<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Phoenix Park Community Nursing Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000476</td>
</tr>
<tr>
<td>Centre address:</td>
<td>St Mary's Hospital, Phoenix Park, Dublin 20.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>0766 959 559 / 0766 959 529</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:rosemary.reynolds@hse.ie">rosemary.reynolds@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Nuala Rafferty</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Angela Ring Gearoid Harrahill</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>146</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>4</td>
</tr>
</tbody>
</table>
About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
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

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 January 2018 10:00</td>
<td>30 January 2018 18:30</td>
</tr>
<tr>
<td>31 January 2018 09:30</td>
<td>31 January 2018 15:30</td>
</tr>
</tbody>
</table>

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

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

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for renewal of registration by the provider. The inspection took place over two days.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority
HIQA). All documents submitted by the provider, for the purposes of application to register, were found to be satisfactory. The fitness of the nominated person on behalf of the provider and the person in charge were assessed through an ongoing fit person process. They demonstrated knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centre’s for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland throughout the inspection process.

As part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents, relatives and staff members of the centre were also sought.

Information in the form of notifications and other associated information was also considered as part of the inspection process.

Recent changes to the clinical management team within the centre were found on this inspection, with a senior nurse manager commencing in a temporary capacity in recent months. During the inspection process, the senior nurse manager nominated to replace the person in charge if absent, demonstrated satisfactory knowledge of their role and responsibilities and sufficient experience and knowledge as required by the legislation.

A number of residents’ and relatives’ questionnaires were given to the inspectors during the inspection. The opinions expressed through the questionnaires were broadly satisfactory with services and facilities provided. In particular, they were very complimentary on the manner in which staff delivered care to them, commenting on their patience, kindness and respectful attitude.

Residents’ healthcare needs were met and they had access to medical officers and consultant geriatrician services within the centre. Access to allied health professionals, such as physiotherapy and speech and language therapists, and to community health services were also available. However, improvements were found to be required in some areas, including staff personnel files, risk management and premises. The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A written statement of purpose was available that broadly described the service provided in the centre and contained all of the information required by Schedule 1 of the Regulations.

Copies of the document were available in the centre. Some minor amendments to the document were required to include all of the fire precautions and associated emergency procedures in the centre. The inspectors were given assurances that these amendments would be made and a revised copy forwarded to HIQA.

**Judgment:**
Compliant

**Outcome 02: Governance and Management**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Actions required from the last inspection to improve monitoring processes and ensure improvements to the quality of care delivered were addressed.
Inspectors found there were improvements to governance systems to provide effective leadership and direction to staff. These included a more coordinated and well communicated approach between the strategic and operational management systems across the campus and within the designated centre. Inspectors found improvements to quality and safety assurance and monitoring processes had improved outcomes for residents and ensured a higher standard of person-centred care. A gradual change to the culture within the centre was noted with a greater awareness of the importance of meeting residents' social care needs in conjunction with their healthcare needs.

The senior management team included the provider representative who is the general manager of St Mary's Hospital campus where the designated centre is located. It also included both persons' in charge, consultant geriatrician and administration support managers such as finances and human resources. Quality and risk systems also included other clinical managers such as, medical registrar, allied health professionals, quality and risk manager, and professional development and training personnel. Operational management through a team clinical nurse managers were also in place and these held regular team meetings on each unit with nursing and both direct and indirect care staff. Regular management team meetings were held at each level, to review all aspects of service delivery. Auditing processes to review clinical care practice and ensure improved outcomes for residents were on-going. Improvements in care practices were found in areas such as use of psychotropic medicine, promoting a restraint free culture, care planning and assessment.

An annual review of the safety and quality of care delivered in the centre as required by the regulations was being complied but not due for completion until April 2018. The provider undertook to provide a copy to the Office of the Chief Inspector. Processes were in place for consulting with residents and relatives. This included a satisfaction survey during 2017 and regular resident meetings facilitated by an independent advocacy service.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The centre maintained a residents' guide which described the facilities and services provided by the centre and a description of the specialities of each unit. There was information for residents posted regarding matters such as facilities available, visiting
arrangements, activities and advocacy services.

Each resident had a written contract of care signed in agreement with the provider which clearly stated the regular fee payable, the resident's contribution and the services to be provided under that fee. It also included the terms of residency for each resident, in that it specified whether the room to be occupied was a single or shared room. However, the contract did not identify any additional fees that may be charged but inspectors were told that currently no additional charges are incurred by residents for the services provided.

Judgment:
Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The centre consists of two separate units and each was managed by suitably qualified and experienced nurses. Both held authority, accountability and responsibility for the provision of the service within separate units.

Through an assessment process, it was noted that there was daily engagement in the governance, operational management and administration of the centre. The persons in charge facilitated the inspection process by providing documents and having good knowledge of residents’ care and conditions.

Judgment:
Compliant

**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Records set out in Part 6 of the Regulations were available and kept in a secure place. The Statement of Purpose and Residents' Guide were complete and available. A copy of the state indemnity protection in place, which meets the requirements of the Regulations, was viewed.

A concise directory of residents was not available but the information required by the regulations was maintained in one file. When checked, the file was found to contain all of the information required in Regulation 19. It was up to date, with records of admissions, discharges and transfers maintained.

General records as required under Schedule 4 of the Regulations were maintained, including key records such as appropriate staff rosters, accident and incident records, nursing and medical records. Planned rosters were in place in all units, and an actual working rota was maintained. All of the operational policies and procedures as required by Schedule 5 of the Regulations were available and were reviewed on a regular basis and within the three year timeframe as required by the regulations.

It was found that all records listed in Schedule 3 of the regulations were maintained in terms of accuracy, were updated regularly and were safe and accessible. However, the inspectors found that not all of the information required under Schedule 2 was in place on some staff files. In a sample of personnel files checked by inspectors, some did not contain confirmation from the national vetting bureau that the Garda Síochána (police) vetting process was fully completed. This was brought to the attention of the provider representative who provided this evidence prior to the end of the two day inspection. The provider also gave assurances that, going forward, no staff will commence in post prior to confirmation from the national vetting bureau being received.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
Suitable arrangements were in place for periods of absence of the person in charge, and the provider complied with their responsibilities to notify HIQA when a change occurred to either the person in charge or the nominated person to replace them.

**Judgment:**
Compliant

---

**Outcome 07: Safeguarding and Safety**
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe care and support

---

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

**Findings:**
Staff had received training on the prevention of elder abuse and all staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse. Procedures to protect residents, such as a robust recruitment system, staff induction and training were also in place and implemented.

In conversations with them, residents spoken with, told the inspectors that they felt safe and secure in the centre and relatives also confirmed that they did not have any concerns for the safety of their loved ones.

Assessment of risks, associated with the use of restraints such as bed rails and lap belts, were in place and regularly reviewed. The use of bed rail restraint had reduced since the last inspection, and the use of alternative measures such as low-low beds, mat and bed alarms had increased.
Falls management systems included appropriate supervision of residents by staff and incident and accident records indicated a low falls rate.

Inspectors reviewed the system in place to manage residents' money and found that reasonable measures were in place to ensure residents' finances were fully safeguarded. The provider acted as pension agent for a number of residents and satisfactory systems were put in place to ensure they were managed appropriately with regular checks and audits in place.

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

Theme:
Safe care and support

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

Findings:
Inspectors checked the fire safety management practices in place, including some aspects of the physical fire safety features of the building. Records for maintenance, fire safety training of staff and policies and procedures relating to fire safety were also viewed.

Emergency lighting and fire-fighting equipment, and directional signage were available throughout the building. The internal and external premises and grounds of the centre appeared safe and secure, with locks installed on all exterior doors. A health and safety statement and related policies and procedures were in place. Risk registers were also in place. These included clinical risks and composite health and safety risk register. The risk register was found to be regularly updated and inspectors noted that risks, associated with some residents leaving parts of the centre without being seen by staff, were included. A review of security within the centre, and on the broader campus, was being conducted by external security specialists, who were assisting the provider to identify appropriate, additional measures to control these risks.

Inspectors found that the building's fire and smoke containment and detection measures were appropriate to the layout of the building, and exits were free of obstruction. Emergency lighting, fire fighting equipment and directional signage were available throughout the building. Completed logs were maintained on daily, weekly, monthly and quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. Certification of testing and servicing of extinguishers, fire retardant materials and the alarm system were documented. Inspectors were told the designated centre is a smoke-free centre and this criteria forms part of the pre-admission process.

The actions required from the last inspection, to improve staff competence and confidence to safely evacuate residents, in the event of an emergency, were partially addressed.

A composite list was available to guide staff on the evacuation of residents if required. Amongst other details, the plan identified the number of staff required to assist each individual resident, and the most suitable evacuation aid to be used, both day and night. Some further improvements to the emergency exit plans in place would be of benefit to enable staff to safely manage an evacuation process. These could include, the level of cognitive understanding, need for supervision or level of expected compliance of each
resident in an emergency situation.

However, actions required related to practiced fire drills were not fully addressed. The inspectors looked at the records of practiced fire drills held in the centre. Although practiced fire drills that included simulation of an actual evacuation to determine the competency of staff to evacuate residents in a timely manner were now held, it was noted these only occurred on an annual basis and regular practiced simulated drills were not held. Samples of the records of the drills held were viewed. These showed where the simulated evacuations reflected evacuation of one ‘resident’ only or whether all residents in a specific compartmented area could be safely evacuated within a reasonable time-frame. It also included the duration of the drill and any learning identified to improve the evacuation process. Inspectors noted that in several of the records, learning identified that more frequent simulated drills were required for staff. Appropriate arrangements for investigating and learning from serious incidents/adverse events which identified residents who were at risk of falls and put in place appropriate measures to minimise and manage the risks was in place. This included an identification of residents at risk of falls using a leaf symbol, colour coded to reflect the level of risk for each resident.

Governance and supervision systems were in place to monitor residents at risk of falls, wandering or negative interactions. These were reviewed on an ongoing basis and an appropriate level of supervision was in place for identified residents.

The inspectors found the designated centre was kept clean and there were measures in place to control and prevent infection. Although the centre was experiencing an outbreak of infection at the time of the inspection, this was being managed in accordance with guidance from the department of public health. Good infection control measures were fully implemented which had contained the infection and prevented it from spreading to other units in the centre.

**Judgment:**
Substantially Compliant

---

**Outcome 09: Medication Management**

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

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

**Findings:**
Overall the inspectors found that residents were protected by the policies and procedures in place regarding medication management.

The inspectors found that the written operational policies and procedures for the ordering, prescribing, storing and management of medicines were appropriately implemented. Staff knew their role and function regarding the management of
medication. Protocols were in place regarding the administration of PRN (as required) medicines with clear rationales and protocols in place. Nursing staff, administering medicines to residents during the lunch time administration rounds, were observed. The administration practice was in line with current professional guidance. Evidence of ongoing training and in-house practice development processes were in place.

A drug and therapeutic committee maintained close oversight of medicine practices throughout the centre. Inspectors found evidence of medication audits and reviews taking place within the designated centre and there were instances where learning from the audits had resulted in improved practice and outcomes for residents. In particular this was evident in the administration of as required anti-psychotic and anxiolytic medicines. Inspectors found the use of these medicines had reduced considerably throughout the centre. Medicine storage and refrigeration practices were safe and in line with regulatory requirements.

**Judgment:**
Compliant

---

**Outcome 10: Notification of Incidents**

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe care and support

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

**Findings:**
A record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector.

**Judgment:**
Compliant

---

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

**Theme:**
Effective care and support
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Residents had access to 24 hour medical care cover and a full range of other services available on referral, including occupational therapy, speech and language therapy, dietician, physiotherapy, chiropody, dental services and optical services. The majority of these were available on the campus where the centre is located. Evidence of referral and review was available, and viewed, with early recognition of the signs of clinical deterioration and appropriate management.
Inspectors found that residents also had access to a high level of nursing expertise to treat and manage symptoms associated with acute illness such as dehydration and infection. Clinical nurse specialists and advanced nurse practitioners were available to prescribe certain medications and administer intravenous fluids and antibiotics. This considerably reduced the requirement for transfer to the acute hospital sector and improved clinical outcomes for residents.
Samples of clinical documentation including nursing and medical records were reviewed. These showed that all recent admissions to the centre were assessed prior to admission. Transfer of information within and between the centre and other healthcare providers was good. Discharge letters for those who had spent time in acute hospital and letters from consultants detailing findings after clinic appointments were maintained.
The systems in place to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents’ health were implemented by the nursing team. In the sample of care plans viewed, these were found to be detailed enough to guide staff on the appropriate use of interventions to manage the identified need and some, though not all reviews, considered the effectiveness of the interventions to manage and or treat the need. Comprehensive risk assessments on which to base care plans were found and there were efforts to plan and deliver care in a person-centred manner.
The inspectors noted that the standard of nursing documentation was coordinated sufficiently to provide a clear picture of residents overall condition.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
The designated centre is located on a large open campus, which also accommodates St Mary’s Hospital, on the edge of the Phoenix Park. It is comprised of two separate units.

Teach Iosa, which was established in 2007 accommodates 100 male and female residents in four wards, Oisin and Conall on the ground floor, Ailbhe and Tara on the first floor (25 male and female residents in each). This unit is built around a court yard garden and the accommodation in each of the four units is comprised of 17 single, two twin and one four bedded bedrooms, all of which have a small patio area, with the exception of the four bedded room and en suite shower facilities. Communal space in each unit is different and includes separate sitting/conservatory areas or combined sitting/dining/recreational rooms. Oisin unit has a family room, quiet prayer room and facilitates the laundry service for Teach Iosa.

Teach Cara has 50 beds in two mixed gender wards Bebhinn (ground floor) and Setanta (first floor) which accommodate 25 male and female residents in each with 17 single, two twin and one four bedded bedrooms. All of which have en suite shower facilities. The Bebhinn unit has a dementia focus and residents admitted to this unit generally have a diagnosis of dementia.

Additional facilities located on the site which serve the designated centre include pharmacy, large main kitchen with full catering team, stores/logistics and maintenance buildings, laundry, and activity centre, chapel of rest and administration buildings.

The inspectors found that Teach Iosa and Teach Cara met most of the residents’ needs. Shared twin and four bedded rooms were observed to be large with sufficient space for the use of assistive equipment such as hoists and appropriate screening. Sufficient storage was available for personal possessions. Appropriate assistive equipment was available and reports were viewed that confirmed they were recently serviced and were in good working order.

Overall for both Teach Iosa and Cara it was found that in general, adequate private and communal space was provided and the design, layout and décor of these units provided a comfortable environment for residents with appropriate furnishings and areas of diversion and interest.

Residents’ bedrooms were personalised with pictures photographs and home furnishings. Call bells were available in reach of residents, grab rails and safe flooring facilitated safe mobility and in general the centre was comfortably warm.

However, issues identified on previous inspections in relation to limited dining room space were again found on this visit. In particular on the Setanta unit where the communal space was limited. There is only one small sitting room, which also serves as the dining room at mealtimes. This room can only accommodate up to 10 of the 25 residents at any one time. A separate smaller room facilitated another three residents during meal times. However, feedback from residents and staff identified that there were other residents, whose choice to eat in the dining room, could not be upheld due to the lack of space.
Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
Policies and procedures which comply with legislative requirements were in place for the management of complaints. Residents spoken with were aware of the process, although it was not displayed.

On review of the record of complaints, there was evidence that all complaints were documented and investigated and that the outcomes were recorded. Complainants were notified of the outcomes, and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved.

There was evidence that any resident who made a complaint had not been adversely affected by reason of the complaint being made

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
Protocols and polices were in place to guide staff on care practices at end-of-life and there was evidence that these were implemented by staff. Inspectors found a high standard of care was delivered to residents to meet their holistic needs. This was supported by feedback from relatives who told inspectors the staff were respectful, supportive and provided care in a dignified manner to their loved ones. Access to specialist palliative care services were available with on site consultant and visits from
the clinical nurse specialist when required/requested. Staff had received training in end-of-life care practices. Appropriate and comfortable facilities were available to families to remain with their loved one. An oratory was available to allow for spiritual prayer, thoughts and reflection for those who wished to avail of it. Residents' spiritual needs were met with religious and chaplaincy services available regularly. The centre was involved with the Irish Hospice Foundation to implement the Ceol Programme which includes all of the care aspects to meet each resident's end-of-life physical, emotional, social and spiritual needs and respects his/her dignity and autonomy. Arrangements were also in place for capturing residents' end-of-life preferences.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Actions from the last inspection to improve options available outside core mealtimes and promotion of independence and choice were addressed. There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents' weights were checked on a monthly basis, and, where required, daily intake charts were in place to monitor food or fluid intake.

Menus were available and all residents were offered choice at each meal. The inspectors observed residents having their lunch in the dining room, where a choice of meals was offered. All staff sat beside the resident to whom they were giving assistance and were observed to patiently and gently encourage the resident throughout their meal. Some residents had their meals in their bedrooms. The tray service of lunch was staggered to ensure all elements were not served together. Residents on modified diets were provided with the same choices as people receiving normal diets, and each element of the meal was separately presented on the plate. A rolling menu was in place to offer a variety of meals to residents. Food was served directly from the kitchenette on each unit by a team of staff. Inspectors noted that each kitchenette was well-stocked with a variety of snacks available for residents outside core mealtimes. These included healthy and nourishing options such as fruit, nuts, cheese or desserts. Sandwiches and salads were also available.
Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Evidence that residents were consulted with, and participated, in the organisation of the centre was found. Regular resident meetings were held, where residents were consulted about future activities or outings and facilitated to give feedback on how the centre was run. There were no restrictions to visiting in the centre and inspectors observed a constant stream of visitors throughout the inspection. Choice was respected and residents were asked if they wished to attend Mass, activities, or exercise programmes. Control over their daily life was also facilitated in terms of times of rising or returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms.

Staff were observed speaking with residents in a respectful and patient manner, especially with residents expressing confusion or agitation. There was a varied activities programme for both physical and mental stimulation. These included arts and crafts, bingo, puzzle games, videos and music. There were also a mix of group and individual sessions including nail care and hand massage. Therapies and activities to reflect the needs of those with dementia were also included such as reminiscence and sensory stimulation techniques and dementia specific activities such as Sonas were also available. All those spoken with praised the staff for the cheerful, professional and respectful manner in which they delivered care. Relatives were also very happy with how staff kept them informed of any changes in their loved ones health condition and on the warm and friendly atmosphere in the centre.

Actions required from the last inspection to improve the frequency and appropriateness of meaningful stimulation to residents on a one-to-one basis were addressed. Inspectors observed that all direct care staff were more involved in spending time with residents, who spent long periods in their bedrooms or in small sitting rooms alone. Interactions between the staff and residents were warm and personable familiar and relaxed. However, actions required from previous inspections to improve access to the community for residents and improve social inclusion through regular outings were not addressed. Inspectors were informed that additional resources in the form of additional
transport and driver had now been provided to facilitate regular social and community inclusion.

The deficiencies in the environment to uphold residents rights to choice were not addressed. Measures previously identified related to the provision of a second sitting at each meal. However this measure had not been progressed. An action to address this issue is contained under Outcome 12.

**Judgment:**
Non Compliant - Moderate

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

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

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

**Findings:**
There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents.
A policy on residents' personal property was in place and implemented using an inventory on clothes and valuables belonging to residents upon admission.

Residents had access to a locked space in their bedroom if they wished to store their belongings.

There was a policy in place of residents’ property in line with the regulations and a list of residents' valuable property and furniture was maintained where required

**Judgment:**
Compliant

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

**Theme:**
Workforce

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

**Findings:**
Suitable and sufficient staffing and skill-mix were found to be in place, on this inspection, to deliver a good standard of care to the current resident profile. The staff rota was checked and found to be maintained with all staff that worked in the centre identified.
Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place in all units. Although agency staff were used to cover gaps in the roster, it was noted that the majority were regular in an effort to maintain consistency of care.
Appropriate and sufficient supervision and guidance, auditing of care delivery, assessments and implementation of care interventions by the clinical nurse management team were in place.

Staff allocation and key worker systems were in place to ensure safe delivery of care and updates on residents’ condition. Appropriate and respectful interactions were observed throughout the day between residents and staff. Overall, it was noted that residents' dignity and choice was respected during care interventions and in their daily lives.

Inspectors spoke with some staff and observed the standard of interactions and care delivery with residents. Inspectors found staff were patient, friendly and respectful to residents. The staff were knowledgeable on the needs, preferences, interests and backgrounds of residents. Residents appeared comfortable with staff and family members knew staff well and spoke highly of the standard of care delivered by them.

Staff were up to date in their mandatory training in fire safety, safeguarding of vulnerable adults, and manual handling. There was a tracking system in place to identify staff due to attend training sessions and to notify them of same. There was a good range of supplementary training facilitated by the centre, including in management of restrictive practices, responsive behaviours, dysphagia, basic life support and end-of-life care. Training for nurses also focused on clinical scope of practice, delegation and assessment and care planning.

A formal staff appraisal system that discussed the continuous performance and training of staff with each staff member was being established.

Inspectors learned that there were a number of volunteers who assisted in the centre on a regular basis at mealtimes and in the provision of activities for residents. Inspectors found that appropriate recruitment processes including the Garda Síochána (police) vetting process were in place for all volunteers. However, it was noted that their roles and responsibilities and the supervision and reporting arrangements were not clearly set out in writing.
Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Phoenix Park Community Nursing Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000476</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>30/01/2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>06/03/2018</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

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

In a sample of personnel files checked by inspectors, some did not contain confirmation from the national vetting bureau that the Garda Síochana (police) vetting process was fully completed

1. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in

---

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
• The Provider Representative confirms that no new staff member will commence in post prior to confirmation being received from the national vetting bureau.
• A full review has been undertaken of the files of all staff recruited in the designated centre since the 30/04/2016 to ensure that the formal Garda declaration form has been received and viewed in respect of all new staff. No issues identified during this process.
• An exercise is currently underway to ensure that all staff who work on this campus will reapply for their Garda clearance to ensure that a Garda declaration in the format required is available for all staff.

Proposed Timescale: 31/12/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements to the systems in place to ensure staff were fully familiar and competent in all aspects of the procedures to be followed in the event of a fire were required.

2. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
• Increase the number of fire drills carried out in the designated centre. Two monthly staff directed fire drills will be scheduled on each ward. Our Quality and Safety Manager will circulate a rota for each of these fire drills and develop a brief report for submission to her office to monitor compliance with same.
• Increase the number of residents and fire compartments included during each fire drill. A number of fire scenarios will be developed in conjunction with our independent Fire Safety Consultant and ward staff will be requested to work through one of these scenarios when completing their staff directed drills.
• Redesign the Mobility Rapid Assessment Forms to include cognition level, supervision needs and level of expected compliance.
• The Provider Representative and the Persons in Charge will meet with the HSE Regional Fire Prevention Officer and the Fire Safety Officer for the campus to devise and implement a robust fire safety management programme in the designated centre to encompass the feedback received from HIQA.

Proposed Timescale: 30/04/2018
# Outcome 12: Safe and Suitable Premises

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Limitations to the space available on some units for dining facilities do not meet the needs of all residents.

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

**Please state the actions you have taken or are planning to take:**
- To increase residents comfort and choice a trial of having two sittings in this dining room will commence.
- The Provider Representative will raise HIQA’s concern with the Designated Centres Capital Development Steering Group. Three options will need to explored:
  - To better maximise the use of the existing space-
  - To apply for funding to extend the current dining facilities to better meet the needs of the residents
  - In the absence of progress on point 1 or 2 to make an application to HSE management to convert the four bedded ward in this unit to a dining area.

**Proposed Timescale:** Bullet point 1 to be completed by the end of April 2018. Actions in bullet point 2 to be completed by the end of December 2018.

---

**Proposed Timescale:** 30/04/2018

# Outcome 13: Complaints procedures

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The complaints procedure was not displayed.

**4. Action Required:**
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
- The designated centre complaints procedure including a picture of the designated Complaints Officer will be laminated and displayed on all residents notice boards on all
wards.
• A copy of the designated centres complaint procedure and a picture of the Complaints Officer will be placed in the Residents Forum Minutes Folder which is located in a public area in all wards and is accessible to all residents and their families.

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

---

**Outcome 16: Residents' Rights, Dignity and Consultation**

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Some residents’ rights to choose to eat in the dining room were not upheld due to the lack of space.

**5. Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**
• To increase residents comfort and choice a trial of having two lunch sitting in this dining room will commence.
• The Provider Representative will raise HIQA’s concern with the Designated Centres Capital Development Steering Group. Three options will need to explored:
To better maximise the use of the existing space-
To apply for funding to extend the current dining facilities to better meet the needs of the residents
In the absence of progress on point 1 or 2 to make an application to HSE management to convert the four bedded ward in this unit to a dining area.

Proposed Timescale: Bullet point 1 to be completed by the end of April 2018. Actions in bullet point 2 to be completed by the end of December 2018.

**Proposed Timescale:** 31/12/2018

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Residents' rights to access the community for residents and improve social inclusion through regular outings were not upheld.

**6. Action Required:**
Under Regulation 09(3)(c)(iv) you are required to: Ensure that each resident has access to voluntary groups, community resources and events.
Please state the actions you have taken or are planning to take:
• With the recent recruitment of a third driver the Provider Representative has given a commitment that the Activities Department on the campus will have a minibus and driver allocated to the designated centre at a minimum of one afternoon per week to facilitate regular residents’ outings.
• The adjacent public park and environs will be used to facilitate more regular shorter outings.
• When 3 to 4 residents from any ward go on an outing the Activities Department staff will be supplemented by a staff member from the ward in question.
• The Provider Representative will review staffing levels in the Activities Department in conjunction with the Director of Nursing.

Proposed Timescale: 31/03/2018

Outcome 18: Suitable Staffing
Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roles and responsibilities and the supervision and reporting arrangements for all volunteers were not clearly set out in writing.

7. Action Required:
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
• A working group has been established to revisit the PPG for volunteers on the campus.
• Informing this review will be the HIQA recommendations to include on all volunteer files a signed contract outlining:
  1. The role and responsibility assigned to each volunteer.
  2. A clear supervision and reporting structure
  3. Contact details for a named designated volunteer support person on the campus

Proposed Timescale: 31/07/2018