**Health Information and Quality Authority**

**Regulation Directorate**

**Compliance Monitoring Inspection report**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Finbarr's Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000580</td>
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<tr>
<td>Centre address:</td>
<td>Douglas Road, Cork.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>021 496 6555</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:Catherine.white3@hse.ie">Catherine.white3@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Mairead Harrington; Mary O'Mahony</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>88</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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</table>
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: 28 November 2017 10:00
To: 28 November 2017 19:00
29 November 2017 08:30
29 November 2017 17:00

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

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<td>Outcome 04: Suitable Person in Charge</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
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<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
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<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection
St. Finbarr's Hospital is situated in Cork city and accommodates 89 residents, 88 of whom are accommodated in five units within large institutional type buildings. The remaining resident is accommodated in a purpose built room located in another unit, as it was more suitable for this resident's needs. The premises was originally built in the late 19th century on extensive grounds and is proximal to other services such as rehabilitation, dental, mental health, blood transfusion and Health Service Executive (HSE) administration offices, which are located on the same campus. Three of the units are on the ground floor and two are on the first floor, however, the units are not adjacent to each other but are situated at various locations throughout the grounds.

This was a monitoring inspection and was carried out over two days to assess ongoing compliance with regulations and standards. The inspectors noted that
Residents appeared to be well cared for and their health needs were met to a good standard. Staff were seen to interact with residents in a respectful and courteous manner and call them by their preferred names. Residents and relatives were complimentary of staff and indicated that staff were caring and responsive to their needs.

Medical services are consultant led in four of the five units, with the assistance of Senior House Officers who are based on site from Monday to Friday and are on-call out-of-hours. Medical cover in the fifth unit is provided by a general practitioner (GP). There was good access to allied health and specialist services such as dietetics, speech and language therapy, psychiatry, dental, and opticians. There was also access to physiotherapy and occupational therapy on a referral basis, however, documentation seen by inspectors indicated that access to these services was limited. For example, a number of residents had been referred for review by occupational therapy, however, staff were requested to prioritise which residents need to be seen as there was insufficient resources available for all of these residents to be reviewed.

Significant improvements remained outstanding in relation to the environment, which had a negative impact on privacy and dignity, and on the quality of life of residents. 61 of 89 residents were accommodated in multi-occupancy bedrooms of three beds or more, and of these, 46 residents were in five and six-bedded rooms. The residents' beds in the five and six-bedded rooms were close together and did not support residents' privacy and dignity. Inspectors were informed by staff that in some of the bedrooms it was necessary to move the bed closest to the doorway in order to use assistive equipment such as hoists and large chairs.

In addition to unsuitable sleeping accommodation, communal and dining space was also unsuitable. For example, there were no separate dining facilities in some of the units and communal space comprised a living/dining room combined that was not of sufficient size for the number of residents living in the centre. There was also inadequate storage space, including suitable storage for residents' personal belongings and storage for equipment.

Residents spent a considerable amount of time in their bedrooms, either in bed or at their bedsides. While it is accepted that a number of these residents were high to maximum dependency, the environment was not conducive to entice residents to spend more time away from their bedrooms.

Other required improvements included:
- Schedule 2 documents were not available in the centre for newly recruited staff
- a resident was being accommodated in a section of the premises that was not part of the designated centre
- records were not always easily accessible
- a significant number of residents had bedrails in place
- not all staff had attended mandatory training
- records were not always maintained of preventive maintenance of equipment
- access to occupational therapy and physiotherapy was limited
The provider's response to the action plan is at the end of this report. HIQA did not agree the response to the actions under Outcome 02, Regulation 23(c); Outcome 05, Regulation 21(1); Outcome 07, Regulations 07(1) and 07(3); Outcome 12, Regulation 17(1); and Outcome 16 with the provider. HIQA were not satisfied that the response adequately addressed the non-compliances in a satisfactory and timely manner.
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:
This centre is operated by the Health Service Executive (HSE). There was a clearly
defined management structure. The provider representative is a general manager for
residential services for older people and has responsibility for 12 other HSE centres,
predominantly in Kerry and West Cork and is based in Killarney. The person in charge
works full time and is supported by a team of senior nurse managers that includes
assistant directors of nursing, clinical nurse managers (CNM) 3 and a night
superintendent. There is also a CNM 2 and CNM 1 based on each of the units.

There were clear lines of authority and accountability and effective communication
systems in place. The person in charge met with the provider representative formally
approximately every six to eight weeks at regional meetings, that were also attended by
other persons in charge. They were also in regular contact via phone calls and emails on
a weekly basis. There are senior nurse managers meetings held approximately every
eight weeks that are attended by the person in charge, assistant directors of nursing,
CNM 3, and the practice development team. Following these meetings there is usually a
CNM 2 meeting, where relevant issues from the senior management meeting are
discussed and are then relayed to staff.

There was a comprehensive programme of audits that included audits of care plans,
medication management, and infection prevention and control. There were associated
action plans for implementing improvements, where they were required. There were
also a number of observational audits completed to monitor staff interaction with
residents to determine if staff engaged positively with residents while providing care and
throughout the day. Inspectors saw evidence of the collection of key clinical quality
indicator data including number wounds, incidence of responsive behaviours, pressure
ulcers, length of time residents spent in bed, and the use of restraint. There was an
annual review of the quality and safety of care completed for 2016. There was evidence
of consultation with residents through residents meetings, however, only a small number of residents attended these meetings. This is further discussed under Outcome 16.

Some improvements were required in relation to governance and management. Documents listed in Schedule 2 of the regulations were not available in the centre for recently recruited staff. While copies of these were made available following a request by the inspectors, the regulations stipulate that these records are kept in the designated centre and available for inspection. This action is addressed under Outcome 5, Documentation.

**Judgment:**
Non Compliant - Moderate

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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:**
The person in charge was full time in post, was suitable qualified and had the required experience in caring for older persons. It was evident throughout the inspection process that she was knowledgeable of residents needs and was involved in the day to day operational management of the centre. Based on interactions with the person in charge throughout the inspection process, it was evident that she had sufficient clinical knowledge and had knowledge of the legislation and of her statutory responsibilities.

**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:**
Residents' records were reviewed by the inspectors, who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspectors.

The designated centre had implemented 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 and these are reviewed and updated at intervals not exceeding three years as required by Regulation 4.

Inspectors reviewed a selection of staff files to assess compliance with Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. While these documents were available for most staff, none of these documents were available in the centre for recently recruited staff. While copies of these were made available following a request by the inspectors, the regulations stipulate that these records are kept in the designated centre and available for inspection.

**Judgment:**
Non Compliant - Moderate

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**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:**
Inspectors were satisfied that there were adequate measures in place to safeguard residents and protect them from abuse. There was an up-to-date policy on Safeguarding Vulnerable Persons at Risk of Abuse. Inspectors reviewed staff training records that indicated an ongoing programme on safeguarding the vulnerable adult, however, a small
number of staff either did not have this training or the training was out-of-date. Staff members spoken with were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse. Residents with whom inspectors spoke said that they felt safe in the centre. Relatives spoken with were complimentary of the care provided by staff in the centre.

The centre was a pension agent for a number of residents, and as had been identified on previous inspections, this was all managed through the HSE national accounts in Tullamore, where robust records were maintained of all transactions. Some improvements were required in relation to the maintenance of records of small sums of money that were held for safekeeping on behalf of residents. Signatures were not always obtained from relatives, verifying the amount of money lodged. Additionally, there was no system for reconciling the amount received by staff at unit level with that lodged centrally in the centre.

There was a policy on responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia). Inspectors were informed that the centre was in the process of changing the type of training provided to staff from professional management of violence and aggression to a more suitable type of training for staff caring for residents with dementia. Training records, however, viewed by inspectors indicated that a significant number of staff had not attended either of these training programmes. Care plans viewed by inspectors contained adequate information in relation to residents that may at times present with responsive behaviour and it was evident that staff were familiar with individual resident's needs in this regard.

The inspectors noted that a significant number of residents had bedrails in place. Notifications submitted to HIQA indicated that in the period July to September 2017, 83 of 89 residents had bedrails in place. While there were adequate risk assessments completed prior to the use of bedrails and safety checks while bedrails were in place, inspectors were not satisfied that there was adequate exploration of alternatives to the use of bedrails. Inspectors noted that in some of the multi-occupancy bedrooms, the proximity of beds to each other may have a prohibitive effect on alternatives to bedrails, such as low profiling beds and crash mats.

**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
There was an up-to-date safety statement. There was an up-to-date risk management policy and associated risk register that addressed the specific risks outlined in the regulations. There was an emergency plan. Inspectors reviewed the risk register which identified hazards and control measures in place to mitigate the risks identified, and was reviewed and updated at regular intervals.

Accidents and incidents were recorded on incident forms. These were reviewed by the CNM 2 and were then submitted to the person in charge and were entered on the HSE national incident management system. Records indicated that each incident was reviewed and there was evidence of action in response to individual incidents. Incidents were reviewed at the senior nurse management meetings and any learning was communicated to clinical nurse managers and staff. Significant incidents were discussed at regional meetings that were attended by other persons in charge and the provider representative.

There were adequate procedures in place in relation to fire safety. Records indicated that fire safety equipment was serviced annually and the fire alarm and emergency lighting were serviced quarterly. There were daily checks of means of escape to ensure emergency exits were not obstructed. Inspectors, however, noted that the fire exit signage in St. Stephen’s did not direct potential evacuees to the emergency exit and instead pointed to a staff changing area. This issue was addressed prior to the completion of the inspection. There were regular fire drills that included simulation of night time staffing levels. The nursing supervisors on night duty routinely discussed and evaluated staff fire safety awareness and knowledge. Training records indicated that a number of staff were overdue fire safety training, however, further training sessions were scheduled to take place over two days in mid-December. Residents had detailed personal emergency evacuation plans completed, detailing their specific requirements for evacuation in the event of a fire.

The environment was generally clean throughout. The centre had a detailed infection prevention and control policy in place. Personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. Arrangements for the disposal of domestic and clinical waste management were appropriate.

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):
No actions were required from the previous inspection.

**Findings:**
There was an up-to-date policy on the management of medication in the centre. The policy addressed the ordering, receipt, storage, administration, and disposal of medicines. Medication trolleys were stored in locked clinical rooms when not in use. Controlled drugs were managed in accordance with relevant guidance and two nurses checked the quantity of medications at the start of each shift. Medications requiring refrigeration were stored appropriately and the fridge temperature was monitored and recorded.

Medication administration was observed and the inspectors found that the nursing staff generally adhere to professional guidance. Inspectors reviewed a sample of residents’ prescription and administration records and each had had photographic identification of the resident and were legible. There was evidence that residents’ medicine prescriptions were reviewed at least every three months by a medical practitioner, crushed medications were prescribed as crushed, and maximum doses were recorded on PRN (as required medicines). Medication errors and near misses were recorded on the incident log and were discussed at management meetings.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 10: Notification of Incidents</strong></th>
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<tr>
<td><em>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</em></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 reviewed the accidents and incident log and saw that there was a comprehensive log of all accidents and incidents that took place in the centre.

Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 have generally been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents as required.

**Judgment:**
Compliant

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

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

**Findings:**
The inspectors noted that residents appeared to be well cared for and their health needs were met to a good standard. Medical services are consultant led in four of the five units, with the assistance of Senior House Officers who are based on site from Monday to Friday and are on-call out-of-hours. Medical cover in the fifth unit is provided by a general practitioner (GP). There are weekly rounds by consultant geriatricians, to which residents have good access. Records viewed by inspectors indicated that residents received frequent medical reviews.

There was good access to allied health and specialist services such as dietetics, speech and language therapy, psychiatry, dental, and opticians. There was also access to physiotherapy and occupational therapy on a referral basis, however, documentation seen by inspectors indicated that access to these services was limited. For example, a number of residents had been referred for review by occupational therapy, however, staff were requested to prioritise which residents need to be seen as there was insufficient resources available for all of these residents to be reviewed. Residents and relatives expressed satisfaction with the medical care provided.

Residents were comprehensively assessed on admission and at regular intervals thereafter using recognised tools for assessing the risk of falling, the risk of developing pressure sores, level of cognitive impairment, and the risk of malnutrition. Care plans were developed for issues identified on assessment and these provided good guidance on the care to be delivered. Care plans accurately reflected the assessed needs of the residents were personalised and identified residents' likes and dislikes, and preferences. Care plans for residents with wounds were reviewed and these included regular scientific assessments of any wounds, including photographs. However, the person in charge was requested to review care plans in relation to the accessibility of information within the care plans. For example, while care plans were personalised and reviewed regularly, it was at times difficult to identify the most recent and up-to-date assessment, due to the manner in which reviews were recorded and the length of time since the front pages of the assessment template were originally populated. This action is addressed under Outcome 5 of this report. There was documentary evidence that the care plan had been discussed with the resident or relative as required and this discussion of care plans was confirmed by residents and relatives. Consent to treatment was documented.
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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The centre is composed of five units located within a larger HSE campus and comprised St. Joseph’s 1, St. Joseph's 2, St. Stephen’s, St. Enda’s and St. Elizabeth’s units. One resident was accommodated in a separate unit located in one of the rehabilitation units, as it was more suitable for this resident's needs. The buildings were constructed in the late 19th century and, with the exception of the St. Josephs' units, were institutional in appearance consistent with the style of that era. The standard of décor was generally adequate and the centre was clean throughout. Areas of the centre had been redecorated and painted since the last inspection. However, this centre was identified as being in major-non-compliance with the regulations on all previous inspections in relation to the design and layout of the centre and this has not changed.

St. Enda’s, St Elizabeth’s and St. Joseph's 1 are all ground floor units while St. Joseph's 2 and St. Stephen's units are both on first floors with access by stairs and lifts.

St. Stephen’s Unit accommodates 16 residents in two six-bedded rooms, one twin bedroom and two single bedrooms. Communal space comprises one sitting/dining room that is not adequate in size for the number of residents living in the unit. There is no access to suitable outdoor space and there are no suitable facilities for residents to meet with visitors in private. There is inadequate storage space for equipment such as hoists and speciality chairs. Inspectors were not satisfied that the sanitary facilities were adequate to meet the needs and number of residents living in the centre. Sanitary facilities are located on the opposite end of the unit to the bedrooms and comprise two bathrooms, one of which contains a toilet, wash hand basin and an assisted shower and the other contains a toilet and wash hand basin only. Lighting in the bedrooms was by fluorescent strip lights that were very hard on the eyes, particularly when residents were laying in bed looking up at the ceiling.

Each resident in the six-bedded unit had a small wardrobe/bedside locker combination
next to their beds. These were not suitable in size to store all of each resident’s clothing. Additional clothing was stored in cupboards on one side of the room, next to the beds of two of the residents. The beds in the six-bedded rooms were close together and there was not sufficient room for each resident to have a chair should they wish to sit beside their bed or for a visitor to sit. As found on previous inspections, strong odours lingered in the bedroom following use of a bedpan by a residents. This did not support the dignity of the resident using the bedpan or of other residents in the room.

St. Elizabeth’s Unit accommodates 20 residents in three six-bedded rooms and two single bedrooms. Communal space comprises one sitting/dining room that is not adequate in size for the number of residents living in the unit. There was no access to suitable outdoor space and an area that had been used by residents previously was no longer available to residents. The beds in the six-bedded rooms were close together and there was not enough space for residents to have a comfortable chair, should they wish to sit in their bedroom. There were large structural support poles at the entrance to the six-bedded rooms that made it difficult to navigate equipment such as speciality chairs and hoists into the rooms, without first moving one of the two beds closest to the door. This would cause considerable disturbance to residents when they are in bed. Additionally, the proximity of beds to each other would not allow for alternatives to bedrails such as crash mats and low profiling beds. Sanitary facilities comprised two bathrooms. The first bathroom contained a shower, toilet and wash hand basin. There was a shower trolley, shower chairs and linen skips stored in the bathroom making the wash hand basin inaccessible. The second bathroom was located off the sitting room and consisted of two rooms, both of which contained a toilet and wash hand basin. However, the second toilet could only be accessed by going through the first toilet, making it unsuitable for use. The second toilet was used to store equipment such as chairs and walking aids.

St. Enda’s Unit accommodates 17 residents in one six-bedded room, two five-bedded rooms and a single bedroom. Since the last inspection an en suite toilet and shower had been built in what was previously a six bedded room and was now a five-bedded room. Similar to St. Elizabeth’s unit, the sitting/dining room was not adequate in size to meet the needs of the residents living in the centre. Having said that, this sitting room was homely in appearance and was decorated to a good standard and had a fire place with an artificial fire. The area immediately outside the sitting room was also homely in appearance with a good standard of décor. The beds in the six and five-bedded rooms were close together and there was not enough space for residents to have a comfortable chair should they wish to sit in their bedroom. There were also large structural support poles at the entrance to the six and five-bedded rooms in this unit that made it difficult to navigate equipment such as speciality chairs and hoists into the rooms without moving one of the two beds closest to the door. In addition to the en suite bathroom in the five-bedded room, sanitary facilities comprised two other bathrooms, each of which had a shower, toilet and wash hand basin. One of the bathrooms, however, was located off the sitting/dining room make it unsuitable to use the shower facility without compromising privacy and dignity.

St. Joseph’s 1 and St. Joseph’s 2 are located in the one building, which is located distal to the main campus entrance. St. Joseph’s 1 is on the ground floor and accommodates 17 residents in seven single, two twin and two triple-bedrooms. For operational
purposes, this unit is divided into two units, with four beds being set aside for residents with responsive behaviour. St. Joseph's 2 is located on the first floor and accommodates 18 residents in seven single, one twin and three triple bedrooms. There are suitable communal and sanitary facilities in both of these units, with a number of bedrooms en suite. There are two enclosed gardens on the ground floor, one for each of the ground floor units. These have been finished to a high standard with shrubs, plant beds and suitable garden furniture. This outdoors space is also intended for residents of St. Joseph's 2, however, access is limited, as residents can only access them when accompanied by staff.

There were records of the preventive maintenance of equipment such as hoists, beds and wheelchairs, however improvements were required. The inspectors were informed that hoists had preventive maintenance carried out six monthly, but only annual maintenance checks were recorded. Similarly, inspectors were informed that there were annual preventive maintenance checks carried out for beds, but records were only created for beds that had a problem detected during the check.

Judgment:
Non Compliant - Major

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:
There was a policy and procedure on the management of complaints. An outline of the complaints procedure was on prominent display in the centre. The person in charge informed inspectors that she monitored the complaints and these were discussed at staff meetings.

There was complaints log held in each unit where complaints relevant to that unit were recorded. Complaints were also recorded centrally and reviewed by the person in charge. Based on a review of complaints records, complaints were recorded in line with the regulations, including, actions taken, the outcome and whether the complainant was satisfied with the outcome. Improvements, however, were required as the complaints record held at unit level did not always accord with what was held centrally. For example, the complaints record for one unit indicated that there were no complaints on a particular month when central records indicated that there was a significant complaint on that month. Even though records indicated that the complaint was satisfactorily addressed improvements were required in relation to record keeping. Additionally,
details of the complaint were recorded in the relevant resident's notes but it difficult to locate this due to the manner in which nurses' notes were recorded. The reference to the complaint was recorded under Temperature, Breathing sand Circulation, which did not appear to be relevant to the nature of the complaint. This action is addressed under Outcome 5.

**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

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

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

**Findings:**

Staff were seen to interact with residents in a respectful and courteous manner and call them by their preferred names. Residents were well dressed and it was evident that staff took care and attention with residents' personal hygiene needs and supported residents to look well.

There was evidence of consultation with residents through residents meetings that were chaired by an external advocate, however, these were attended by only a small number of residents. Records indicated that where issues were raised, these were brought to the attention of the person in charge. Plans were in place for a more comprehensive consultation process to ensure more residents views were elicited, however, this had not yet been implemented throughout the centre. The process could also be enhance through relative surveys to provide feedback on behalf of residents with communication difficulties.

The centre operated an open visiting policy and this open visiting policy was observed throughout the inspection. Visitors were seen to come and go throughout both days of inspection and it was evident that staff and visitors were familiar with each other. Relatives spoken with by the inspectors were complimentary of the care provided to residents and of the caring attitude of staff. However, the inspectors saw that many visitors visited residents in the multi-occupancy bedrooms, as there were limited private or communal rooms for visiting. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying
Residents were facilitated to exercise their political and religious rights. Staff confirmed that residents can vote in the centre, if they wish to do so and a polling station would be brought to the centre for the residents for this purpose. Two Catholic Priests attend the centre regularly and mass takes place monthly in each of the units and residents can also go to the chapel in the campus of the centre to attend mass every Sunday. Residents also had access to ministers from other religious denominations as required.

Residents were supported to take part in meaningful activities, which met their interests. The centre was suitably resourced with daily entertainment and leisure facilities such TV, radio, newspapers and magazines. Two dedicated activities coordinators, who both worked 32 hours per week, were available to the centre. Inspectors saw a variety of activities on-going during the two days of inspection. On the first day of the inspection residents were seen being taken to an outing in a local shopping centre. The inspectors spoke to some of these residents on their return later in the evening. Residents confirmed that they had an enjoyable day out shopping for Christmas presents and also had lunch in a restaurant close to the shopping centre. Residents were offered a choice of group activities as well as one-to-one sessions. Each resident had a 'My Day, My Way' record in their charts which identified their likes/dislikes and preferences. In addition to occasional outings the programme of activities included, arts and crafts, hand and nail care, relaxation therapy, Sonas, bingo, and music.

Inspectors observed that a significant number of residents spent long periods of the day in their bedrooms, either in bed or on a chair at their bedside. For example, at lunchtime on the second day of inspection in St. Elizabeth's and St. Enda's units, of the 36 residents accommodated there on the days of inspection, 20 residents were in their bedrooms and all but one were in bed. Inspectors visited three of the units in the centre at 18.00 hours on the first evening of the inspection and found that the majority of residents in the centre were either in bed or sat beside their bed. While it is accepted that a number of these residents were high to maximum dependency, the environment was not conducive to entice residents to spend more time away from their bedrooms. In one of the bedrooms, a resident was constantly moaning, while other residents were sleeping. Records viewed by inspectors stated that in one of the multi-occupancy bedrooms a resident had been constantly shouting overnight. Inspectors were informed that this resident was moved to the sitting room to minimise the disturbance to other residents. On one occasion inspectors observed that a resident was using a bedpan with the screens pulled around the bed, however, visitors were free to come and go in the bedroom.

In St. Stephen's, St. Elizabeth's and St. Enda's units, there were no separate dining facilities and a small number of residents had their meals in the sitting room, predominantly eating their meals from bedside tables, either independently or with the assistance of staff. In one unit inspectors noted that there were white boards above the beds and at least one of these contained personal information that would compromise the dignity of the resident.

Residents have access to independent advocacy services and there was information on display in the centre to inform residents of how to contact an advocate should they wish
to do so.

**Judgment:**
Non Compliant - Major

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

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**Theme:**
Workforce

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

**Findings:**
Inspectors observed staff interacting with residents in a respectful and caring manner. Residents and relatives were complimentary of staff and indicated that staff were caring and responsive to their needs. There were adequate systems of communication between staff to support them provide care to residents in a safe and effective way. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. Inspectors saw records of regular staff meetings at which operational and staffing issues were discussed.

Duty rosters were maintained for all staff and, based on the observations of inspectors, there were adequate numbers and skill-mix of staff to meet the needs of the residents on the days of inspection. The centre, however, was heavily reliant on agency staff to maintain adequate staffing levels.

Inspectors viewed the staff training matrix. As already discussed in this report, a small number of staff required training in safeguarding residents from abuse and in manual and people handling. A significant number of staff required training in responsive behaviour and in fire safety. Fire safety training was scheduled to take place in the weeks following this inspection. Staff members spoken with by inspectors confirmed that they were supported by management to attend training.

There were adequate systems in place for the supervision of staff. There was a clinical nurse manager 1 and clinical nurse manager 2 based in each of the units, to whom all staff reported. The clinical nurse managers in turn reported to clinical nurse managers 3, assistant director of nursing and director of nursing, who were based in the
administration section of the centre. An appraisal process had commenced some time ago but had not advanced since the last inspection and only involves staff at managerial grades.

There were a number of volunteers that regularly attended the centre and all received supervision and support while working in the centre and had their roles and responsibilities set out in a written agreement between the designated centre and the individual.

Inspectors reviewed a selection of staff files to assess compliance with Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. While these documents were available for most staff, none of these documents were available in the centre for recently recruited staff. While copies of these were made available following a request by the inspectors, the regulations stipulate that these records are kept in the designated centre and available for inspection. This action is addressed under Outcome 5, Documentation.

**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:**

John Greaney
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>St Finbarr's Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000580</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>28/11/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>17/01/2018</td>
</tr>
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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 fulfill 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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to governance and management, for example:
1. documents listed in Schedule 2 of the regulations were not available in the centre for recently recruited staff.
2. inspectors were informed that a resident was being accommodated in a single room in a section of the premises that was not part of the designated centre.

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

**Please state the actions you have taken or are planning to take:**
1. HIQA did not agree this action plan with the provider.
2. The resident being accommodated in the single room will be accommodated in another room that is currently part of the designated centre.

**Proposed Timescale:** 31/01/2018

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**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors reviewed a selection of staff files to assess compliance with Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. While these documents were available for most staff, none of these documents were available in the centre for recently recruited staff. While copies of these were made available following a request by the inspectors, the regulations stipulate that these records are kept in the designated centre and available for inspection.

2. **Action Required:**
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**
HIQA did not agree this action plan with the provider.

**Proposed Timescale:**

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**Theme:**
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to records management. For example:
• the person in charge was requested to review care plans in relation to the accessibility of information within the care plans. For example, while care plans were personalised and reviewed regularly, it was at times difficult to identify the most recent and up-to-
date assessment, due to the manner in which reviews were recorded and the length of
time since the front pages of the assessment template were originally populated
• even though records indicated that complaints were satisfactorily addressed
improvements were required in relation to record keeping. Details of one complaint
were recorded in the relevant resident's notes but it difficult to locate this due to the
manner in which nurses' notes were recorded. The reference to the complaint was
recorded under Temperature, Breathing sand Circulation, which did not appear to be
relevant to the nature of the complaint.

3. **Action Required:**
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph
(1) in such manner as to be safe and accessible.

**Please state the actions you have taken or are planning to take:**
A full review of care plans will take place. This will involve creating an index system for
ease of access. Only information current to resident care needs will be contained within.
Older information will be filed separately. Front pages in each section will be updated as
required every three months to ensure the current status of the resident is maintained
and easily visible.

Staff have been instructed to record all complaints in each Wards Complaint log.

**Proposed Timescale:** 31/03/2018

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Training records viewed by inspectors indicated that a significant number of staff had
not attended training programmes on managing responsive behaviour.

4. **Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date
knowledge and skills, appropriate to their role, to respond to and manage behaviour
that is challenging.

**Please state the actions you have taken or are planning to take:**
HIQA did not agree this action plan with the provider.

**Proposed Timescale:** 30/06/2018

**Theme:**
Safe care and support
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspectors noted that a significant number of residents had bedrails in place and were not satisfied that there was adequate exploration of alternatives to the use of bedrails.

5. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
HIQA did not agree this action plan with the provider.

Proposed Timescale: 31/03/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Signatures were not always obtained from relatives, verifying the amount of money lodged. Additionally, there was no system for reconciling the amount received by staff at unit level with that lodged centrally in the centre.

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

Please state the actions you have taken or are planning to take:
The policy in SFH is that any comfort monies are brought directly by families to the Administration office where the family are issued directly with a receipt. Monies received are then lodged directly into Patient Private Property Accounts. However, a similar system will be put in place in each ward to ensure that any monies received from relatives are appropriately documented and reconciled.

Proposed Timescale: 31/01/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Training records indicated that a number of staff were overdue fire safety training.
7. **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:**
Further training dates will be secured in January 2018 to ensure that all staff are up to date with Fire Training

**Proposed Timescale:** 31/01/2018

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**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 access to physiotherapy and occupational therapy on a referral basis, however, documentation seen by inspectors indicated that access to these services was limited. For example, a number of residents had been referred for review by occupational therapy, however, staff were requested to prioritise which residents need to be seen as there was insufficient resources available for all of these residents to be reviewed.

8. **Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
Residents are referred for assessment for Occupational Therapy and Physiotherapy as required. Nurse Management will ensure that therapy resources are appropriately allocated.

**Proposed Timescale:** 31/03/2018

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**Outcome 12: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
1. multi-occupancy bedrooms that did not support residents’ privacy and dignity
   b. multi-occupancy bedrooms with beds too close together
   c. inadequate communal space
   d. inadequate sanitary facilities
   e. inadequate storage space for residents personal property and possessions
   f. inadequate storage space for equipment
   g. inadequate secure outdoor space
2. lighting in some of the bedrooms was by fluorescent strip lights that were very hard on the eyes, particularly when residents were laying in bed looking up at the ceiling.

9. **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:**
1. HIQA did not agree this action plan with the provider.

2. A review is taking place to ensure that lighting in each unit is appropriate for the resident’s.

**Proposed Timescale:** 31/03/2018

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There were records of the preventive maintenance of equipment such as hoists, beds and wheelchairs, however improvements were required. The inspectors were informed that hoists had preventive maintenance carried out six monthly, but only annual maintenance checks were recorded. Similarly, inspectors were informed that there were annual preventive maintenance checks carried out for beds, but records were only created for beds that had a problem detected during the check.

10. **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:**
Six monthly maintenance checks are routinely carried out on equipment in SFH. These are now documented on a six monthly basis as required.

**Proposed Timescale:** 01/12/2017
### Outcome 16: Residents' Rights, Dignity and Consultation

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Inspectors observed that a significant number of residents spent long periods of the day in their bedrooms, either in bed or on a chair at their bedside.

**11. Action Required:**
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

**Please state the actions you have taken or are planning to take:**
HIQA did not agree this action plan with the provider.

**Proposed Timescale:** 31/03/2018

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Improvements were required in order to support the privacy and dignity of residents, for example:
- on one occasion inspectors observed that a resident was using a bedpan with the screens pulled around the bed, however, visitors were free to come and go in the bedroom
- the size and layout of the multi-occupancy rooms meant that there was very little space between some of the residents’ beds
- inspectors observed that some residents were trying to rest while other residents were making noises that would disturb them
- in one unit inspectors noted that there were white boards above the beds and at least one of these contained personal information that would compromise the dignity of the resident
- many residents had their meals each day from a bedside table.

**12. 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:**
HIQA did not agree this action plan with the provider.

**Proposed Timescale:** 31/12/2021
Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While there were residents' meetings, these were poorly attended and a more comprehensive system of obtaining feedback from residents and relatives was needed.

13. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
HIQA did not agree this action plan with the provider.

Proposed Timescale: 01/01/2018

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate facilities for residents to receive visitors in private and there was inadequate space in the multi-occupancy bedrooms for visitors to sit at residents' bedsides.

14. Action Required:
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident’s room, if required.

Please state the actions you have taken or are planning to take:
HIQA did not agree this action plan with the provider.

Proposed Timescale: 31/12/2021

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff training records confirmed an ongoing programme of training in moving and handling of residents, however, a small number of staff were overdue this training.

15. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

**Please state the actions you have taken or are planning to take:**
SFH records indicate that 98% of staff are currently up to date in Moving and Handling training. Further training is scheduled in January 2018 to accommodate the 2% outstanding.

**Proposed Timescale:** 31/01/2018