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:	The Royal Hospital Donnybrook
Centre ID:	ORG-0000478
Centre address:	Morehampton Road, Donnybrook, Dublin 4.
Telephone number:	01 406 6600
Email address:	gknowles@rhd.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	The Royal Hospital Donnybrook
Provider Nominee:	Graham Knowles
Person in charge:	Olivia Sinclair
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	60
Number of vacancies on the date of inspection:	66

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.

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 2009 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 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:
21 May 2014 10:00	21 May 2014 19:30
22 May 2014 08:00	22 May 2014 15:30

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

Outcome 01: Statement of Purpose
Outcome 02: Contract for the Provision of Services
Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 05: Absence of the person in charge
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 09: Notification of Incidents
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents Rights, Dignity and Consultation
Outcome 17: Residents clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This announced inspection was the fifth inspection of this centre and took place over two days. The purpose of the inspection was to inform the decision of the Authority in relation to the application by the provider to renew the registration of the centre which was granted registration in 2011. The centre is managed by a board of management and is a non profit organisation.

Since the previous inspection in May 2013 the provider had made internal changes to both numbers put forward for registration and the units being used for the designated centre. For instance including the Phoenix ward on the ground floor which can accommodate 10 residents as opposed to the Larches unit which could

accommodate 22 residents. This unit is primarily for use by residents who are under 65 years. The current application for registration is therefore for a total of 66 residents. Prior to the inspection the inspector received 16 completed questionnaires from relatives and residents. The commentary was positive and demonstrated satisfaction with the care provided, and the routines and activities available. However staff shortages were referenced and lack of direct information from the medical teams in relation to the progression of care were identified.

The findings of the inspection are presented under 18 outcomes.

The inspector was satisfied that there was evidence of good governance structures in place. There was evidence of continued commitment to ongoing staff training. There was good practice overall in relation to risk management, fire safety procedures and health and safety of staff and residents. Resident's heath and social care was well supported and monitored with allied services available on-site. Overall safeguarding practices in relation to vulnerable adults were found to be good with some improvements required.

This inspection also reviewed the actions required following the inspection of May 2013 and found that of the 21 actions required following that inspection five actions had been satisfactorily completed with partial completion of all other actions. Complaints were managed transparently and there were systems for eliciting resident's views and for reviewing the quality and safety of care. Fire safety procedures were satisfactory.

Improvements were required in the process for ensuing that residents were consulted in regard to their care plans, care planning for identified risks and risk management in relation to some features of the premises.

The provider is also required to submit a plan for changes to the physical environment to ensure it can meet the requirements of the Standards for 2015.This was agreed in the previous action plan for submission by October 2013.The inspector acknowledges that this presents significant challenges to the provider.

The actions required are outlined at the end of this report.

Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 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:
Leadership, Governance and Management

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

Findings:
The statement of purpose had been forwarded to the Authority as part of the application for registration. It was found to be in compliance with the regulatory requirements. Admissions to the centre and care practices implemented were congruent with the statement.

Judgement:
Compliant

Outcome 02: Contract for the Provision of Services
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:
Leadership, Governance and Management

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

Findings:
Examination of the contract for the residents indicated that the signed contract was detailed and specified the services to be provided to each resident and the provider made all efforts to ensure the contract was signed within one month of admission. However, although the contract stated the overall fees to be paid it did not detail the charges for additional items which is limited to a charge for hairdressing should residents choose to avail of this. The provider agreed to remedy this promptly.

Judgement:

Compliant

Outcome 03: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
The person in charge is suitably qualified and experienced and has continued her professional development with qualifications in nursing and health care management. She is the director of nursing for the entire hospital campus as well as the nominated person in charge of the designated centre. She is engaged full time in post. She is supported by a team consisting of an assistant director of nursing, environmental and clinical governance systems and clinical nurse managers at ward levels. There is a financial controller, human resource manager, and an allied health service manager who report to the provider. The nursing staff report to the clinical nurse managers. Care assistants report to the nursing staff and all subsequently report to the person in charge. The person nominated to act on behalf of the provider was intrinsically involved in the governance of the centre as the chief executive officer. Governance arrangements, including monitoring of practices and reporting systems were clearly outlined and satisfactory and responsibilities were understood.

Judgement:
Compliant

Outcome 04: Records and documentation to be kept at a designated centre
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

Theme:
Leadership, Governance and Management

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

Findings:

The inspector found that the records required by regulation in relation to residents, including medical records, nursing and general records were up to date, easily retrieved and maintained in a manner so as to ensure completeness. All of the required policies were in place and had been revised. However, the policy on residents unauthorised absence and self harm required some amendments which are outlined under Outcome 7; Health and Safety. Documents such as the residents guide and directory of residents were also available. The inspector saw that insurance was current and included the liability for resident's personal property as required by the regulations. Reports of other statutory bodies were also available. Written evidence of compliance with the statutory fire authority had been forwarded to the Chief Inspector as part of the application for registration.

Judgement:
Compliant

Outcome 05: 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:
Leadership, Governance and Management

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

Findings:
The inspector was informed that there had been no periods when the person in charge was absent which required notification to the Authority apart from normal annual leave. All of the documentation required for the person who is nominated to act in the absence of the person in charge had been forwarded to the Authority and was satisfactory. The nominated person has suitable experience and qualifications. The inspector was satisfied that the arrangements were suitable

Judgement:
Compliant

Outcome 06: 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.

Theme:
Safe Care and Support

Outstanding requirement(s) from previous inspection:

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

Findings:
The inspector reviewed the policy and procedures on the prevention, detection and reporting of abuse and found that it was satisfactory and in line with all guidelines.

Records demonstrated that all staff had received updated training in the prevention, detection and response to abuse between 2012 and early 2014 and were able to demonstrate an understanding of their own responsibilities in relation to this and the dynamics of potentially abusive behaviours. They also expressed their confidence in the provider to act on any concerns raised. Residents informed the inspector that they felt safe and well cared for in the centre. They were familiar with the person in charge and expressed their confidence in being able to address any issue with her.

The inspectors reviewed the records of an incident of alleged verbal misconduct reported to the person in charge. The incident was investigated appropriately and the correct personal were informed. However, the records in relation to this were not entirely complete. For example the original statement by the resident was not adequately recorded, there was a delay in informing the appropriate person within the centre and the complainant was not clear of the outcome or whether the incident was in fact finalised.

The inspector examined the details of monies and valuables held for safe keeping by the provider and found that the records were correct, transparent, adequately recorded and witnessed and residents could at any time be given a detailed statement of their finances. Arrangements for the management of monies for whom the provider acted as agent were also transparent.

Judgement:
Non Compliant - Moderate

Outcome 07: 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:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was a current and signed health and safety statement available. Systems for review of safety and risk were evident with ward rounds undertaken by the safety officer and clinical risk manager. The risk management policy had as required by the previous inspection, had been revised to include the risk of self harm and a policy to support this had also been developed. The inspector found that the risk management policy

contained all of the matters prescribed by the regulations including the process for learning from and review of untoward events.

The emergency plan was detailed and it contained all of the required information including arrangements for the interim accommodation of residents should this be required. An integrated generator was available for use and emergency phone numbers were readily available to staff. Each ward held a current profile of the residents for use by the emergency services.

A risk register was available and found to be centre-specific and pertinent to the resident population. Risk management was supported by individual risk assessments for residents and a review of incidents was implemented to assist in the prevention of re-occurrences and thereby learning from untoward events. Core safety features including non–slip flooring and hand-rails and call-bells were installed. Training records demonstrated that staff had undergone specific training in moving and transporting residents and in the safe use of hoists. Staff were able to articulate this to the inspector and good practice was observed. Where deemed appropriate alarms were used to alert staff for some residents who were deemed to be at risk of falls. There was a no smoking policy on the premises and those who were granted an exemption to do so were risk assessed and did so under family supervision in an area to the rear of the premises.

Fire safety procedures were satisfactory with the fire alarm and emergency lighting serviced quarterly and other equipment serviced annually as required. Daily checks on the exit doors and fire panel were recorded at ward level. The fire procedure was displayed and staff were able to demonstrate a good knowledge of the procedure to be used in such an event. Fire safety training had taken place annually for all staff and this training included the use of the fire compartments and the ski sheets which were in place on each bed. Fire drills were held circa twice yearly in different sections of the premises. Fire evacuation chairs were visible on each floor.

The inspector was satisfied that the safety of residents was prioritised. However, some improvements were required in order to ensure risks were identified and addressed via the risk register. The inspection of 2013 found that the stairwells which are accessible from the wards upstairs were protected by waist-high safety glass half doors which posed a potential risk to residents who may inadvertently access them. Although this was included in the risk register following that previous inspection there was no clear plan of accident prevention had been implemented. The main safety feature identified in the register was the care would be taken not to admit residents at risk of wandering. It did not however take account of residents changing cognitive status. In addition, two wards on the first floor contained large patio type doors. There was a chest high protective barrier directly outside the doors. However, the drop outside the barrier as observed was circa 15 feet in height. These doors and the risk to residents had not been included in the risk register as potential hazards.

There were centre-specific policies on the management of resident's unauthorised absence, or who may wander, and, who may self-harm. While these policies gave considerable guidance in terms of what actions to take after the incident they did not identify the preventative measures which would be implemented. The self harm policy did not indicate for staff what the actual risks might be or how they might present

themselves.

The units identified for registration are in effect three separate sections over two floors within a large hospital setting. There was no differentiation between the various services in the hospital and the designated areas and this means that residents may inadvertently wander throughout the entire premises. It also means that unauthorised persons who visit patients in other sections of the premises have full access to the residents. Some of whom are extremely vulnerable by virtue of their health care status.

Judgement:
Non Compliant - Moderate

Outcome 08: Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Safe Care and Support

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

Findings:
The action in relation to the medication management policy, namely the use of PRN (as required) medication, and medication administered via altered routes required from the previous inspection had been satisfactorily resolved. Current policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the management, administration storage of and accounting for controlled drugs were satisfactory. There are appropriate documented procedures for the handling, disposal of and return of medication.

There was evidence that resident's medication was regularly reviewed by the medical director, medical officer or mental health clinicians. Records also demonstrated that staff observed residents response to medication. An audit of medication storage and administration was undertaken and found practices to be in order. There was evidence that any errors or incidents were reported and addressed with appropriate actions promptly. Medication errors or incidents were also included in the internal audits undertaken three monthly. Staff informed inspectors that residents were assessed for self-administration of medication but at the time of inspection no residents were self-administering.

However, inspectors observed poor practice in administration in that staff placed medication in tubs beside residents and there was no monitoring of whether the residents took the medication or whether it was safe to do this in the communal dining room. This is contrary to the centres policy. This was brought to the attention of the clinical nurse amender and the person in charge agreed to ensure this did not re-occur and that it was not in line with policy.

Judgement:
Non Compliant - Minor

Outcome 09: 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:
No actions were required from the previous inspection.

Findings:
An examination of the accident and incident records, resident's records and notifications forwarded to the Authority demonstrated that the provider was in compliance with her legal responsibilities to maintain such records and notify any incidents to the Authority. Records demonstrated that appropriate actions were taken following any incident and such occurrences are monitored as part of the monthly and quarterly audit system.

Judgement:
Compliant

Outcome 10: Reviewing and improving the quality and safety of care
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

Theme:
Effective Care and Support

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

Findings:
A number of systems are currently utilised to monitor and review the quality and safety of care. A resident's forum meeting has been in place for some time but efforts to increase the numbers participating and the frequency of the meetings had been implemented. The minutes of the meetings were displayed in prominent positions in each ward. The records reviewed by the inspector demonstrated that the meetings were used to inform the residents of any planned changes and also to elicit their views on activities, meals and routines or any issues residents wished to address. There was evidence that changes were made including adaptations to the call systems to prevent night time disturbances, suggestions for trips were elicited and acted upon and arrangements for exemptions to the smoking ban were also activated. The meetings are

attended by the volunteer advocate who also spends time with the residents who cannot participate in the meetings. Residents were aware of the person in charge and informed the inspector that they could make suggestions to the staff if they wished.

There were systems developed for collating data in relation to a number of significant areas including wound care, medication, falls and incidents which occurred. These were reviewed by the clinical review and governance teams at monthly and quarterly intervals. These were seen to result in actions such as reminders to staff to implement clinical guidelines and communication systems in regard to medication changes. At the time of this inspection a system for surveying the residents in the long stay designated centre had not been implemented and the person in charge stated that this was being considered. However, inspectors were satisfied that current systems were satisfactory.

Judgement:
Compliant

Outcome 11: Health and Social Care Needs
Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There were 60 residents accommodated in the three units, which were the subject of this application for registration, at the time of inspection. The dependency level of residents on the days of inspection were assessed as 32 maximum dependency, 25 high dependency and 3 as medium dependency. From a review of 10 care plans and medical records the inspector was satisfied that the healthcare requirements of residents were met to a good standard. A significant amount of work was undertaken in assessing residents using evidenced based assessments for pressure area care, falls prevention, nutrition and other needs specific to the residents. As required following the previous inspection post fall assessments were undertaken and the residents' condition was monitored for contributory factors. All care plans reviewed were implemented within the required time frame and more frequently if this was required. The plans demonstrated a good knowledge of the individual residents and this was confirmed by speaking with staff.

Residents accommodated in the centre are under the care of the medical director and medical officer who are present in the centre Monday to Friday. Out-of-hours cover is also available. Allied health services including dietician, speech and language, occupational therapy and physiotherapy were also employed within the service and reviewed the residents regularly. Full multidisciplinary ward reviews of residents took place circa two monthly or more frequently if required. A number of residents stated that they had benefited greatly from the ongoing intervention of physiotherapy. There was evidence of access to mental health services as required and ongoing review by these services was also evident.

Nursing notes, maintained on a daily basis were reviewed by the inspector. These were detailed and correlated with the care plans, and clearly outlined the care provided and any changes observed by staff. Where residents were transferred to other services or acute care settings the inspector saw evidence that adequate information was provided by the staff. A senior nurse had specialised in wound care and prevention and was seen to monitor and review any such incidents. The treatment plans as outlined were seen to be adhered to by staff and staff could articulate clearly to the inspectors the care plans for treatment. Resident's weights, vital signs and bloods were monitored as required and recorded.

The care plans and practices demonstrated an understanding of the needs of residents with cognitive impairment or dementia and provided guidelines for staff in supporting the resident. Staff were found to be knowledgeable, understanding and respectful of the behaviours and symptoms displayed by residents. Behavioural monitoring charts were used to detect patterns and responses that were helpful. These were then reviewed by the clinical director who provided guidance for staff . A range of complex health needs including tracheotomy, enteral feeding systems, head injury were supported by detailed care plans.

However, in small number of cases of cases the care planning documentation did not reflect the actual needs of the residents. For example, a resident assessed as at high risk of developing pressure areas did not have a care or prevention plan in place. Staff were able to articulate the care given which included dietary support and the use of pressure relieving equipment. The inspectors confirmed that this was in place. Although a seizure management protocol had been developed as indicated in the provider's action plan a resident did not have a care plan for the management of epilepsy and the falls risk assessments or care plan did not provide guidance for this event. In another instance the guidance for the management of seizures directed the use of medication which was not actually available in the centre. Residents and relatives spoken with confirmed that they were consulted with regard to their care but this was not evident from the care planning and assessment documentation maintained.

Inspectors found that the policy in relation to the use of methods of restraint had as required been reviewed and was satisfactory. Lap belts were used on seating under the direction of the occupational therapist and where these were used for safety in transporting residents they were removed or residents' could remove them themselves. Where bed rails were contra-indicated alternatives such as low beds and floor mats were used to prevent injury. A number of residents told the inspector they preferred the bed rails up in order to feel secure.

Residents social care needs were well supported with some improvements required. A significant number of residents used motorised wheelchairs and made good use of the wide corridors and doorways to remain independent. There was an experienced activities co-ordinator whose function was to organise and oversee activities. A significant number of volunteers are available and currently nine staff from a work experience scheme work five days per week providing activities. There were detailed schedules for activities and they included interesting items such as regular music or choir sessions, art, pottery, quizzes and Sonas and various outings. The staff undertaking the latter had received the appropriate training. Evening activities included bingo and films. Activities were alternated to take place in the different units or in the communal hall on the ground floor. Residents also has access to the coffee shop. Newspapers and books were readily available.

Some residents who did not wish to participate in these activities were supported with individual time. Activities staff read to them and some had started knitting. The volunteers and activities staff also took residents for walks in the grounds and on outings of interest. Transport was available for use in these situations. However, inspectors observed that significant numbers of residents did not participate in the activities. For example, from all units on one afternoon circa 11 residents attended the activity. As the communal rooms are furnished primarily for dining the residents were observed spending significant time sitting beside their beds in the shared wards watching television. The inspector met with the co-ordinator who concurred with this and stated that for some of the residents it was proving very difficult to provide interesting or stimulating activities due to their infirmity or cognitive impairment.

Judgement:
Non Compliant - Moderate

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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Care and Support

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

Findings:
Some of the actions identified in relation to the premises on the previous inspection related to a unit which did not form part of this inspection as the provider had not applied for the registration of that section. However, the numbers of residents accommodated in that ward had been reduced and therefore the actions identifiedin the

previous inspection report were no longer relevant.

There are 66 residential care places for people and 60 residents were present on the day of inspection. Three units are currently being used for long term residential care of residents over and under 65 years of age: Oaks, Cedars and Phoenix. The latter is a new addition to the application for registration. Oaks is situated on the ground floor and Cedars and Phoenix are on the first floor. Oaks and Cedars each accommodate 28 residents each and the Phoenix unit can accommodate 10 residents. All units accommodate both male and female residents.

The Oaks and Cedars units contain three single rooms and five wards which accommodate five residents. Phoenix has four single rooms and three bays which can accommodate 6 residents in groups of twos. Cedars and Oaks contain an open area which is primarily used for dining and Phoenix contains a kitchen/ dining area and large day room. All units contain a small room which is used for visitors. There are sufficient assisted toilets and showers in each section. All bedrooms are fitted with ceiling hoists and shared wards have retractable wall mounted laminated screens or curtains. Each unit has a sluice room, linen room, clinical room, two nurses' stations and a nurse's office. Suitable non-slip flooring and hand-rails were used throughout. A kitchenette is available on each floor from which meals are served.

Although Cedars and Oaks have the large dining room they are not used for relaxation as the dining equipment takes up most of the space and the seating area in each is very small. The day room in Phoenix is very large but contains minimal furniture and therefore has a spartan appearance. While the bed numbers had been reduced in the Phoenix ward the additional space had not been utilised to improve the overall appearance of the ward areas. Storage remains an issue with linen skips in sluice rooms and equipment in bathrooms.

There were suitable staff facilities available. Storage for cleaning equipment and chemicals was secure. The units were decorated to a high standard and well maintained and very clean. There was evidence of safe procedures and policy for the prevention and control of infection including the availability and use of protective equipment and the disposal of clinical waste. Staff were knowledgeable on the management of infection and good practice was observed. There is an enclosed garden which residents can safely use. Laundry services are outsourced.

Full-time maintenance personnel are employed and the maintenance logs seen by the inspector indicated that any issues identified were reported and acted upon promptly. A functioning call-bell system is available. Records examined indicted that equipment for residents use and safety including the call-bells, specialist beds, hoists heating systems and vehicles were serviced in 2014 and additionally as required. Staff had training in the correct use of the hoists and were able to articulate the safe use of the hoist to the inspector. Staff were also able to demonstrate their knowledge of the use of the equipment such as the pressure relieving mattresses. There was sufficient space in the wards for ease of movement and the use of equipment.

The measurements made available to the authority in relation to the space required for residents in shared wards met the requirements of the current standards. However, the

provider is aware that he is required to provide a plan to the authority in relation to the use of shared wards and the requirements of the Standards for residential care for older persons.

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

Findings:
There are written operational policies and procedures for the making and management of complaints. which was compliant with the regulations.The policy included external appeals via the ombudsman and the Health Service Executive (HSE) advocacy service, and encouraged local resolution where possible. A synopsis was posted in a suitable area of the premises. The clinical nurse manager in charge of each ward maintains records of complaint made and there was evidence that where appropriate they were resolved satisfactorily at that point. The details were forwarded to the person in charge who reviewed the outcome. There was evidence that the views of the complainant on the outcome were elicited. There was evidence that issues were managed appropriately and promptly by the ward mangers. While some residents and all relatives spoken with indicated that they were aware of how to make a complaint and felt confident in doing so some other residents stated they were not sure what they could do.

Judgement:
Non Compliant - Minor

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:
No actions were required from the previous inspection.

Findings:
There was a policy on end of life care. Records reviewed indicated that there was advanced planning in some instances and although these were not seen by the inspectors multidisciplinary family and resident meetings took place in cases where this was deemed necessary. Inspectors saw documentation on resuscitation. This did not indicate what consultation may have taken place and was not consistently dated. Care plans or assessment documentation did not reflect decisions or preferences apart from stating the religious affiliation of the resident. However, the person in charge informed the inspectors that decisions in regard to treatment or intervention was discussed with families at the multidisciplinary meetings and recorded separately. Given the number of shared wards unless a single room is available at the time there is no option available for residents.

There was evidence of good access, liaison and support from palliative care services and staff have training in cardio pulmonary resuscitation. Families were facilitated to remain in close proximity should they wish to do so, and could use visitors rooms and had access to refreshments and food. The person in charge stated that they were currently reviewing the end of life procedures and practices.

Judgement:
Non Compliant - Moderate

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:
No actions were required from the previous inspection.

Findings:
There was evidence that the provider was in substantial compliance with this regulation. Relevant policies and guidelines were in place to support nutrition. Residents were offered a choice at mealtimes and as observed these were social occasions and residents who required assistance were given this in a sensitive manner and without haste. Considerable work had been undertaken in reviewing the meals and their nutritional value by the dietician and this process was ongoing. Meals observed including modified meals, were presented in an appetising manner. Snacks and hot and cold drinks including juices and fresh drinking water were readily available throughout the day. The inspector noted that staffing levels were adequate to supervise meal times. Residents and relatives all spoke positively about the food in terms of its nutritional value and the fact that it was very tasty. Inspectors observed that breakfast was staggered and continued late into the morning.The choice included a hot cooked

breakfast. Although the main meals come from a central location there was a small kitchen on each which was stocked with snacks so that staff could provide these to residents at any time. The chef was observed on the wards checking whether the residents liked the food or not and inspectors were informed that this occurred regularly.

There were effective systems in place for monitoring resident's nutritional needs. The malnutrition universal screening tool (MUST) was undertaken within twenty four hours of admission and repeated three monthly. Residents weights were taken monthly and any changes resulted in a review of the assessment. Referrals to dietician or speech and language therapists were evident. The intervention was recorded and these included the correct positioning for residents when eating if this was required. Staff were able to articulate these directions to the inspectors. There was evidence of referral to dentistry also. Assistive equipment, prescribed by occupational therapists, such as cutlery and crockery was observed which supported residents continued independence. The commencement of food and fluid charts and the monitoring of these was evident. Residents were provided with additional supplements as deemed necessary and prescribed by the medical officer. From observation and meetings with the staff responsible for catering it was apparent that there were effective tools utilised between the catering and nursing staff as to the modifications of meals or fluids , and resident preferences. Care plans for the management of specific regimes such as enteral feeds, bowel care or diabetes were in place.

Judgement:
Compliant

Outcome 16: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each residents 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.

Theme:
Person-centred care and support

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

Findings:
Residents who could communicate with the inspectors were able to articulate their medical and care needs and indicated that they were consulted in regard to their care. It was apparent that there was choice in regard to their daily routines. Feedback processes in use included the resident's forum. There was also evidence that residents were supported with information and encouragement regarding their healthcare in order to maximise their continued health. Newspaper and other media such as television were evident. One resident had been using Skype to stay in touch with relatives. While mealtimes are protected visiting times were generally not restricted and regular visitors were observed. A significant number of residents were seen to be using motorised

wheelchairs to maintain their independence and mobility. Some went out on public transport. Screening was available in all wards and inspectors saw that this was used by staff to ensure privacy when care was being given. There is a small visitors room in each section so that visits' an take place in private if the residents is able to access this. Voting arrangements had been made and taken place for the recent elections. The large volunteer group assists in ensuring that resident maintain links with the community and can participate in local and interesting events. Telephones were available.

A number of factors in the premises and the practices mitigate against full compliance with this outcome. In the Phoenix ward male residents accommodated in single rooms must enter and cross through the female shared ward in order to access the kitchen and day room. The dependency level of the residents in the female shared ward does not allow them in any way to protect their own privacy and dignity in this instance. Inspectors observed that photographs taken to instruct staff on the correct positioning of residents in bed, although necessary to their care ,were taken in manner which did not promote or protect the residents privacy and dignity

Judgement:
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:
No actions were required from the previous inspection.

Findings:
There was a current policy on resident's personal property and possessions but it referenced only personal financial accounts. Systems on the wards for itemising personal possessions were in place; however, these only detailed items considered valuable such as watches or jewellery, or picture frames. There was locked storage available for each resident at their bedside but the shared wards had limited space for clothing and personal possessions. Residents clothing was seen to be labelled. Laundry is outsourced but there is a washing machine in the Phoenix ward and a resident informed the inspectors that he does some of his washing himself. Some complaints were noted in regard to items of clothing going missing but the records indicated that all efforts were made to locate the items and in most cases this occurred. Residents also said this issue was not a significant problem and staff made every effort to sort it out if it did occur. Any items left for safeguarding were found to be held securely, itemised and accurate.

Judgement:
Non Compliant - Moderate

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.

Theme:
Workforce

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

Findings:
The inspector reviewed the actual and planned staff roster and from observation was satisfied that there was a sufficient number and suitable skill mix of staff on duty day and night to meet the needs of residents and take account of the size and layout of the premises. In one unit due to the dependency levels additional nursing staffs was made available. In total there were four nurses in each section until 14:30 and this was reduced by one until either 20:00hrs or 22:00hrs. Care assistant staff were also adequate in numbers with between three and four available. The nurse in charge of each section was also present Monday to Friday and a night duty nurse manager was present from 20:00hrs each night. The person in charge is also rostered weekdays. Catering and household staff were sufficient in number.

Examination of the recruitment procedures and a sample of five personnel files demonstrated that improvements had been made in recent recruitment procedures and efforts were been made to address deficits from historical appointments. All documentation including evidence of registration with professional bodies for staff required was present. There was Garda Síochána vetting for volunteers. Garda Síochána vetting was also sourced for staff on work experience schemes, however, there was no agreed system for seeking the necessary information such as references for these personal. Induction and six monthly appraisal took place for newly recruited staff.

Examination of the training records demonstrated that outside of the mandatory training, that training of relevance to the direct care needs of residents was prioritised, this included falls prevention training for 12 staff, training in acquired brain injury for 14 staff, respiratory and tracheotomy care for 16 staff, and cardio-pulmonary resuscitation and venapuncture procedures. A clinical nurse manager has undergone training in challenging behaviours and dementia and is responsible for imparting this information to the remaining staff. Training in the prevention of infection was also undertaken and relevant staff had undertaken food safety training. The ward managers were responsible for identifying staff training needs as part of personal development planning. Responsibilities were clearly defined. Unit and team meetings took place regularly and handover records indicated that these were comprehensive. The inspector found that staff were aware of the policies and procedures and articulated their various roles

competently.
Judgement: Non Compliant - Minor

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	The Royal Hospital Donnybrook
Centre ID:	ORG-0000478
Date of inspection:	21/05/2014
Date of response:	17/06/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure 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 2009 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 06: Safeguarding and Safety

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the prevention detection and reporting of abuse was not adequately implemented.

Action Required:
Under Regulation 6 (1) (b) you are required to: Put in place a policy on and procedures for the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
The policy and procedures for the prevention, detection and response to abuse will continue to robustly be implemented, including training of staff.

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

Proposed Timescale: Ongoing.

Outcome 07: Health and Safety and Risk Management

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some risks in the centre had not been identified and policies in relation to aspects of specified risk required amendment to prevent accidents or injury to residents.

Action Required:
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Please state the actions you have taken or are planning to take:
A door alarm system has been sourced and will be applied to the upstairs entry doorway to the stairwell. These will be utilised in addition to the effective systems in place at present.

The patio doors have been risk assessed and restricted to open to 5 inches only.

Residents and their families access all areas of the premises safely as they wish including the concert hall, coffee shop, art room, oratory. The units are not locked units. The entire complex is protected by security personnel 24/7. Official visitors to the centre i.e. contractors, individuals attending for meetings, are required to sign in at reception and are provided with temporary I.D. badges. Units in the designated centres operate a sign in system for visitors.

Proposed Timescale: 17/06/2014

Outcome 08: Medication Management

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The administration of medication was not consistently managed safely.

Action Required:
Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Please state the actions you have taken or are planning to take:
The hospital policy on medication management is now consistently implemented by nursing staff on all units. Medication management will continue to be monitored through regular audit.

Proposed Timescale: 17/06/2014

Outcome 11: Health and Social Care Needs

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of issues such as skin integrity and seizure was not supported by care plans which guided practice and systems which ensured that the medication or other requirements necessary to deliver care were available.

Action Required:
Under Regulation 6 (3) (a) you are required to: Put in place suitable and sufficient care to maintain each residents welfare and wellbeing, having regard to the nature and extent of each residents dependency and needs.

Please state the actions you have taken or are planning to take:
Care plans reflecting the assessed needs of residents including skin integrity and seizures are now in place for all residents. Care planning will continue to be monitored through regular audit.

Buccal midazolam was available from another area of the designated centre if it was required. A supply is now available on all units where residents are at risk of seizure.

Proposed Timescale: 17/06/2014

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Activation for some residents and those with complex needs was not adequately implemented.

Action Required:
Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Please state the actions you have taken or are planning to take:
Specialist multi-sensory therapy is provided in a dedicated multi-sensory room for residents for whom this therapy is appropriate. This is provided by Occupational

Therapy staff as opposed to the Recreation staff. The person in charge has ensured that this is now reflected in residents' care plans.

Proposed Timescale: 17/06/2014

Theme:
Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence that care plans were developed and agreed with the residents.

Action Required:
Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

Please state the actions you have taken or are planning to take:
Until recently, residents and as appropriate family members were asked to sign to confirm they were involved in developing and agreeing their care plan. On review this was discontinued as policy as it was unwieldy for residents, family members and staff and impossible to implement consistently. The person in charge is consulting with residents and their family members to establish how to provide evidence-other than what Inspectors are told by residents and staff and what is observed by Inspectors-to provide additional evidence to Inspectors that the person in charge is complying with this Regulation.

Proposed Timescale: 31/07/2014

Outcome 12: Safe and Suitable Premises

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Communal accommodation was not sufficiently furnished to meet the needs of the residents.

Action Required:
Under Regulation 19 (3) (e) part 1 you are required to: Provide adequate private and communal accommodation for residents.

Please state the actions you have taken or are planning to take:
Additional furnishings and decoration will be provided to further enhance the communal areas in consultation with residents to improve the appearance and feel of the environment.

Proposed Timescale: 31/07/2014

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The shared wards do not comply with the objectives as set out in the statement of purpose and the Standard requirements for 2015.

Action Required:
Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Please state the actions you have taken or are planning to take:
As acknowledged by HIQA in various discussions, the uncertainty regarding the scope of application of residential standards across the multiplicity of services offered by the Hospital has mitigated against progressing this issue for the last twelve months. We sought clarification during that time. Following the visit we welcome the outcome of discussions giving clarification, and understand that our registration will be amended. This will enable us to enter meaningful discussions with the HSE regarding action to be taken in the absence of a capital plan. It is clear from the studies we have undertaken to date that any works would entail significant service disruption and are questionable in terms of their appropriateness. Actions that do not require capital expenditure will be discussed with the HSE.

Proposed Timescale: 30/09/2014

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents were not aware of the complaint procedure and how to implement it.

Action Required:
Under Regulation 39 (3) you are required to: Make each resident aware of the complaints procedure as soon as is practicable after admission.

Please state the actions you have taken or are planning to take:
Information on the complaints process is made available to residents in written form and verbally at admission, and at intervals during Residents Council meetings and Family Forum meetings. The person in charge will ensure that residents, and their family members, are made aware of the complaints procedure in written form and verbally in this way on a consistent basis.

Proposed Timescale: Ongoing.

Outcome 16: Residents Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that the accommodation and all practices undertaken preserved residents privacy and dignity.

Action Required:
Under Regulation 10 (e) you are required to: Put in place adequate arrangements to ensure the operations of the designated centre are conducted with due regard to the sex, religious persuasion, racial origin, cultural and linguistic background, and any disability of residents.

Please state the actions you have taken or are planning to take:
See action plan under Outcome 12 above re premises.

While the limitations of the physical environment are acknowledged, staff will continue to use appropriate screening to promote privacy and dignity.

Photographs for treatment and care practices are taken with the consent of the resident or, where this is not possible with the consent of their family. Photographs are kept confidentially as part of the healthcare record. The person in charge will ensure that residents' privacy and dignity is promoted where photographs form part of residents' care and treatment plans.

Proposed Timescale: 17/06/2014

Outcome 17: Residents clothing and personal property and possessions

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policy on residents personal property and possessions was not satisfactory.

Action Required:
Under Regulation 7 (1) you are required to: Put in place written operational policies and procedures relating to residents personal property and possessions.

Please state the actions you have taken or are planning to take:
The Policy has been amended to incorporate residents' clothing and personal possessions.

Proposed Timescale: 17/06/2014

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Records maintained for residents personal possessions were not adequate to ensure they were safeguarded.

Action Required:
Under Regulation 7 (2) you are required to: Maintain an up to date record of each residents personal property that is signed by the resident.

Please state the actions you have taken or are planning to take:
Residents clothing has been added to the property list. Residents Property Forms will be included in nursing documentation audit going forward to facilitate monitoring.

Proposed Timescale: 17/06/2014

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Space and storage for residents possessions in the shared wards was not satisfactory.

Action Required:
Under Regulation 7 (3) you are required to: Provide adequate space for a reasonable number of each residents personal possessions and ensure that residents retain control over their personal possessions.

Please state the actions you have taken or are planning to take:
See action plan for premises under Outcome 12 above.

Proposed Timescale: 30/09/2014

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Adequate information on persons sourced from external agencies was not procured.

Action Required:
Under Regulation 34 (c) you are required to: Ensure volunteers working in the designated centre are vetted appropriate to their role and level of involvement in the designated centre.

Please state the actions you have taken or are planning to take:
All volunteers are recruited and vetted and documentation retained by the Volunteer co-ordinator.

A request for copies of references for individuals in the Community Employment Scheme who assist with recreational activities will be made to the relevant Government Department.

Proposed Timescale: 31/07/2014