

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Marymount University Hospital & Hospice
Centre ID:	OSV-0000582
Centre address:	Curraheen Road, Curraheen, Cork.
Telephone number:	021 450 1201
Email address:	info@marymount.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	St Patrick's Hospital (Cork) Limited
Provider Nominee:	Sarah McCloskey
Lead inspector:	Breeda Desmond
Support inspector(s):	Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	63
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
21 October 2015 08:00	21 October 2015 17:30
22 October 2015 09:00	22 October 2015 15:00

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	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an unannounced follow up inspection and it was the ninth inspection undertaken by the Authority in this centre. In addition to following up on issues identified in the previous inspection, unsolicited information was received by the Authority alleging inadequate maintenance practices in this centre. Consequently, documentation and practices relating to maintenance in the centre were inspected along with other governance and operational documentation. The allegations of the unsolicited information were not substantiated. As part of the inspection process, inspectors spoke with residents, staff, Chief Executive Officer (CEO), Person in Charge, deputy Person in Charge, Clinical Nurse Managers (CNMs), Maintenance Manager, Head of Finance and administration staff.

The provider nominee and person in charge displayed knowledge of the standards

and regulatory requirements.

The physical environment was comfortable and bright and appeared well maintained; there were external secure landscaped gardens. However, there was unrestricted access to sluice rooms, kitchens and store rooms. Inspectors identified that residents were at risk from significant water temperatures in these unrestricted sluice rooms and kitchens; risk in store rooms included unrestricted access to chemicals and disposable equipment. The provider nominee was issued with an immediate action plan on the first day of inspection and these rooms were secured before the end of the first day of inspection.

Issues identified in the previous registration inspection relating to fire safety precautions that warranted an immediate action plan were remedied.

Improvements to ensure compliance with Regulations included:

- concerns' logs demonstrated that possible allegations of abuse were not recognised as such
- proposed staffing levels were not always achieved
- all staff did not have up-to-date training in protection of vulnerable adults
- a daily record of nursing care as described in the Regulations, was not always maintained
- water temperatures throughout the centre
- the doorway leading from the balcony into the dining room on each floor was a trip hazard and this had not been identified as such
- PRNs (as required medications) administration recording required attention as it was unclear which PRN medication was administered for one particular prescription.
- there were virtually no care plans to direct or inform care for respite residents
- residents' documentation regarding signing and dating records
- the admissions policy and the respite admissions policy did not direct staff regarding planning care for either long stay or respite residents being admitted
- risk assessments for smoking and bedrails did not quantify the level of risk.

The action plan at the end of this report sets out the actions necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 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:

The statement of purpose was reviewed and services and facilities were described accurately. Issues requiring attention to reflect the changes in Regulations were remedied before completion of the inspection. All items listed in Schedule 1 of the Regulations were detailed in the statement of purpose and was reviewed annually.

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):

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

Findings:

Clearly defined management structures that identified the lines of authority and accountability were demonstrated and staff were aware of these. An annual report of service provision for the overall centre was demonstrated, however, an annual review of the quality and safety of care delivered to residents in the centre to ensure that such

care is in accordance with relevant Standards set by the Authority under Section 8 of the Act, was not evidenced. While residents meetings were convened to enable consultation and participation in the organisation of the centre, consultation with residents and relatives to inform the annual review as described in the Regulations, did not occur.

Judgment:

Non Compliant - Moderate

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 post of the person in charge was full time and held by a registered nurse with the required experience of nursing dependant people. She demonstrated good knowledge and understanding of the Regulations and National Standards to ensure suitable and safe care. Clear management and accountability structures were in place. The person in charge was engaged in governance, operational management and administration associated with her role and responsibilities.

The person in charge was supported in her role for older persons' services by two assistant directors of nursing (ADONs). The ADONs deputised for the person in charge when necessary and they were involved in the management of the designated centre.

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

<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: Most issues that were identified on the previous inspection regarding documentation to be kept at the designated centre were remedied. The inspector was satisfied that the records required in Schedule 2 (staff files), Schedule 3 (residents' records) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Policies relating to Schedule 5 (operating policies and procedures) were now reviewed every three years, in compliance with the Regulations. Schedule 4 (general records) which included maintenance of residents' finances were now adequately maintained. The inspector requested that the relevant forms (receipt/lodgement/property control accounts) be reviewed to ensure robustness and this was remedied during the inspection. A daily record of nursing care as described in Schedule 3 was not always maintained in compliance with Regulation 21 (records). Contact details of access to the Chief Inspector were now included in the residents' guide in compliance with Regulation 21. Overall records were seen to be stored in line with best practice and legislative requirements. The person in charge relayed to inspectors that policies and procedures were being further updated at the time of inspection.</p>
<p>Judgment: Substantially Compliant</p>

<p><i>Outcome 07: Safeguarding and Safety</i> <i>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.</i></p>
<p>Theme: Safe care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: Staff spoken with demonstrated their knowledge of protection of residents in their care and actions to be taken if they had a concern about the standard of care. However, following review of the staff training matrix, all staff did not have up-to-date training in protection of vulnerable adults.</p>

The clinical nurse managers (CNMs) spoke with residents on a daily basis and with relatives and supervised staff as part of ensuring the safety of residents. Feedback from residents was positive and people stated they could speak with the nurse in charge if necessary. However, following review of the complaints log, inspectors identified that while issues raised were dealt with in a timely manner via their complaints policy, they were not recognised as possible allegations of abuse even though one issue of neglect was raised by a senior social worker for adult abuse. Therefore, issues were not investigated appropriately, the Authority was not notified of possible allegations of abuse and learning to mitigate recurrences could not happen.

The policy for adult protection was up-to-date, and it contained the information as stipulated in Regulation 36 regarding immediate notification to the Authority of an allegation of abuse.

Residents' finances were examined and these were now maintained in line with best practice. Records demonstrated that there was on-going education for staff regarding maintaining residents' finances appropriately.

Judgment:
Non Compliant - Major

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

Theme:
Safe care and support

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

Findings:
There was unrestricted access to sluice rooms, kitchens and store rooms. Inspectors identified that residents were at risk from significant water temperatures in sluice rooms, kitchens and one bathroom; risk in store rooms included unrestricted access to chemicals and disposable equipment. The provider nominee was issued with an immediate action plan regarding these risks on the first day of inspection and these rooms were secured before the end of the first day of inspection.

Water temperatures were highlighted with the maintenance manager who addressed the hot water temperature in the bathroom identified. The inspectors requested that a centre-wide temperature assessment be undertaken to mitigate the associated risks.

The health, safety and risk management policy contained details on the identification and prevention of risks in conjunction with the recording and investigation from serious incidents or adverse events. The emergency plan was available with alternative accommodation detailed, should the need arise. Minutes from the 'Risk Committee'

meetings were demonstrated; meetings were held fortnightly. Items discussed included clinical risk, incident/accident/near misses reports, and operational risks. These reports included a summary of actions from the previous meeting with progress status and responsibilities assigned. Committee members included the CEO, staff from the human resources department, catering and housekeeping, pharmacist, facilities support, palliative care and the volunteer co-ordinator. Weekly health and safety audits of the environment were undertaken. The Quality Assurance, Risk Management and Audit Committee met every two months and reports from these meeting were submitted to the Board of Directors. The newsletter called 'risky business' informed staff of risks identified and guidance on preventing similar problems in the future. These were a two-monthly publication and in a format that was easy to follow.

Specific balcony risk assessments formed part of residents' documentation if a balcony was part of their bedroom accommodation. The main balcony leading from the dining rooms on each unit was included in the risk register. However, the doorways leading from the balcony into the dining room on each floor presented as a potential trip hazard and these hazards had not been identified as such.

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. There were hand hygiene gel dispensers available throughout the centre. Advisory signage for best practice use of hand hygiene gels was displayed and the inspectors observed that opportunities for hand hygiene were taken by staff. Staff, including cleaning staff, had completed training in hand hygiene and infection prevention and control.

Current relevant fire certification for maintenance and servicing was evidenced. All issues relating to fire safety highlighted on the last inspection were remedied. A current insurance policy was available.

All staff had completed their mandatory training in moving and handling of residents.

Laundry was segregated at source and staff described best practice regarding safe handling of unclean laundry and the appropriate use of alginate bags was observed.

Judgment:
Non Compliant - Major

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:

The centre-specific medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines was updated. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Controlled drugs were maintained in line with best practice professional guidelines. Medication trolleys were securely maintained within the secure nurses' station. Medication fridges were in place in each unit with temperatures recorded.

A sample of prescriptions was reviewed and they were in compliance with professional guidelines. Medication management audits were completed by the senior pharmacist and these were evidenced during inspection. Issues identified from these audits were brought to the risk management committee with feedback to all relevant staff. There was documentary evidence of this.

There was a robust medication management system in place for respite residents admitted. Best practice was observed by inspectors regarding administration of medicines. However, PRNs (as required medications) administration recording required attention as it was unclear which PRN medication was administered for one particular prescription.

Judgment:

Substantially 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:

A record of incidents and accidents was maintained in the centre. As described earlier in this report, oversight of these was conducted by the risk management committee. However, as detailed in Outcome 7 Safety and Safeguarding, there was under-reporting of allegations of potential abuse because issues raised were seen as complaints and not recognised as allegations of abuse. Actions for this non-compliance was under Outcome 7 Safeguarding and Safety.

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):

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

Findings:

A sample of residents' assessments and care plans were reviewed by inspectors on each unit. It was identified on previous inspections that care plans were not person-centred, nonetheless, there was a significant improvement noted in documentation of long-stay residents with person-centred information to guide and direct staff to meet individuals' needs and wishes. There was evidence that residents and relatives were involved in care planning.

A sample of documentation was reviewed for residents admitted for respite care. While risk assessments for activities of daily living were in place for respite residents with risks identified, there were virtually no care plans to direct or inform care. The admissions policy and the respite admissions policy did not direct staff regarding planning care for either long stay or respite residents being admitted.

Clinical risk assessments were completed for residents, for example, skin integrity and pressure, dependency, falls and nutrition. However, the evaluation and decision making regarding the risk assessments for bedrails and smoking were not based on a risk matrix, therefore the level of risk could not be determined and the decision making process was subjective. While most of the assessments were signed and dated, not all were, consequently, the review date could not be determined. A daily narrative of each resident's condition was not always completed.

The behaviour monitoring chart recorded resident's behaviour throughout a challenging episode, however, this format did not lend itself to enable opportunities for staff to learn or mitigate/change practice.

The medical director was available five days a week and there was out-of-hours medical cover when necessary. A sample of medical records reviewed demonstrated that residents were reviewed on a regular basis. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results were evidenced.

There was a dedicated physiotherapist for the centre as well as a well equipped physiotherapy department. Other specialist services available to residents included podiatry, occupational therapy, speech and language therapy. Optical services were

facilitated in-house and dental services were available externally. Dietician services were available upon referral.

Mealtime was observed and a positive experience was noted. Residents gave positive feedback regarding meals and mealtime. A monthly lunch club was set up as part of the activities programme. The venue was rotated between the three units each month to enable residents have a fine dining experience where residents came together with dedicated staff to socialise at lunch time.

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

Findings:
The complaints procedure was displayed prominently and the complaints policy was in compliance with the Regulations.

The complaints logs were reviewed and they demonstrated that issues of potential abuse were not recognised as such. Issues were investigated under the complaints policy rather than under protection, therefore, there was under reporting to the Authority of potential allegations of abuse. The action for this non-compliance is under Outcome 7 Safeguarding and Safety.

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

<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: The activities schedule was varied and included group activities as well as one-to-one sessions. Activities included various different musicians, for example, there was a rhythm and blues band playing for the jazz festival week during the inspection; mass was held in the centre three times a week; there was a mobile library facilitated by volunteers once a week; arts and crafts, beauty care, exercises and creative movement, to mention a few.</p> <p>The notice boards for 'Residents/Relatives' only displayed information relevant to them, for example, access to advocacy, the activities programme and health information such as flu vaccine leaflets. Residents meetings were convened every two months and minutes from these were demonstrated with follow-ups recorded of issues raised in subsequent meetings.</p>
<p>Judgment: Compliant</p>

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

<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: The proposed numbers and skill-mix of staff appeared adequate to meet the assessed needs of residents. However, these staffing levels was not always achieved, therefore the CNMS had to forego their allocated protected time for administration duties and staff supervision to undertake resident care.</p> <p>Current registration with regulatory professional bodies was in place for all nurses. The staff training matrix examined demonstrated that manual handling and lifting, cardio-pulmonary resuscitation, hand hygiene and fire safety training was up-to-date for staff.</p>
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Deficits in staff training included adult protection and behaviours that challenge.

CNMs had completed performance review training to enable them to effectively undertake staff appraisals. Staff appraisals were demonstrated for staff and a robust recruitment process was described by the HR manager. An anonymous staff survey was conducted in October 2015; the results of which were awaited and would be published. The HR manager outlined that the results from this survey would inform future leadership initiatives.

Judgment:

Non Compliant - Moderate

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:

Breeda Desmond
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Marymount University Hospital & Hospice
Centre ID:	OSV-0000582
Date of inspection:	21/10/2015
Date of response:	

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

An annual report of service provision for the overall centre was demonstrated, however, an annual review of the quality and safety of care delivered to residents in the centre to ensure that such care is in accordance with relevant Standards set by the Authority under section 8 of the Act, was not evidenced.

1. Action Required:

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

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:

To implement an annual report on quality & safety based on the work of the already established Committees for e.g. Risk, Quality, Health & Safety, Quality Risk Management & Clinical Audit.

Compile Quality & Risk Report for 2015. Report to be completed by 30th March 2016.

Proposed Timescale: 30/03/2016

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

While residents meetings were convened to enable consultation and participation in the organisation of the centre, consultation with residents and relatives to inform the annual review as described in the Regulations, did not occur.

2. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

Please state the actions you have taken or are planning to take:

Feedback mechanisms that are in place for families/residents/patients are:

- SFOP Newsletter.
- Your Service – Your Say.
- Monthly Advocacy Meetings.

The Annual Report will include this consultation with residents, patients and families in our Service. See attached Appendix 1 – template for report.

Compile Quality & Risk Report for 2015. Report to be completed by 30th March 2016.

Proposed Timescale: 30/03/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The admissions policy and the respite admissions policy did not direct staff regarding planning care for either long stay or respite residents being admitted.

3. Action Required:

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

Please state the actions you have taken or are planning to take:

The Admission Policy will be altered to reflect this.

Proposed Timescale: 31/12/2015

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A daily record of nursing care as described in the Schedule 3 (4) (c), was not always maintained in compliance with Regulation 21.

4. 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:

A daily initiative to be implemented in nursing documentation.

Proposed Timescale: 31/12/2015

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

PRNs (as required medications) administration recording required attention as it was unclear which PRN medication was administered for one particular prescription.

5. 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:

This was a one off event and was immediately rectified, i.e. prescription was changed.

Proposed Timescale: 04/12/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

All staff did not have up-to-date training in protection of vulnerable adults.

6. Action Required:

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

Please state the actions you have taken or are planning to take:

All new staff in the designated centre have received training on site, however some are due an update and this will be facilitated in the next 3 months.

Proposed Timescale: 31/03/2016

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Occasionally issues were dealt with via the complaints policy as they were not recognised as possible allegations of abuse even though one issue of neglect was raised by a senior social worker for adult abuse.

7. Action Required:

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

Please state the actions you have taken or are planning to take:

All complaints are always screened for potential abuse by the Director of Nursing but was not evidenced. This will now be documented.

Proposed Timescale: 04/12/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Because concerns raised were not identified as possible allegations of abuse, they were not investigated appropriately and learning to mitigate recurrences could not happen.

8. 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:

One complaint that came in to Marymount from an external source: the social worker (for prevention of elder abuse) which was about a respite patient. This case was identified by the Director of Nursing as an abuse allegation and had already been reported by the original source (the social worker) to HIQA. This was verified by the Director of Nursing of Marymount on receipt of same. All future complaints will be screened for potential abuse and will subsequently be followed as per policy/complaints log. Documentation has been altered to evidence same. All potential abuse allegations will be reported to HIQA.

Proposed Timescale: 04/12/2015

Outcome 08: Health and Safety and Risk Management
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Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A centre-wide water temperature assessment was necessary to mitigate the associated risks.

9. Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:

A centre-wide water temperature assessment had been undertaken:

- All tap outlets are checked every 6 months and recorded. They were satisfactory in July 2015.
- All outlets with higher than normal readings have been rectified.
- 6 month temperature checks to continue.

Proposed Timescale: 04/12/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The doorway leading from the balconies on each floor into the dining rooms was a trip hazard and had not been identified as such.

10. Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:

The doorways leading to balconies have a lip which is a design to prevent flooding. This has always been treated as trip hazard and ramps are readily available for use as requested. All trips/slips and falls are reported. There has been 0 reported incidents or falls directly associated with this since moving to the premises. Patients/residents are accompanied if required. All patients/residents have a falls risk assessment completed on admission.

Proposed Timescale: 04/12/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

While risk assessments for activities of daily living were in place for respite residents with risks identified, there were virtually no care plans to direct or inform care.

11. Action Required:

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

Please state the actions you have taken or are planning to take:

Specific respite care plans are now under development and will be fully operational by 31st December 2015.

Proposed Timescale: 31/12/2015

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

While most of the assessments were signed and dated, not all were, consequently, the review date could not be determined.

12. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding

4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:

Ward Managers to train staff of same, assessment will be reviewed and shortfalls will be corrected. Annual documentation audits take place.

Proposed Timescale: 28/02/2016

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The behaviour monitoring chart recorded resident's behaviour throughout a challenging episode, however, this format did not lend itself to enable opportunities for staff to learn or mitigate practice.

13. Action Required:

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

Please state the actions you have taken or are planning to take:

The assessment tool will be reviewed and recommendations will be implemented.

Proposed Timescale: 31/01/2016

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The evaluation and decision making regarding the risk assessments for bedrails and smoking were not based on a risk matrix, therefore the level of risk could not be determined and the decision making process was subjective.

14. Action Required:

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

Please state the actions you have taken or are planning to take:

Form to be redesigned to include a risk matrix.

Proposed Timescale: 31/01/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The numbers and skill-mix of staff was not always appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the centre.

15. Action Required:

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

Please state the actions you have taken or are planning to take:

Staffing is currently under review with our HSE colleagues. An independent evaluation by the HSE took place on the 5th November 2015. Following the evaluation, a business case is being developed for submission to the HSE for resources to fund additional staffing. Recruitment has been ongoing for last number of months and will continue. Nurse recruitment however is a challenge due to national shortage of nurses currently and therefore an exact date to predict when all staff are in place is not possible. Ongoing. Aim to be fully staffed by 1st February 2016.

Proposed Timescale: 01/02/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Appropriate staffing levels was not always achieved, therefore the CNMS had to forego their allocated protected time for administration duties and staff supervision to undertake resident care.

16. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:

As per previous.

In addition, Marymount always plans to protect management time for CNMs however where there is a shortfall in staffing clinical care is prioritised.

Proposed Timescale: 01/02/2016