risk matrix.

Care services within the centre were well resourced. A resident medical director was in place. The services of two physiotherapists were available. Support of pharmaceutical services were available both on site and locally. Activities were managed by a qualified nurse. Additional resources included the on-site attendance of a podiatrist and dentist. The services of a dietician or speech and language therapist were available by appointment. Optical services were also provided on an annual basis or by appointment. Occupational therapy services were accessible. Consultancy services in relation to both gerontology and psychiatry were available as required.

The admission policy set out the procedure for assessing all residents. Residents were assessed on admission by a suitably qualified person. Admissions were made in consultation with the public health nurse as appropriate. Care plans were developed in line with admission assessments and residents' changing needs. Admission assessments identified relevant information on the background of residents and their personal preferences, as well as a full profile of their medical and healthcare needs. A sample of care plans was reviewed on inspection and the information around care in this sample was found to be person-centred and relevant. It was evident that validated assessment tools had been used to determine residents' needs in areas such as mobility, environmental risk, diet and cognitive impairment, for example. Specific care plans were in place based on these assessments. These care plans provided relevant directions and

advice to staff on appropriate interventions to be considered when delivering care. Nominated nursing staff had responsibility for individual residents. Measures to promote the maintenance of good health included the regular recording of health observations and the implementation of a 'flu vaccine programme. Regular nursing notes and communication notes were maintained and the entries were relevant to the assessed needs of the resident. Correspondence relating to advice and assessments, following referrals or transfers were filed for individual residents. All care plans were reviewed regularly, and at least on a four monthly basis or to reflect the residents' changing care needs. Care plans reviewed reflected consultation with residents and their families as appropriate and residents were seen to be consulted as to their preferences in how they received care. While care plans were regularly reviewed, the review information was sometimes incomplete and did not fully reflect the current circumstances of the resident. For example, the revision of a moving and handling care plan had not been supported by a further physiotherapy assessment following a change in the resident's needs.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
The designated centre was a purpose-built facility that had been in operation on the current site since 2011. A palliative care hospice and education centre also operated from the same premises. The building was set on its own grounds on the outskirts of Cork city. Ample car parking facilities were available. A canteen area on the lower ground floor provided a catering service that both residents and visitors could access.

The centre provided accommodation for up to 63 residents, with 61 in occupancy at the time of inspection. Accommodation was of a high standard and laid out over three floors, comprising 51 single rooms and three four-bedded rooms. All rooms were well equipped, providing an overhead hoist and individual communication and entertainment consoles for residents. Each room provided a bedside locker, chair and wardrobe. All single rooms included an en-suite facility and a private balcony. Each floor had a reception area with residents' rooms laid out to either side of a central, communal sitting area. This central area led out onto a large, communal balcony that provided seating

and a view of the local area. Each floor also had a spacious, communal sitting area, with tables that were laid for dining during mealtimes. Residents on the ground floor had access to an enclosed garden area with seating. Residents could also take walks in the extended grounds.

The multi-occupancy rooms were large enough to provide furniture and any assistive equipment required. Screens were in place to support privacy and dignity. These rooms accommodated residents at the centre who were on respite. Alternative space was available to residents for consultation and treatment in private. There were separate areas for residents to meet their visitors in private should they so wish. Residents admitted to the centre for continuing care were provided with their own room. Ample storage space was available throughout the centre. Sluice and laundry facilities were appropriately equipped. Access between floors was facilitated by a lift that was regularly serviced. An adequate number of toilets were available for use. Residents also had access to an assisted bath facility. Bathrooms and circulation areas provided grab-rails that supported residents to mobilise independently. Call-bells were fitted as required throughout. Staff were provided with suitable changing and storage facilities. Residents had the facility of a large recreation area in the main building that had a separate utility to support baking and art and craft activities. There was also a large gymnasium area for exercise activities.

The kitchen was well equipped with facilities to support a catering service in keeping with the size and occupancy of the centre. Each floor also had its own kitchenette facility to support this function. The laundry area was suitable in design to meet its purpose with sufficient space and facilities to manage laundering processes. The design and layout of the premises was in keeping with the statement of purpose and fulfilled the requirements of the regulations in meeting the needs of residents in relation to privacy, independence and wellbeing.

Judgment:
Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
A site specific complaints policy and procedure was in place that covered both written and verbal complaints. The policy cited relevant legislation and provided a clear outline of the procedure to follow in making a complaint, including expected time frames for

resolution. The complaints procedure was clearly displayed in public access areas of the centre. It summarised how to make a complaint and also identified the complaints' officer. It set out the appeal process and provided relevant contact details. Information on the complaints process was in the statement of purpose and also available to residents as part of the residents' guide. Residents and relatives spoken with understood how to raise any concerns they might have. At the time of inspection the complaints reviewed had been satisfactorily resolved and no referrals were being considered via the appeal process. The record of complaints included all relevant information on the complainant, the nature of complaint, any action taken and whether the outcome was resolved satisfactorily.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Management demonstrated a commitment to engagement and consultation with residents in the running of the centre. Consultation was promoted and a survey entitled 'Your Say' had been completed as part of the annual quality review. Satisfaction survey forms were available in the foyer of each ward and on every floor. Suggestion boxes were available throughout the centre. Regular resident meetings took place and minutes of these were available for review. Independent advocates regularly attended the centre and facilitated in the resident meetings. Communication systems were in place to support consultation with residents in relation to their preferences, around accommodation and meals for example. An inspector met with the catering and services managers who described these arrangements. The centre provided access to a prayer room and pastoral services were available. Mass was held regularly at the centre.

There were no restrictive visiting arrangements and visitors were variously present throughout both days of the inspection. Residents could receive visitors in their rooms or in a private visiting space. Several communal areas, including a public canteen, were also available to both residents and visitors. Residents and visitors spoken with by inspectors remarked positively on their experience of care at the centre. In particular staff attitude and care was complimented.

A general trained nurse acted as activities manager and was supported in this role by two healthcare assistants and a volunteer. A meaningful programme of activities was in place that considered the different abilities and communication needs of all residents. Activities were provided on a group or individual basis according to the assessed needs of the resident. The service was well resourced and the recreation area for activities was nicely furnished and decorated. It also had an adjacent facility with equipment for baking, or creating arts and crafts. Interactive projects were encouraged that promoted independence and choice. Residents had been supported in their engagement with a community funded initiative on the relevance of personal heroes. Residents had access to secure outside space, including a garden area with pathways and a grotto. On the days of inspection a range of activities were observed, including group sessions of music and a physical activity session with a physiotherapist. A hairdresser regularly attended residents in the centre.

Inspectors noted that interactions between residents and staff were courteous and friendly. Staff were seen to communicate appropriately with residents and were familiar with their circumstances and preferences. All residents had access to a personal communication and entertainment console that also provided them with private phone access. Appropriate provisions were in place to protect and promote privacy and dignity. All single rooms were provided with en-suite facilities and interstitial blinds were in place that residents could open or close as they preferred. Respite residents were accommodated in large, bright four-bedded wards, also with en-suite facilities. The inspector spoke with some of these residents who said they were comfortable and felt they were very well cared for. Appropriate screening for privacy was provided. Alternative space was also available for treatment and consultation, or to meet visitors in private.

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

Findings:
The previous inspection had identified issues with the levels and skill-mix of staff relative to the size and layout of the centre. Management confirmed that actions were ongoing in relation to addressing this issue and a number of functional roles around practice development, infection control and manual handling training had been filled since the previous inspection. The skill-mix and level of staff on duty during the inspection were in keeping with the needs of the resident profile, having consideration for the size and layout of the centre. Management confirmed that arrangements were ongoing to ensure a full complement of staff was in place at all times. However, on one day of inspection the duty staff did not reflect the planned rota and staff levels were below complement due to staff absence. Management redeployed resources as necessary and the protected time of two clinical nurse managers was used to meet this staff shortfall.

A training schedule had been developed that reflected the regime of care as set out in the statement of purpose, and in keeping with the assessed needs of the resident profile. The programme of training available included dementia and related behaviours, medicines management, first aid and infection control. Staff who spoke with inspectors said that they were encouraged by management to take up training and professional development opportunities. Systems in place to support the identification of training needs included an annual appraisal process. Copies of the standards and regulations were readily available and accessible. Staff spoken with understood their statutory duties in relation to the general welfare and protection of residents. Inspectors noted that the interactions of staff with residents observed throughout the inspection were consistently positive; all staff in their various roles demonstrated person-centred care and attention when engaging with residents.

Robust recruitment and vetting procedures were in place. Staff records were well maintained. Where there were gaps, these are recorded for action against Outcome 5 on Documentation. A member of management was responsible for ensuring that Garda vetting was in place for all staff members; an audit of this process confirmed compliance. Where volunteers were engaged at the centre the required documentation in relation to supervision and Garda vetting were in place.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mairead Harrington
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Marymount University Hospital & Hospice
Centre ID:	OSV-0000582
Date of inspection:	24/01/2017
Date of response:	23/02/2017

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Quality management systems in relation to the implementation of audit and training schedules was inconsistent.

1. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively

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

monitored.

Please state the actions you have taken or are planning to take:
The Audit Committee have reconvened. An updated Audit Schedule has been devised. Audits are underway.

Training.
Training dates have been arranged and staff booked on same.

Proposed Timescale: 30/04/2017

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:
There were some gaps in the maintenance of documentation, including:
- the employment history of one staff member,
- incomplete references on a staff file,
- instances of unsigned consent forms in some care plans.

2. Action Required:
Under Regulation 21(2) you are required to: Retain the records set out in Schedule 2 for a period of not less then 7 years after the staff member has ceased to be employed in the designated centre.

Please state the actions you have taken or are planning to take:
HR will audit files by April 2017. Any deficits will be immediately verified. Clinical documentation audit undertaken. Plan to roll out results to ward staff.

Proposed Timescale: 30/04/2017

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:
Several staff members were overdue refresher training in relation to safeguarding.

3. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
All staff have had initial training in detection, prevention and report of abuse, however refresher training was not within timeframes specified. A Policy on the Safeguarding of Vulnerable Adults is in place and training dates are scheduled.

Proposed Timescale: 31/03/2017

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:
Refresher training in fire safety and manual handling was overdue for some members of staff.

4. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Refresher training has been put in place.

Proposed Timescale: 30/04/2017

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
In one instance the timeframe for submission of a notification, in relation to an infectious outbreak, had not been in keeping with requirements.

5. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
All notifications are usually sent from Marymount within specific timeframes. One was omitted in error and sent on as soon as possible.

Proposed Timescale: 22/02/2017

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:
In some instances care plan reviews did not reflect the current circumstances of the resident.

6. 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:
Documentation Audit underway. Staff were informed of omissions.

Proposed Timescale: 22/02/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
On one day of inspection the duty staff did not reflect the planned rota.

7. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Marymount is making every attempt to have sufficient staff on duty. Discrepancy was due to staff absence. There are back up plans for when this does not happen due to unforeseen circumstances. Staffing/roster review will be undertaken by May 2017.

Proposed Timescale: 31/05/2017