Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Mount Carmel Community Hospital (Short Stay Beds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Braemor Park, Churchtown, Dublin 14</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>14 January 2020</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0005337</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0027222</td>
</tr>
</tbody>
</table>
About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The centre, located in South Dublin, is owned by the Health Service Executive (HSE) and operated by Mowlam Healthcare on their behalf. It offers 105 short stay beds to men and women over 18, with a focus of caring for those over 65. The aim of the service is to facilitate the discharge of medically stable patients from hospitals in the Dublin area to the centre with a care programme to enable them to return home, or where appropriate move on to long-term residential care. It is staffed with a multidisciplinary team including nurses, healthcare assistants, a general practitioner (GP), physiotherapist and occupational therapist. The service is provided on the ground, first, second and third floor of a large premises. It is divided in five units that are all staffed independently. Units had a range of single and multi-occupancy bedrooms. The building is easily accessible and provides parking for a number of vehicles. It is also close to local bus routes.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 97 |
How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (hereafter referred to as inspectors) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. **Capacity and capability of the service:**

   This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. **Quality and safety of the service:**

   This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.
This inspection was carried out during the following times:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 14 January 2020</td>
<td>10:15hrs to 18:40hrs</td>
<td>Sarah Carter</td>
<td>Lead</td>
</tr>
</tbody>
</table>
What residents told us and what inspectors observed

The inspector spoke with 9% of residents. The residents spoken with were staying on different floors of the centre and chatted with the inspector in their bedrooms or in the day rooms on their unit. The inspector also observed residents coming and going from an activity group and moving around their units.

Residents spoke kindly of staff, saying they felt well cared for and that the staff were “brilliant” and responsive to their needs. They felt there was enough staff, and those spoken with said they had not experienced any delay in getting staff to come to their aid if they needed help.

Residents spoke highly of their accommodation, and the inspector had spoken with residents who had their own room and some who shared their bedrooms. The residents said they felt they had enough space, and those using wheelchairs were able to move around their space without any restrictions.

The activity programme was well received by the residents spoken with and while they didn't like all the activities they felt they had enough to do. Residents also emphasised how important the coffee dock on the ground floor was to them and that they enjoyed meeting their visitors there.

Residents mostly praised the food, and took their meals in the dining rooms. The inspector observed several other residents on different floors also eating in their bedrooms, and was informed this was the residents own choice.

Residents also reported that they saw the doctor as needed, and those that needed physiotherapy were accessing this treatment during the week.

The inspector observed residents well-dressed and up and around their units or in the coffee dock area. There were also several residents in bed throughout the day which may reflect the acute illnesses and conditions that residents were often admitted to this centre with.

The activity group that took place in the afternoon appeared to have attracted a good group, and it sounded like residents were enjoying this. As the group took place on a specific floor, residents were accompanied to the area from their unit by staff.

In two of the units the inspector observed there was a trend where residents gathered at a central point on the units, close to the nurses’ station and at different times throughout the day, some pleasant, airy and stimulating day rooms and relaxation areas were not in use.
There were systems in place to govern the centre and assist the provider and the person in charge (PIC) to ensure the service was running safely and for the benefit of the residents.

These systems included:

- An audit schedule; audits were taking place on key clinical areas and the outcomes of the audits included communication on the lessons learned. These updates were shared with clinical staff.
- Regular management meetings; a range of meetings took place between the provider representative and the PIC with a standing agenda, which also looked at key issues, including resident’s incidents, staffing and complaints.
- A robust response to serious incidents; there was evidence that incidents that occurred had been reviewed comprehensively and systems had been put in place to minimise or remove the risk of the incident re-occurring.
- An annual review had been prepared for 2019 was available in draft form, and included evidence of consultation with residents. It was to be completed with identified and measurable quality improvement plan at the next management meeting.

One area of the governance system that required strengthening was the oversight of the maintenance schedule in the building. Evidence was seen where faults or breakages were recorded and compiled into a maintenance log. However the dates of completion of the task were not included in this log. One particular maintenance issue was identified by the inspector on the day, and this had been first notified to management in May 2018. Further issues with building maintenance and wear and tear were also identified by the inspector in other areas of the building. However maintenance issues were not included in the audit schedule seen nor was it an agenda item in the various management meetings whose minutes the inspector reviewed. This will be discussed further in the next section of the report.

The governance structure and lines of authority were clear across both the delivery of care and the operation of the service. As the centre had expanded in 2019, additional managers were recruited to assist the admissions of residents directly from Dublin hospitals, and the residents discharge to other designated centres.

A correct resident’s directory was maintained in the centre. It reflected the details of residents transferring in and out of the service.

The provider and the person in charge worked closely together to plan the staffing resource every two weeks. As residents of varying levels of dependency were admitted and stayed in the centre for varying lengths of time, this metric required close monitoring to ensure residents needs could be met by adequate numbers of staff with adequate experience. There were a number gaps in the staffing roster on
the day of inspection and these were being filled by nurse managers who were usually supernumerary. The staff vacancies were being activity addressed, with recruitment at an advanced stage. In addition agency staff were being accessed and used to fill gaps as an interim measure.

Staff were observed to be kind, caring and respectful in their approach to residents, and the inspector noted on the day that all staff, including the provider representative and the person in charge were knowledgeable about the residents conditions and backgrounds.

Staff received appropriate training and there was safeguarding training taking place on the day of inspection. A comprehensive training matrix was maintained. A very small number of staff were due to complete training, and training dates were scheduled and organised for the weeks after the inspection.

The complaints records were well maintained, and recent complaints had been clearly logged and managed. The approach to complaints was pro-active and if feedback was received in the resident’s survey and not in a formal complaint, it was proactively addressed by the management team.

Regulation 15: Staffing

There were appropriate numbers and skill mix of staff on duty to meet the needs of residents. Registered nurses were always on-site.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training and were adequately supervised in their roles.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained and contained all the requirements of schedule 3.
Judgment: Compliant

**Regulation 21: Records**

Records relating to staff training, the recording of complaints, the investigation of allegations of abuse and the restraint register were all reviewed and found to be maintained to a good standard.

Judgment: Compliant

**Regulation 23: Governance and management**

There were sufficient resources in place to meet the residents needs.

The governance structures and lines of authority and accountability were clear.

The governance systems in place ensured the service was appropriately monitored. One area was identified for improvement - the oversight of maintenance and fixes required in the building. This is also and this is dealt with under regulation 17 below.

An annual review had been prepared and referred to consultation with residents.

Judgment: Substantially compliant

**Regulation 34: Complaints procedure**

There was an effective complaints procedure in place, and a copy of this was displayed within the centre. Complaints were investigated promptly and there was a person identified to review the appointed complaints persons work.

Judgment: Compliant

**Quality and safety**

Care was planned and delivered by trained staff to improve resident’s well-being and to prepare them for long term care.
Residents’ had comprehensive suites of care plans in place that were updated regularly. A sample of care plans were reviewed throughout the centre and for residents who had been admitted in recent days as well as over six months ago. Care was well organised, and specialist interventions were available as required.

Residents’ rights were safeguarded by a policy, and by staff who were fully trained in responding to allegations of abuse. Any allegations received were investigated by the person in charge and any findings implemented and followed up through good governance systems.

The provider was ensuring resident’s safety by the deployment and monitoring of fire prevention and response systems. The provider had made significant investments in 2019 to bring the standards of fire prevention and safety up to an acceptable level. Residents’ were protected from the risk of fire by modern fire doors and a fully trained staff. Staff were knowledgeable about how they would respond in the event of a fire. One area of concern was identified on inspection where two bedroom doors, which were fire doors did not have self-closers, and both sections of the door were propped open by a foot pedal. The provider informed the inspector that these doors were being upgraded immediately after the inspection.

Residents’ safety was further protected by a comprehensive risk management approach in the centre. Areas identified as a risk, were assessed by the person in charge and her team and there was oversight of risks by the senior management team. Major incidents were fully reviewed and the findings arising from any reviews were implemented. These included improving staff responses to specific issues and increasing specific staffing resources.

One area where the residents safety was compromised was noted arising from a deficit in the premises. One area of the first floor was shabby and not in a good state of repair. The roof was leaking and the control measures in place to manage the risk of slips trips and falls from water included a bucket to collect the water and a safety bollard. The leak had first been reported over 18 months ago, however due to complications in the design of the roof the provider informed the inspector it had not been possible to fix it. The centre provides care for up to 105 resident’s, 18 of whom were resident in the unit that this roof and corridor area lead to. Many residents in this unit were mobile, further increasing the risk that a resident’s may slip or fall as a result of leaking water or the buckets to gather the water and signage being used. The corridor where the leak was led to Hazel Unit which was also displaying signs of wear and tear. The day room, was not well decorated and uninviting. There were stains on the floor covering and several marks on the wall. Residents did not appear to use this room, instead preferring to sit at the nurses’ station area, an area where there was no real opportunity for relaxation and which lacked stimulus. An additional large multi-occupancy bed room, which had been registered last year in the centre, presented additional maintenance issues. This room was observed to have inadequate heating. In addition there was a small side room off this room, and the current method of trailing an electric flex in the door, which meant it didn’t close fully resulted in an additional risk to resident’s safety in the event of a fire.
The remainder of the premises seen on other floors was satisfactory and in a good state of repair. Resident’s equipment was in good working order. The building was accessible by a couple of different elevators. There was access to the outdoors via the reception area on the ground floor. There were communal areas and seating areas on each unit.

**Regulation 17: Premises**

A significant portion of the premises was of sound construction and in a good state of repair.

Equipment in place for the residents to use, was in a good state of repair and evidence was seen of regular servicing.

However the corridor access to Hazel Unit was unsatisfactory, showing signs of wear and tear on the walls, and there was evidence of a long term leaking roof.

One bedroom in Hazel Unit was inadequately heated.

The day / TV room in Hazel unit showed signs of wear and tear and was uninviting.

Judgment: Not compliant

**Regulation 26: Risk management**

The risk management processes in the centre were clear.

Hazards were identified and control measures put in place by the management team.

Risks were centrally recorded on a risk register and there was evidence of investigation and learning from serious incidents.

Judgment: Compliant

**Regulation 28: Fire precautions**

The provider had invested significant resources to address fire safety concerns in
the centre since the last inspection (May 2019).

Staff were found to have received training, and gave consistent and clear information about how they would respond in a fire.

The fire and emergency plan was clear.

However the inspector identified 2 fire doors on Hazel Unit that did not have self closers and where both sections were propped open by foot pedals. This means that in the event of a fire alarm, these doors would not close automatically which increased the risk to the residents safety in the area.

An assurance was given by the provider on the day of inspection that this issue would be addressed immediately, however no further information was received indicating this had been completed.

Judgment: Substantially compliant

**Regulation 5: Individual assessment and care plan**

Care plans were in place for residents within 48hr of their admission. Care plans were clear and detailed the resident's needs and the approaches to be taken to address those needs. Care plans were updated regularly.

Judgment: Compliant

**Regulation 6: Health care**

Access to appropriate medical care, and specialists was in place in the centre. Residents had access to physiotherapists and occupational therapists in the centre. There was evidence seen that residents care plans were updated following any specialist intervention.

Judgment: Compliant

**Regulation 8: Protection**

Measures were in place to protect residents from abuse, and staff were fully trained to respond to any allegations. The person in charge investigated any allegations received in a satisfactory manner.
Judgment: Compliant
Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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</thead>
<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 19: Directory of residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
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**Compliance Plan for Mount Carmel Community Hospital (Short Stay Beds) OSV-0005337**

**Inspection ID:** MON-0027222

**Date of inspection:** 14/01/2020

**Introduction and instruction**

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

**Section 1** is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

**Section 2** is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action within a reasonable timeframe to come into compliance.
Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. Specific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider’s response:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 23: Governance and management:</td>
<td></td>
</tr>
<tr>
<td>The maintenance log has been reviewed and the template has been amended around how maintenance requests/requirements are identified and recorded and it now includes dates when tasks have been completed. Maintenance issues will now be included in audit schedule and will feature as an agenda items for appropriate management meetings.</td>
<td></td>
</tr>
<tr>
<td>Completed: - February 2020</td>
<td></td>
</tr>
</tbody>
</table>

| Regulation 17: Premises                        | Not Compliant             |
| Outline how you are going to come into compliance with Regulation 17: Premises: |                           |
| Corridor access to Hazel                       |                           |
| The wall has been repaired and the skirting board has been replaced at corridor access to Hazel. Completed 22nd January 2020. |                           |
| Heating in Bedroom in Hazel                    |                           |
| Two high output radiators which were already ordered before inspection to improve the heating in Hazel room 5 have been installed and are fully operational. |                           |
| Completed 16th January 2020                    |                           |
| Day Room Hazel Ward                             |                           |
| The flooring in the Day Room in Hazel has been replaced with new flooring. |                           |
| Completed 28th January 2020                    |                           |
A painting contractor was engaged to paint the day room and this work was completed on 13th February 2020.

All medical gases and electrical trunking has been disconnected and removed from the walls in the day room, and additional soft furnishing have been placed in this room to make this room more inviting to patients. Completed 29th January 2020.

Leaking Glass Roof – one of the corridor access to Hazel Ward. Contact has been made with HSE Estates and Contractors have been on site to assess how the glass roof can be repaired/replaced to ensure there are no more leakages. Costing/Plan from contractor is being prepared, following which this will be actioned further with HSE Estates. March 2020

<table>
<thead>
<tr>
<th>Regulation 28: Fire precautions</th>
<th>Substantially Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The hold open pedals have been removed on the 2 doors identified and free swing closers have been fitted while Masterfire were fitting free swing closers to both sets of doors to Room 5 in Hazel Ward which had already been ordered. Doors commissioned and tested.

Completed 27th January 2020.
Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17(2)</td>
<td>The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>14/02/2020</td>
</tr>
<tr>
<td>Regulation 23(c)</td>
<td>The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>14/03/2020</td>
</tr>
<tr>
<td>Regulation 28(2)(i)</td>
<td>The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>27/01/2020</td>
</tr>
</tbody>
</table>