**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:** | Unit 1 St Stephen's Hospital |
| **Centre ID:** | OSV-0000715 |
| **Centre address:** | St Stephens Hospital,<br>Sarsfield Court,<br>Glanmire,<br>Cork. |
| **Telephone number:** | 021 482 1411 |
| **Email address:** | sinead.glennon@hse.ie |
| **Type of centre:** | The Health Service Executive |
| **Registered provider:** | Health Service Executive |
| **Lead inspector:** | Caroline Connelly |
| **Support inspector(s):** | None |
| **Type of inspection** | Announced |
| **Number of residents on the date of inspection:** | 12 |
| **Number of vacancies on the date of inspection:** | 7 |

## 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

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

| From: | To: |
|---|---|
| 09 January 2018 09:30 | 09 January 2018 18:00 |
| 10 January 2018 09:00 | 10 January 2018 15:30 |

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

| Outcome | Our Judgment |
|---|---|
| Outcome 01: Statement of Purpose | Compliant |
| Outcome 02: Governance and Management | Compliant |
| Outcome 03: Information for residents | Substantially Compliant |
| Outcome 04: Suitable Person in Charge | Compliant |
| Outcome 05: Documentation to be kept at a designated centre | Substantially Compliant |
| Outcome 06: Absence of the Person in charge | Compliant |
| Outcome 07: Safeguarding and Safety | Non Compliant - Moderate |
| Outcome 08: Health and Safety and Risk Management | Substantially Compliant |
| Outcome 09: Medication Management | Compliant |
| Outcome 10: Notification of Incidents | Compliant |
| Outcome 11: Health and Social Care Needs | Compliant |
| Outcome 12: Safe and Suitable Premises | Non Compliant - Moderate |
| Outcome 13: Complaints procedures | Compliant |
| Outcome 14: End of Life Care | Compliant |
| Outcome 15: Food and Nutrition | Compliant |
| Outcome 16: Residents' Rights, Dignity and Consultation | Non Compliant - Moderate |
| Outcome 17: Residents' clothing and personal property and possessions | Compliant |
| Outcome 18: Suitable Staffing | Compliant |

**Summary of findings from this inspection**

This report sets out the findings of an announced registration renewal inspection. The provider had applied to renew their registration which is due to expire on the 24 June 2018. As part of the inspection the inspector met with the residents, relatives, the person in charge, the clinical director, the two Clinical Nurse Managers (CNM), nurses, care staff, support staff, the pharmacist, a physiotherapist, a occupational therapist, the catering manager, the hospital administrator and numerous other staff

members. The inspector observed practices, the physical environment and reviewed all governance, clinical and operational documentation such as policies, procedures, risk assessments, reports, residents' files and training records to inform this application.

The person in charge was new to the service since the last inspection but had been the person in charge of the unit in the past. An interview was conducted with her during the inspection. She was supported in her role by the CNM2 who managed the unit on a day to day basis and the CNM1 who generally worked opposite to the CNM2. The overall management team displayed a good knowledge of the standards and regulatory requirements and were found to be committed to providing quality person-centred care to the residents. They were proactive in response to the actions required from the previous inspection and the inspector viewed a number of improvements throughout the inspection which are discussed throughout the report.

A number of quality questionnaires were received from relatives and the inspector spoke to many residents and relatives throughout the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Residents and relatives praised the food and activities. Relatives stated collectively that they feel their relative is very well looked after. One relative stated that, "the staff are wonderful and have always given amazing support in difficult times". Relatives were complimentary about their ability to visit and staff being open with information about their relative. Family involvement was encouraged and the inspector saw numerous visitors in and out of the centre during the two day inspection. There was a residents/relatives advocacy group which facilitated the residents' voice to be heard and this was run by the CNM2.

At the time of inspection there were 12 residents residing in the centre all with a formal diagnosis of dementia. The inspector observed that the majority of the residents had high or maximum dependency needs and required a high level of assistance and monitoring due to the complexity of their individual needs. The inspector found that residents’ overall healthcare needs were well met and they had access to appropriate medical and allied healthcare services. The quality of residents’ lives was enhanced by the provision of a choice of interesting things for them to do during the day and an ethos of respect and dignity for residents was evident. All staff fulfilled a role in meeting the social needs of residents and inspectors observed that staff connected with residents as individuals. Overall, the inspector found the person in charge; Clinical Nurse Manager 2 (CNM2) and the staff team were very committed to providing a quality service for residents with dementia.

Premises issues with related privacy and dignity issues, restraint and policy formation required action. These areas and other actions required are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

**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 01: Statement of Purpose*
*There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A detailed Statement of Purpose was available to staff, residents and relatives at reception. This contained a statement of the designated centre's vision, mission and values. It accurately described the facilities and services available to residents, and the size and layout of the premises.

The statement of purpose was updated during the inspection to includ the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007 and was found to meet the requirements of legislation.

**Judgment:**
Compliant

*Outcome 02: Governance and Management*
*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The centre was operated by the Health Service Executive (HSE) who was the registered provider. The provider nominee who had responsibility for another designated centre was available to the management team. The inspector saw that there was a clearly defined management structure in place. The centre was managed by a full time person in charge who was supported in her role by a CNM2 and a CNM1. The CNM2 took responsibility for the clinical care and the CNM1 was available in her absence. The lines of accountability and authority were clear and all staff were aware of the management structure and were facilitated to communicate regularly with management.

The person in charge and provider nominee were both new to the service since the last inspection. The provider nominee had attended the HIQA offices for an interview in 2016. An interview was conducted with the new person in charge during the inspection. The management team displayed a good knowledge of the standards and regulatory requirements and were found to be committed to providing quality person-centered care to the residents. They were proactive in response to the actions required from the previous inspection and the inspector viewed a number of improvements throughout the inspection which are discussed throughout the report.

There was evidence of regular management meetings, the meetings were a forum for discussion, sharing of ideas and promotion of developments in services and practices. The person in charge also held regular management meetings attended by the CNM's Results of audits and key performance indicators were reviewed and discussed.

There had been a number of improvements to the centre since the last inspection. Resources were invested in the premises and décor. The curtain rails were reconfigured to divide the bed space in the previous six bedded rooms to provide larger space for four residents now residing in those rooms. Colourful murals were in place at the entrance to the centre and at the entrance to the bedrooms. Some new signage was in place.

The inspector saw evidence of the monitoring of the quality and safety of care provided to residents. This was through the collection of key clinical quality indicator data which included pressure ulcers, falls, the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk, and health and safety. The inspector saw that there were systems in place for monitoring the quality and safety of care provided to residents. These included internal audits and reviews, however the inspector saw that the number of audits undertaken in 2017 had significantly reduced from previous years. The audits undertaken on medication management were comprehensive, audit outcomes and any corrective actions were documented and had resulted in changes to practices particularly around the management of medication prescriptions. However further auditing and review of the service is required in 2018.

There was evidence of consultation with residents and relatives through resident/relative advocacy meetings chaired by the CNM. The inspector noted that issues raised by relatives were brought to the attention of the person in charge and items were followed up on subsequent meetings. The inspector saw that a comprehensive annual review of the quality and safety of care and support in the designated centre had been undertaken by the management team in accordance with the standards for 2016. This

review was made available to the inspector and there were a number of recommendations and actions from this review that are currently being actioned. However the 2017 review had not been commenced at the time of the inspection but the person in charge assured the inspector that it would be prioritised.

**Judgment:**
Compliant

*Outcome 03: Information for residents*
***A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A Residents' Guide was available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

Samples of residents' contracts of care were viewed by the inspector. The inspector found that contracts had been signed by the residents/relatives and found that the contract was clear, user-friendly and generally outlined all of the services and responsibilities of the provider to the resident and the fees to be paid. The contracts had been updated to include any additional charges. However, the contracts also did not include the bedroom that the resident will occupy and the number of other residents in that bedroom as is required by legisation.

**Judgment:**
Substantially Compliant

*Outcome 04: Suitable Person in Charge*
***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge was new to the person in charge role since December 2017 but had undertaken the role in the past. She underwent an interview with the inspector and displayed a good knowledge of the standards and regulatory requirements and was found to be committed to providing quality person-centred care to the residents.

The inspector interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. The inspector was satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. She demonstrated a commitment to her own professional development and held numerous post registration qualifications including a management qualification.

Staff and relatives identified her as the person who had responsibility and accountability for the service and said she was approachable and were confident that all issues raised would be managed effectively.

**Judgment:**
Compliant

***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:**
The inspector saw that the designated centre had most of the written operational policies as required by Schedules 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Policies were centre specific, comprehensive and referenced the latest national policy, guidance and published research. However there was no emergency policy available and the risk management policy did not meet the requirements of legislation in that it did not include the measures in place to address the specific risk factors required by the regulations.

The inspector saw that all records were securely stored and easily retrievable. Residents' records were held for a period of not less than seven years. Evidence was also seen that the centre was adequately insured against injury to residents and loss or damage to residents' property.

The inspector reviewed a sample of staff files and found that the requirements of Schedule 2 had generally been met. However photo identification was not available for one staff member and the centre had in place HSE Garda Vetting Liason Officers Garda vetting report confirmation forms for staff which is not a disclosure in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations. A full vetting disclosure was not available for staff members at the time of the inspection, however these were submitted to the inspector following the inspection.

**Judgment:**
Substantially Compliant

*Outcome 06: Absence of the Person in charge*
*The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There had been a change of person in charge since the last inspection and the provider was aware of the responsibility to notify HIQA. Notification was received of the absence and of the appointment of the new person in charge.

Suitable deputising arrangements were in place to cover for the absence of the person in charge. The CNM's were in charge of the unit on a daily basis and when the person in charge is on leave. The inspector met and interacted with both CNM's throughout the inspection and both demonstrated a good awareness of the legislative requirements and their responsibilities under the Health Act. There were also a number of Assistant Director's of Nursing who provided managerial advice to the centre on a rotational and on call basis as required in the absence of the person in charge.

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

**Findings:**
The inspector was satisfied with the measures in place to safeguard residents and protect them from abuse. The policy on elder abuse was up to date and referenced the most recent Health Service Executive policy 'Safeguarding Vulnerable Persons at Risk of Abuse'. The inspector reviewed staff training records and saw evidence that since the last inspection staff had received up to date mandatory training on detection and prevention of elder abuse. Staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report incidents to. Relatives and residents with whom the inspector spoke said that they felt safe in the centre. Relatives spoken with had no concerns and were very complimentary regarding the quality of care delivered in the centre.

The centre generally did not maintained day to day expenses for residents, but had just commenced collecting money from relatives for residents hairdressing and this was kept in a locked safe. Since the last inspection there were now signatures for lodgements and withdrawals and a record kept of all hairdressing services provided and payments for same signed by the hairdresser and nurse in charge. The inspector found this to be a more robust system. Resident's maintenance contribution was paid directly to the finance office usually by direct debit. Since the last inspection invoices were now available to residents or relatives demonstrating fees paid and any outstanding balances on their accounts.

A policy on managing responsive behaviours was in place. The inspector saw training records and staff confirmed that staff had received training in professional management of aggression and violence (PMAV). There was evidence that efforts were made to identify and alleviate the underlying causes of behaviour that posed a challenge. Residents were regularly reviewed by the psychiatrist and the support of the psychology service was availed of as appropriate to residents needs. The records of residents who presented with responsive behaviours were reviewed by the inspector who found that these were managed in a very dignified and person centred way by the staff using effective de-escalation methods. On this inspection the inspector saw that all responsive behaviours were appropriately responded to and there were no issues with responsive behaviours in the centre.

There was a centre-specific restraint policy which aimed for a restraint free environment and included a direction for staff to consider all other options prior to its use. There were ten residents out of the twelve residents using bedrails at the time of the inspection. This was found to be a very high percentage of bedrail usage. Although the

inspector observed that bedrails and their use followed an appropriate assessment. The inspector saw that alternatives such as low profiling beds, crash mats, and bed alarms were not being used as alternatives to restraint and therefore the least restrictive alternative was not always used. Restraint in the centre required review to ensure the centre aimed for a restraint free environment and included a direction for staff to consider all other options prior to its use. The centre needs to be compliant with national guidelines issued by the DOHC.

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

**Findings:**
The inspector saw that the health and safety and risk management policy was up-to-date. However as outlined in outcome 5 this did not contain all the items as listed in the Regulations in relation to specific risks. The requirement for an emergency plan was also identified as being required with alternative accommodation detailed, should the need arise.

There was a current policy in place for infection prevention and control. Advisory signage for best practice hand washing was displayed over hand wash sinks and hand hygiene gel dispensers and the inspector observed that opportunities for hand hygiene were taken by staff. Staff had completed training in infection prevention and control and hand hygiene. Gloves and aprons were provided and discussion with housekeeping staff indicated that there was a colour coded cleaning system in place for housekeeping and staff were knowledgeable of infection prevention and control practice. The centre was generally bright and clean throughout.

There were fire policies and procedure in place with the procedure prominently displayed throughout the centre. Records showed that the emergency lighting, fire fighting equipment and the fire detection and alarm system were being serviced. However the last quarterly service for the emergency lighting was not available at the time of the inspection. It is noted that faults with the fire detection and alarm system were recorded in the fire safety register and reported to the appropriate company for service. The inspector noted that the records indicated that exits were being checked.

The inspector found that the needs of residents in the event of a fire were assessed by way of detailed Personal Emergency Evacuation Plans (PEEPs). Fire drill records were

available indicating that fire drills were being carried out in the centre as part of the fire safety training for the centre and the person in charge said she planned to undertake additional fire drills. There was adequate staff available and as there was always a member of staff at the main reception 24 hours a day staff from other units would be immediately be deployed if required. The provider had made necessary arrangements for fire safety training to be provided to staff during 2017 which was confirmed by staff and an up-to- date training matrix. There were no residents who smoked in the centre.

**Judgment:**
Substantially Compliant

*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 were written operational policies advising on the ordering, prescribing, storing and administration of medicines to residents. There was evidence on the medication prescription sheets of regular review of medications by the medical staff. The inspector observed nurses administering the lunch and morning medications, and this was generally carried out in line with best practice. Medications were prescribed and disposed of appropriately in line with An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007).

There were appropriate procedures for the handling and disposal for unused and out of date medicines and the documenting of same. The pharmacist provided ongoing support to the centre and provided regular medication training.

Controlled drugs were stored in accordance with best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with one of the nursing staff which accorded with the documented records. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Medication trolleys were securely maintained within the secure treatment room.

Comprehensive medication audits were undertaken by the pharmacist and there was evidence of actions taken as a result of findings. The pharmacist visited the unit on a regular basis providing medication reviews, stock control, advice and education for staff. Medication errors were recorded and investigated accordingly.

**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:**
The inspector 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 had 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. Notifications received by the Authority were reviewed upon submission and prior to the inspection.

**Judgment:**
Compliant

*Outcome 11: Health and Social Care Needs*
*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**
Effective care and support

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

**Findings:**
The medical director who is a consultant psychiatrist had responsibility for St Stephen's hospital including Unit 1. The medical team consisted of two consultant psychiatrists; two medical registrars, one senior house doctor and one intern from the general practitioners' (GP) training rotation scheme, which rotated every six months. This team of doctors provided 24 hour medical care and there was evidence that residents had timely medical reviews. Weights and blood pressure were recorded monthly and more

often if the clinical condition warranted.

Residents also had access to allied healthcare professionals including physiotherapy, occupational therapy, dietetic, speech and language therapy, dental, and podiatry and ophthalmology services. Residents in the centre also had access to psychology services in house to review and follow up residents with mental health needs and residents who displayed behavioural symptoms of dementia. Treatment plans were put in place which was seen to be followed through by the staff in the centre.

The inspector saw that there were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Each resident's needs were determined by comprehensive assessment with care plans developed based on identified needs. Care plans were generally updated in line with residents changing needs. Residents and their families, where appropriate were involved in the care planning process, including end of life care plans which reflected the wishes of residents with dementia.

The inspector saw that residents had a comprehensive assessment completed prior to and on admission. The nursing assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Each resident had a care plan developed within 48 hours of their admission based on their assessed needs. There were care plans in place that detailed the interventions necessary by staff to meet residents' assessed healthcare needs. They contained the required information to guide the care and were regularly reviewed and updated to reflect residents' changing needs. There was evidence that residents' families where appropriate participated in care plan reviews. The inspector found that the care plans guided care and were person centred and individualised. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs.

Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions to prevent ulcers developing. Nursing staff advised the inspector that there were no residents with pressure sores or major wounds at the time of inspection.

**Judgment:**
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:**
Unit 1 is a dementia specific unit situated within the 117 acres of grounds at St Stephen's Hospital, Sarsfield's Court, Glanmire, Co Cork. It is situated approximately two kilometres from Glanmire village and seven kilometres from Cork city. There are extensive walk-ways as well as a pitch and putt club within the campus and there is ample parking for visitors and staff.

Unit 1 is a single storey detached building which can accommodate 21 residents. Services provided includes 24 hour nursing care for long-stay, respite, and palliative care to older people with a diagnosis of dementia. There were 12 residents living there at the time of inspection, all with a diagnosis of Dementia. Since the previous inspection there had been a number of changes to the environment. Residents' accommodation now comprised of one single room, and five four-bedded rooms. The six and five bedded rooms had been reconfigured to four bedded rooms and the extra space was reallocated between the bed areas. This afforded residents the extra space to accommodate their wardrobes and bedside chairs. However multi-occupancy bedrooms continue to present constraints in meeting residents' individual and collective needs being mindful of privacy and dignity. There were no en-suite facilities and residents used toilets and bathrooms across the corridor or commodes as required. Although larger wardrobes with bedside lockers attached were procured for residents there was a lack of personalisation of bed spaces and a general lack of homely soft furnishings and décor in the bedrooms. Very colourful murals had been painted on the wall at the entrance to the centre and at the entrance to each bedroom. There was some new signage available, however the inspector recommended further use of colour and signage in the centre which is particularly relevant for residents with dementia to assist them to recognise toilets and their own bed space.

Communal space included a dining room and sitting room. There was a seating area inside the main entrance to Unit 1. There was a visitors' room for families to visit in private and an over-night guest room with kitchenette facilities. There were five toilets, one of which was an assisted toilet and there were two assisted shower facilities, Residents had access to an enclosed garden with walkway and garden furniture with panoramic views of the valley and countryside.

Staff facilities included staff changing room with lockers and staff room with kitchenette facilities. There was a large canteen within the hospital grounds which all staff could avail. There were hand-washing facilities available in each bedroom and clinical rooms and hand gel dispensers for staff and visitors to the centre. Infection prevention and control guidelines were in place. The sluice room was upgraded on a previous inspection and was secure, clean and tidy.

There were contracts in place to service equipment such as the hoists, call-bell system and on-going repairs to beds and special mattresses and these were up to date.

Although the premises were bright and airy, there were a number of issues identified with the premises which were found not to meet the needs of the residents.

The multi-occupancy bedrooms do not ensure that each resident may undertake personal activities in private.

Further consideration of the colours, signage, decoration and soft furnishings is required to ensure a more homely environment is provided to meet the needs of residents with dementia to enable them to flourish.

**Judgment:**
Non Compliant - Moderate

*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:**
The centre had a clear policy and procedure in place which was accessible and named the complaints officer and the independent appeals person. The procedure was prominently displayed around the centre and clearly identified who you could complain to.

The inspector viewed the complaints logs and saw that complaints were recorded in line with the regulations, including, actions taken, the outcome and whether the complainant was satisfied with the outcome. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded.

**Judgment:**
Compliant

*Outcome 14: End of Life Care*
*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

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

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

**Findings:**
Resident's religious needs were facilitated with mass taking place regularly in the centre and the rosary said frequently. Mass took place during one of the days of the inspection and a large number of residents attended along with their family members. Residents from other religious denominations were visited by their ministers as required. The inspector reviewed the centre's policy on end-of-life care which was seen to be comprehensive to guide staff in providing holistic care at the end of life stage. The inspector reviewed a sample of residents' care plans with regards to end-of-life care and noted that they comprehensively recorded residents' preferences at this time. All information was accessible to staff. Most families stated that in the event of their family members needs changing in the future they would prefer to be cared for in the centre. The CNM2 stated that the centre was well supported by the specialist team from the local community.

The centre had a well equipped single en-suite room used for end of life. Family rooms were available for relatives to stay in with comfortable chairs and tea/coffee making facilities as required. The inspector observed these facilities being used during the inspection as there was a resident at end of life.

Overall the inspector found that care practices and facilities in place were designed to ensure residents received end of life care in a way that met their individual needs and wishes and respected their dignity and autonomy.

**Judgment:**
Compliant

*Outcome 15: Food and Nutrition*
***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

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

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

**Findings:**
There were systems in place to ensure residents' nutritional needs were met, and that they residents received adequate hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. Residents were provided with a choice of nutritious meals at mealtimes and

residents spoken to were very complimentary about the food and choice provided. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements.

The inspector met with the catering manager who explained the layout of the kitchen and food safety precautions in place. There was a very comprehensive system in place. The dry goods store was well stocked. Cold rooms and freezers were available. There was a good system of communication between the unit staff and the catering manager and a variety of specialist diets were available. Modified diets were presented in an attractive format and there was a good choice of modified diets available. Catering staff had received appropriate training and were very aware of resident's preferences and choices. Menus had been assessed by a dietician to ensure the nutrition content was maximised.

Mealtimes in the dining rooms were observed by the inspector to be a social occasion. Staff sat with residents while providing encouragement or assistance with their meal. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT). Files reviewed by the inspector confirmed this to be the case. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

The inspector was satisfied that each resident was provided with nutritious and wholesome fresh food, baking and drinks at times and in quantities adequate to their needs.

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

**Findings:**
Feedback from questionnaires distributed prior to the inspection, and interviews with residents and relatives during the inspection, confirmed that residents and relatives

were very happy with the care provided and staff in the centre. There was feedback that the environment had improved since the previous inspection.

Residents' religious preferences are facilitated through regular visits by clergy to the centre with mass held once a month and administration of sacrament of the sick. The current residents increased dependency and cognitive impairment made it difficult for them to exercise their political rights. The inspector observed that residents' choice was respected and control over their daily life was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal room.

The inspector noted that residents received care in a dignified way that respected them individually. The centre operated an open visiting policy which was observed throughout the inspection. Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Relatives who spoke to the inspector commended staff on how welcoming they were to all visitors and they regularly had tea/coffee with their relative during their visits They said that if they any concerns they could identify them to the CNM2 and were assured they would be resolved. There was a visitors' room and a visitors' kitchen that could be used at anytime but was generally used at end of life as visitors tending to visit in the lounge or bedrooms.

Minutes of advocacy meetings held quarterly and demonstrated that relatives attended these meetings. The CNM 2 relayed information to relatives about many topics including inspections, care planning, flu vaccinations, life story books and residents' clothing.

Respect for privacy and dignity was evidenced throughout both days of inspection. Screening was provided in multi-occupancy bedrooms to protect the residents' privacy. Since the previous inspection a blind had been installed to a glass panel in the bedroom door on the window of the single bedroom. This will protect the privacy of residents using this room. However, the layout of the multi-occupancy rooms without en-suite facilities did not allow for residents to undertake personal activities in private. They also did not allow for much personalization of the bed space and the four bedded rooms continued to lack a homely feel. Staff were observed communicating appropriated with residents who had dementia. Effective communication techniques were documented and evidenced in residents care plans. The CNM2 and the person in charge said they had used other methods of communication such as picture enhanced communication tools but this had not been required at the moment with the current residents.

There was a varied programme of activities available to residents which included sonas, imagination gym, music, sing-songs, chair based exercise, religious activities and other more individualised activities. The inspector saw staff doing one to one activities with the residents as well as group based activities. Staff had completed training in hand massage and this was particularly beneficial for residents who were confined to their beds. There was a multi-sensory room in the unit which was used for one to one and small group activities including relaxation. Staff members with families had completed the 'Life Story' as part of their reminiscence therapy. The inspector met the occupational therapist who visited the unit weekly to provide activities individual and group but was

also available to provide seating assessments and assessments for other specialist equipment. An activities record detailing the residents' involvement in the activity was completed by therapy staff. Relatives spoken with gave positive feedback on the activities and often joined in with the groups. The person in charge and CNM2 told the inspector that it is the role of all staff to provide social stimulation for residents and staff were facilitated to attend various activities training to enable them to fulfil the role.

**Judgment:**
Non Compliant - Moderate

*Outcome 17: Residents' clothing and personal property and possessions*
*Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*

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

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

**Findings:**
There was a policy in place on residents' personal property and possessions. A record is kept in each resident's file of their personal belongings which is kept up to date. Since the previous inspection bed space had been increased for residents by the division of the bed space in the multi-occupancy rooms from six areas down to four allowing residents more space around their beds. However although some residents had photos and pictures brought in from home displayed in their bedrooms, the layout of the multi-occupancy rooms did not allow for much personalization of the bed space and the four bedded rooms continued to lack a homely feel.

Personal laundry was completed on site and residents and relatives expressed satisfaction with this service and residents clothing was returned to them in a good condition.

**Judgment:**
Compliant

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

**Theme:**
Workforce

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

**Findings:**
Relatives and residents spoke very positively of staff and indicated that staff were caring, responsive to the residents' needs and treated them with respect and dignity. This was seen by the inspector throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents.

The staff numbers and skill mix throughout the day was adequate to meet the needs of residents and hygiene of the centre cognisant of the size and layout of the centre. Multi-task attendants were responsible for the kitchen. Cleaning duties were the responsibility of contract cleaners with supervision by their contract supervisor. The role of care assistants was well established in the centre and the inspector saw that this was worked well.

Staff files demonstrated that staff appraisals were undertaken on an annual basis and there was evidence of a comprehensive induction programme for new staff. Current registration with regulatory professional bodies was in place for nurses.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. The inspector saw that staff had available to them copies of the Regulations and standards. In discussions with staff, they confirmed that they were supported to carry out their work by the CNM2 and person in charge. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There was evidence that residents knew staff well and were seen to engage easily with them throughout the inspection.

Mandatory training was in place and staff had received up to date training in fire safety, safe moving and handling and safeguarding vulnerable persons. Other training provided included food safety, hand hygiene, infection prevention and control, falls prevention, restraint, dementia specific training, end of life, continence promotion, food and nutrition, hydration and the management of dysphasia. A number of staff had undertaken activity training including sonus and imagination gym. Staff confirmed that there was a high level of training made available to them.

**Judgment:**
Compliant

## Closing the Visit

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

### Acknowledgements

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

### *Report Compiled by:*

Caroline Connelly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

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

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | Unit 1 St Stephen's Hospital |
| **Centre ID:** | OSV-0000715 |
| **Date of inspection:** | 09/01/2018 |
| **Date of response:** | 06/02/2018 |

## 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 03: Information for residents

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The contracts did not include the bedroom that the resident will occupy and the number of other residents in that bedroom as is required by legislation.

**1. Action Required:**
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident

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

shall reside in the centre.

**Please state the actions you have taken or are planning to take:**
The contracts of care now include the room numbers of the bedrooms that the resident occupies and also includes the number of other residents in the bedroom.

Proposed Timescale: Implemented

**Proposed Timescale:** 06/02/2018

**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:**
There was no emergency policy available and the risk management policy did not meet the requirements of legislation in that it did not include the measures in place to address the specific risk factors required by the regulations.

**2. Action Required:**
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
Emergency policy is now in place. Risk Management policy has been updated. Copies of same were forwarded to the HIQA Inspector on 17. 01. 2018.

Proposed Timescale: Implemented

**Proposed Timescale:** 06/02/2018

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The inspector reviewed a sample of staff files and found that the requirements of Schedule 2 had generally been met. However photo identification was not available for one staff member.

**3. 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:**
Photo identification for one staff member is now in place in the staff file.
Copy of same sent to the HIQA Inspector on the 19.01.2018
Proposed Timescale: Implemented

**Proposed Timescale:** 06/02/2018

## Outcome 07: Safeguarding and Safety

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There were ten residents out of the twelve residents using bedrails at the time of the inspection. This was found to be a very high percentage of bedrail usage. The inspector saw that alternatives were not being used and therefore the least restrictive alternative was not always used. Restraint in the centre required review to ensure the centre aimed for a restraint free environment and included a direction for staff to consider all other options prior to its use. The centre needs to be compliant with national guidelines issued by the DOHC.

**4. 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:**
•Key worker and medical staff reviewed each resident using bed rails in consultation with family members.
•As a safety measure and following Multidisciplinary review, low beds and mattress sensor alarms are in use.
•There are currently four out of twelve residents that continue to use bedrails and a system is now in place to regularly review same.

Proposed Timescale: Implemented

**Proposed Timescale:** 06/02/2018

## 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:**

Evidence of the last quarterly service for the emergency lighting was not available at the time of the inspection.

**5. Action Required:**
Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

**Please state the actions you have taken or are planning to take:**
Certificates received from Horizon Safety Systems Ltd. Evidence of the quarterly service for the emergency lighting is in place and certificates were submitted to the HIQA Inspector on 19.01. 2018.

Proposed Timescale: Implemented

**Proposed Timescale:** 06/02/2018

**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:**
Although the premises was bright and airy, there were a number of issues identified with the premises which were found not to meet the needs of the residents.

The multi-occupancy bedrooms do not ensure that each resident may undertake personal activities in private.

Further consideration of the colours, signage, decoration and soft furnishings is required to ensure a more homely environment is provided to meet the needs of residents with dementia to enable them to flourish.

**6. Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**
Approval has been granted by the Area Administrator for:
• Painting of sitting room and doors in the unit
• Additional signage for the unit
• Soft furnishings

**Proposed Timescale:** 12/03/2018

**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:**
The layout of the multi-occupancy rooms without en-suite facilities did not allow for residents to undertake personal activities in private. They also did not allow for much personalization of the bed space and the four bedded rooms continued to lack a homely feel.

**7. 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:**
• Residents and families have been consulted in personalising space in bedrooms.
• Funding has been approved for comfortable bedside chairs. Currently sourcing same.
• Area Administrator, Person in Charge and Clinical Nurse Manager 2 will view other sites and write up a schedule of accommodation needs for Unit 1 in line with HIQA Standards, for onward progression to estates.

**Proposed Timescale:** 12/03/2018