



**Health  
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An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# Report of an inspection of a Designated Centre for Older People.

## Issued by the Chief Inspector

Name of designated centre:	Mount Alvernia Hospital
Name of provider:	Health Service Executive
Address of centre:	Newberry, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	24 March 2021
Centre ID:	OSV-0000723
Fieldwork ID:	MON-0032235

## About the designated centre

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

Mount Alvernia is set on a rural site, southwest of Mallow town in Co. Cork. The building is bright and well lit with natural light on all upper floors. The building was originally built as a community hospital in the 1950s and the physical layout retains an institutional presentation, with accommodation and facilities laid out along a single corridor on each floor. Facilities on the ground floor include administration offices, the main kitchen facility and a dining area for staff. There is also a chapel and a hairdressing facility for residents to use on this floor. The grounds provide residents with opportunities for exercise and recreation with outside seating, paved walkways and an orchard. The centre provides long-term residential care for residents over the age of 18 requiring continuing care in relation to a range of needs including chronic illness, dementia and enduring mental health issues. Resident accommodation is laid out over the top three floors. Information as set out in the statement of purpose describes St Camillus' unit, on the first floor, as providing accommodation in four single and five twin bedrooms. Communal areas on this floor include a dayroom and dining room. A separate room to receive visitors in private is also available. On the second floor, Clyda unit, provides four twin and three single bedrooms as well as one three-bedded ward. Communal areas on this floor include a day room and dining area. Avondhu unit on the third floor provides focused care for residents with a cognitive impairment or dementia, and this unit is accessible via a keypad secure system. Accommodation here includes four single and five twin bedrooms. There is also a sitting room and dining area as well as a small separate room for residents to receive visitors should they so wish. There are no en-suite bathroom facilities in any of the rooms and all residents share toilet and shower facilities on each floor. Storage areas for equipment and supplies are located variously throughout the centre.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:

39

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:**

Date	Times of Inspection	Inspector	Role
Wednesday 24 March 2021	10:00hrs to 18:00hrs	Noel Sheehan	Lead
Wednesday 24 March 2021	10:00hrs to 18:00hrs	Abin Joseph	Support

## What residents told us and what inspectors observed

The overall feedback from residents was that the person in charge and staff were kind and caring and that they were happy living in the centre which was homely and met their needs. Inspectors met the majority of the residents during the inspection and spoke in more detail with 14 residents throughout the day. Inspectors observed that residents appeared to be well cared for, which was further reflected in residents' comments that their daily personal care needs were met. Residents, where possible, were encouraged to be as independent as possible and inspectors observed residents moving freely around the corridors, communal areas and in the external grounds throughout the day. Residents movement in and out of the dementia specific Avondhu unit was restricted with key pad locked door. This arrangement was reported to the office of the chief inspector in the quarterly notifications of restraints used in the centre.

Inspectors arrived at the centre in the morning to conduct an unannounced risk based inspection. Inspectors were welcomed by the person in charge (PIC). On arrival inspectors were guided to complete the infection control protocols according to the centre's policy. This included temperature checks, face covering and completion of visitor's log book. After the initial meeting with the PIC, inspectors took a walk around the centre with the PIC.

Mount Alvernia is set on a rural site, southwest of Mallow town in Co. Cork. The building was originally built as a community hospital in the 1950s and the physical layout retains an institutional presentation. The accommodation and facilities laid out along a single corridor on four floors. Facilities on the ground floor included administration offices, the main kitchen facility and a dining area for staff. There is also a chapel and a hairdressing facility for residents to use on this floor. Resident accommodation is laid out over the top three floors. None of the bedrooms in the centre had en-suite facility, however there were communal toilets, showers and baths on each resident accommodation floor. The grounds provided residents with opportunities for exercise and recreation with outside seating, paved walkways and an orchard.

The centre was generally bright and clean throughout. The standard of decor varied considerably on each of the floors with the first floor having a higher standard of decor than the second floor and the second floor having a higher standard of decor than the third floor. The residents on the first floor were more independent and many of the bedrooms on this floor were furnished to a good standard and had a degree of personalisation. The bedrooms on the other floors were less personalised, and much like the standard of decor, the degree of personalisation decreased from floor to floor as you ascend the building.

Person-centred care was demonstrated by management and staff who ensured that residents were supported medical and health care needs. Residents were also seen to spend time in their rooms as well as the communal sitting areas, sometimes

watching TV or listening to the radio. Some residents spoke with the inspectors told that they missed the in house mass and outings. On the day of inspection, staff were seen to encourage residents to engage in some activities such as hand massage, sing songs etc. Residents had access to dining room, sitting room and nurses' station in their own ward.

Inspectors observed some residents spending time outdoors in the morning and afternoon. There was an outdoor smoking facility near the car park utilised by four residents on the day of inspection. Inspectors spoke with and observed several residents during the inspection. Not all residents were able to communicate with inspectors but residents who spoke with inspectors gave positive feedback relating to the care they received and stated they were happy in the centre. Nevertheless, improvements were required in relation to premises, storage, resident's activities, fire drills, risk management and notification of incidents. General decor, paint works and building maintenance required attention especially on the two top floors. PIC and the registered provider informed the inspectors that funding has been approved for an extensive refurbishment program of the centre and it was to be commenced soon.

Staff promoted a person-centered approach to care and were observed to be kind and respectful towards residents. Inspectors observed resident and staff engagement throughout the inspection, and found that it was evident that staff knew residents well and residents were comfortable and relaxed in the presence of staff. Residents were complementary about the food they received in the centre. Inspectors observed, food were presented well and served in a respectful manner. Improvements required in relation social distancing in dining area during meal times. Inspectors observed resident freely approaching staff for various needs and support and they received instant attention from staff. Inspectors observed some residents using outdoor smoking facility independently.

Visiting arrangements were in place for residents to receive window and indoor visits from their family and friends on compassionate grounds. Some of the residents reported that they were delighted to have window visits from their families during COVID-19 level five restrictions. One of the residents told the inspectors that she is happy that her children are living nearby and they could visit her at any time. One residents was delighted to show the birthday card she bought for the upcoming birthday of her granddaughter.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered to residents.

## Capacity and capability

Overall, there were effective management systems in this centre, ensuring good

quality care was delivered to the residents. The registered provider had ensured that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Mount Alvernia Hospital is a designated centre for older persons that is owned and operated by the HSE. The provider had a clearly defined governance structure in place to promote and enable a quality service which included the person in charge who reports to a general manager for mental health services. The person in charge is supported by clinical nurse managers in each of the units.

The registered provider representative (RPR) held regular governance and management meetings. The centre was managed on a daily basis by an appropriately qualified person in charge responsible for the direction of care. She was supported in her role by three clinical nurse managers (CNM), a nursing and healthcare team, as well as administrative, catering and household staff. The lines of accountability and authority were clear and all staff were aware of the management structure and were facilitated to communicate regularly with management.

The RPR and management team displayed a strong and clear commitment to continuous improvement in quality person-centred care through regular reviews of all aspects of the service and resident care utilising key performance indicators and provision of staff training. An annual review of the quality of care was completed and included an action plan for continuing improvement. Team handover meetings were conducted at the beginning and end of each shift as part of information sharing and education where interventions and forward planning regarding care was discussed along with progress on interventions and suggestions; responsiveness to COVID-19 was highlighted and discussed during these sessions.

The service was appropriately resourced with staffing levels in line with that described in the statement of purpose. Staff reported it to be a good place to work and there was low turnover of staff. Staff meetings and shift handovers ensured information on residents' changing needs was communicated effectively. There was evidence that staff received training appropriate to their roles and staff reported easy access and encouragement to attend training and to keep their knowledge and skills up to date, however, fire safety training and fire drills had not taken place for a considerable period of time. This enabled staff to provide evidence-based care to residents.

The person in charge was the identified COVID-19 lead within the centre. A comprehensive contingency plan had been developed to incorporate a number of areas including governance and management, staffing, resources, infection control, cohorting and waste management. There was a plan with regard to isolation if required. A contact sheet of emergency contacts including crisis management team, GP, public health team and senior staff was also made available to staff to ensure that all potential support personnel could be contacted if required. Systems are in place to ensure that all resources were available and an ample stock of supplies was maintained. Staff had already been segregated to work in distinct units in the designated centre. There was ample PPE stock on site and there had been liaison

with suppliers to ensure supply lines. All resources had been addressed within the contingency plan including PPE, cleaning equipment, O2, pharmacy, and communication devices. Staff training and development had been enhanced to respond to the challenges posed by COVID-19.

Most of the required improvements from the previous inspection had been implemented in the areas of regulation 05 Care planning and assessment; regulation 29, medication management; regulation 17, premises; regulation 26 risk management. However there were repeated non compliance in relation to regulation 16 staff training; regulation 09, residents rights and regulation 17 premises.

### Regulation 15: Staffing

At the time of the inspection there were 38 residents living in the centre and there was one resident in hospital. A review of staff rosters and discussions with staff indicated there were adequate levels of nursing and care staff on duty to meet the assessed needs of residents living in the centre.

Judgment: Compliant

### Regulation 16: Training and staff development

- There was evidence that newly recruited staff had received an induction, with evidence of sign off on key aspects of care and procedures in the centre.
- There was evidence of a good system of staff performance appraisal.
- Staff training records were made available to the inspector and indicated that staff had attended a range of training modules related to infection control processes, hand hygiene procedures, COVID-19 information and the wearing of personal protective equipment (PPE). Staff had undertaken mandatory and appropriate training such as, safeguarding training and manual handling. Staff confirmed their attendance at this training.
- However, fire safety training had not been undertaken since early 2020.

Judgment: Substantially compliant

### Regulation 21: Records

- Records as requested during the inspection were made readily available to the inspectors. Records were stored securely. A sample of five staff files viewed by the inspectors were assessed against the requirements of schedule

2 of the regulations.

- Garda vetting was in place for all staff and the the person in charge assured the inspectors that nobody was recruited without satisfactory Garda vetting.
- Staff files were not easily navigated and were missing a number of items as required by schedule 2.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The inspector found effective governance and management systems were in place for oversight of the centre on a day to day basis. The person in charge was responsible for clinical management and supervision. However, on this inspection Inspectors identified serious issues regarding fire safety preparedness. Areas of non compliance in relation to the provision of a meaningful activities programme, staff training and upkeep of the premises remained outstanding from previous inspections.

There were adequate systems in place for oversight of practice through ongoing audits and supervision of staff to ensure that staff were following the most up-to-date guidance. On the day of inspection, the inspector observed that staff were adhering to infection control guidelines including the appropriate use of PPE and adherence to good hand hygiene practices.

The registered provider and person in charge had taken the necessary steps in relation to governance and management to prepare for an outbreak of COVID-19. The person in charge was the identified COVID lead within the centre. A comprehensive contingency plan had been developed to incorporate a number of areas including governance and management, staffing, resources, infection control and waste management.

While management systems were in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored, the registered provider had shown a lack of understanding of their statutory responsibilities regarding submission of a completed application to renew the registration of the centre within the necessary time line by the chief inspector in contravention of section 48(3) of the Health Act 2007; implementation of fire precautions as required by regulation 28, notifications of incidents regulation 31, risk management regulation 26, regulation 27 infection control, residents rights regulation 9.

Judgment: Not compliant

## Regulation 31: Notification of incidents

The required incidents had not been notified within the required statutory time lines to the Office of the Chief Inspector since the previous inspection.

Judgment: Not compliant

### Regulation 34: Complaints procedure

- A centre-specific complaints policy was in place.
- The complaints policy identified the nominated complaints officer and also included an independent appeals process, as required by the regulations.
- The complaints log detailed the complaint, investigation, responses, however the outcome of complaints and whether the complainant was satisfied was not recorded.
- One complaint viewed had not been dealt with according to the complaints procedure.

Judgment: Substantially compliant

### Registration Regulation 4: Application for registration or renewal of registration

The registered provider had failed to submit a completed application to renew the registration of the centre within the necessary timeline by the chief inspector in contravention of section 48(3) of the Health Act 2007.

Judgment: Not compliant

### Regulation 14: Persons in charge

The person in charge was a registered nurse with the required managerial and nursing experience in keeping with statutory requirements. She and her management team were actively engaged in the governance, operational management and administration of the service. The person in charge demonstrated a commitment to the development of oversight and quality improvements ensure the provision of a safe and effective service.

Judgment: Compliant

## Quality and safety

Overall, residents were supported and encouraged to have a good quality of life which was respectful of their wishes and choices. However, improvements were required in the areas of infection control, fire safety procedures, premises and provision of a meaningful activity programme.

Residents needs were being met through a good program of individual assessments and care plans and good access to healthcare services. Improvements were required to the layout of facilities and storage, especially on Avondhu and Clynda ward, as also identified on previous inspections. The centre provided accommodation for residents in mainly single and twin rooms, each of which was equipped with a wash-hand basin. Storage facilities including a wardrobes and personal lockers were not adequate in some of the bedrooms. All rooms had good natural light and many bedrooms on the upper floors overlooked local countryside. Some rooms were individualised to varying degrees. All bedrooms had a television.

Actions identified on the previous inspection in relation to activities had not been fully addressed. Residents in the centre did not have adequate opportunity to engage in meaningful and suitable activities as identified in their assessment and care plans. The centre did not have a dedicated activity staff and Nurses and health care assistants on duty were providing some activities during the day. The main activities were chats, walks, sing songs, television watching and newspaper reading. Residents in each floor had opportunities to attend periodic residents meeting where they could voice their opinion in relation to the running of the centre. The minutes of these meetings indicated that residents were generally happy and complementary about the service needed. Some requests from residents such as increased meal portions and more frequent walks had been addressed by the clinical nurse managers of the respective ward.

The inspector found a good standard of care was evident in meeting residents' health care and nursing needs. Care plans were individualised and staff spoken with had a well-developed knowledge and understanding of the needs and personal circumstances of individual residents. Appropriate resources were available to support residents' needs; medical practitioners attended the centre regularly and related health services, such as physiotherapy and speech and language therapy, were available as necessary. Regular assessments took place using standardised tools, and reviews were routine or according to changing needs. Documentation and information in the care plan was easy to identify. Care plans reviewed by inspector indicated that, residents end of life care preferences were clearly assessed and documented. Professional guidance from GP and palliative care specialists were also incorporated in end of life care plans reviewed.

The centre provided facilities for residents to meet with visitors adhering to Health Protection Surveillance Centre (HSPC) COVID-19 visiting guidelines. Residents who spoke to the inspector said that they were able to receive window visits from their relatives and staff were helpful in providing them with information in relation to

the changing COVID-19 restrictions and guidelines.

Staff were trained for safe use personal protective equipments, hand hygiene, infection prevention and control measures. Each floor in the centre had a COVID-19 folder which contained the latest HSPC guidelines and some of these guidelines were also displayed on the notice boards. Nonetheless, significant improvements improvements required in this area, which are described below under regulation 27

Nursing staff demonstrated an effective understanding of safe administration of medicines to residents. Controlled drugs were appropriately stored and the monitoring of stock and administration was documented. Medication management audits were in place and the use of psychotropic medicines was monitored. The person in charge and clinical nurse managers and nurses who spoke with inspectors confirmed that appropriate arrangements were in place in relation to pharmacy services. The inspector reviewed documentation around prescribing and administering medicines and noted that all records were maintained in keeping with requirements. The centre had systems in place for the management of hazards that might present a risk to residents; for example policies and procedures relating to risk management and health and safety were site-specific and up-to-date.

There was a plan in place for emergencies and a personal emergency evacuation plan for each resident. Nevertheless, fire drills were not carried out frequently enough and some staff were not fully aware about the actions to be taken in the event of a fire in the building. Inspectors requested immediate action to address this. A number of staff fire training was overdue. The PIC confirmed that fire training has been arranged for all staff in April 2021. Improvements were required in relation to the implementation of certain control measures identified and documented in risk assessment documents. The outdoor smoking area was sometimes blocked by parked vehicles which made it difficult for residents to access this facility.

There was a culture that promoted the welfare of the resident in the centre, supported by appropriate policies and procedures for the prevention, detection and response to abuse. Staff spoken with were clear in their understanding of what constituted abuse and the procedure for reporting information. Residents spoken with stated that they felt safe in the centre and were clear who they could go to should they have any concerns they wished to raise. The centre actively promoted the independence of residents and where restraints, such as bed rails, were in use appropriate risk assessments had been undertaken. Care plans contained assessments and consent forms, and a restraint register was in place that reflected regular monitoring.

## Regulation 11: Visits

The centre provided facilities for residents to meet with visitors adhering to health surveillance and protection centre (HSPC) COVID-19 visiting guidelines. Residents spoken with the inspector said that they were able to window visit their relative and

staff were helpful in providing them with information in relation to changing COVID-19 restrictions and guidelines.

Judgment: Compliant

### Regulation 12: Personal possessions

- Improvements were required to the layout of facilities and storage, especially on Avondhu and Clyda ward, as also identified on previous inspections.
- Storage facilities including wardrobes and personal lockers were not adequate in some of the bedrooms.

Judgment: Substantially compliant

### Regulation 13: End of life

Appropriate care and comfort, which addressed the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided when a resident was approaching the end of his or her life. The end of life religious and medical preferences of the resident also were taken into account. There was evidence of residents' and family's consultation and participation in end of life care planning.

Judgment: Compliant

### Regulation 17: Premises

The premises did not conform to the matters listed in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and did not fully meet the needs of residents as set out in the statement of purpose.

- Access to outside recreational space was inadequate for residents on the third floor.
- Areas of the centre required redecoration with scuff marks on walls, skirting boards and door frames.
- A number of clinical items such as syringes, nebulisers and dressings etc were stored in unlocked presses in the dining area on Avondhu unit.
- Most residents did not have a chair in their bedroom.

Judgment: Not compliant

### Regulation 18: Food and nutrition

The residents in the centre had access to a safe supply of fresh drinking water at all times. Residents were offered choice at mealtimes and they were provided with adequate quantities of food and drink. Residents weights were monitored on a monthly basis and they were assessed for malnutrition using a validated tool. Specialist advice from dietitian and speech and language therapist (SALT) were also incorporated in care plans for residents with high risk of malnutrition and dysphagia (swallowing difficulty)

Judgment: Compliant

### Regulation 26: Risk management

There was a risk management policy that addressed the requirements of the regulations. There was an associated risk register and it was evident that the register was reviewed on an on-going basis. However findings on this inspection identified a number of risks that are detailed under regulation 27 infection control and regulation 28 fire precautions.

Judgment: Compliant

### Regulation 27: Infection control

The findings of this inspection were that residents were at risk of infection as a result of the provider failing to ensure that infection prevention and control practices promoted safe care. In particular the provider did not demonstrate compliance with Regulation 27 through the implementation of the National Standards for Infection Prevention and Control in Community Settings to include all relevant guidance such as that issued by the HPSC. For example:

- Social distancing among staff and residents during meal times
- Sluice room was cluttered and the hand washing sink was not accessible
- Some signs in the centre were not laminated which made it difficult to clean as per IPC guidelines
- Multi-task staff were involved in both house keeping and catering service which posed a cross-infection risk
- Common service lift was used for both clean laundry and food trays

Judgment: Not compliant

### Regulation 28: Fire precautions

Improvements were required in the following areas;

- Inspectors were not assured that there were adequate arrangements in place to ensure residents could be safely evacuated. Fire drills were not conducted at regular intervals and staff were not fully aware of the fire evacuation procedure in the centre.
- Staff did not have up to date fire safety training.
- Fire evacuation floor plans were not of sufficient scale to be easily readable and were not available in all significant locations throughout the centre.
- One main fire exit in the basement laundry area was blocked with trolleys.
- The registered provider was not taking adequate precautions against the risk of fire in that the arrangements for the storage of oxygen cylinders required review.
- The external smoking area was not always easily accessible by the residents as cars were parked in front of this area
- Residents were not facilitated to wear high visibility jacket or smoking apron as per their risk assessment record

Judgment: Not compliant

### Regulation 29: Medicines and pharmaceutical services

A dedicated pharmacy service was available for the centre. Records of medication related interventions in respect of the residents were kept safe in an accessible place. All medicinal products dispensed or supplied to the residents were stored securely at the centre. Medicinal products were administered in accordance with the directions of the prescriber. There was system in place to safely return the out of date and unused medications to the pharmacy for safe disposal.

Judgment: Compliant

### Regulation 5: Individual assessment and care plan

Care plans for each residents were developed based on a list of valid assessment tools immediately after the residents' admission to the designated centre and these care plans were formally reviewed, at intervals not exceeding four months. There

was evidence of consultation with residents and residents' families while developing and reviewing the care plans.

Judgment: Compliant

### Regulation 6: Health care

Residents in this centre had access to appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by Nursing and Midwifery Board of Ireland (NMBI) from time to time. Residents had the option to choose from a local GP service or to continue link with their own GP. Residents also had access to additional professional expertise and treatment when required. These additional professional services included consultant psychiatrist, podiatry, SALT, dietitian, OT (occupational therapy), community physiotherapy, palliative care etc.

Judgment: Compliant

### Regulation 7: Managing behaviour that is challenging

Staff had up to date training, knowledge and skills, appropriate to their role, to respond to and manage behaviour that was challenging. The centre facilitated one to one support and supervision for residents with challenging behaviour if required. Residents with challenging behaviours were managed in a least restrictive manner. Restraints were used in accordance with national policy.

Judgment: Compliant

### Regulation 8: Protection

There were systems and reasonable measures in place to protect residents from abuse. Staff in the centre had adequate training and knowledge in relation to the detection and prevention of and responses to abuse. The centre had arrangements in place to investigate any incident or allegation of abuse.

Judgment: Compliant

### Regulation 9: Residents' rights

Improvements were required in the following areas

- Similar to findings on the previous inspection, there was a need to significantly improve the social care element of the lives of residents living in the centre in the context of the provision of a programme of meaningful activities. Residents were frequently left in sitting rooms with music DVDs playing in the background. Only limited organised activities were provided and residents' days lacked stimulation. This was particularly relevant for residents on the third floor who did not have free access to the external grounds, but was also for residents on the other floors, as their main form of occupation during the day was to have a walk on the grounds.
- The centre did not have dedicated activity staff which impacted residents' opportunity to engage in meaningful activities as per their assessed needs, interest and capabilities.

Judgment: Not 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:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Registration Regulation 4: Application for registration or renewal of registration	Not compliant
Regulation 14: Persons in charge	Compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Mount Alvernia Hospital OSV-0000723

Inspection ID: MON-0032235

Date of inspection: 24/03/2021

## 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. **S**pecific 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:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Fire Evacuation Training has been arranged for 23/4/21 &amp; 26/4/21. Fire Extinguisher training has been arranged for 11/5/21 &amp; 12/5/21. All staff will attend the fire training. Fire evacuation drills have been carried out in all wards 1/4/21 &amp; 7/4/21 &amp; 8/4/21. Two further fire drills have been arranged for 14/4/21 &amp; 15/4/21. Once all staff have attended a fire drill &amp; can demonstrate a clear understanding of what is expected of each member of staff in the event of a fire we will move to 2 arranged fire drills every 2 weeks. Fire action cards have been distributed to the CNM2s and they will discuss Fire safety &amp; what to do in the event of a fire at staff meetings. The Daisy chain of who to contact in the event of a fire is displayed over the telephone in each ward. Fire evacuation training will be carried out with all new staff to ensure they are aware of their responsibility in the event of a fire. The person in charge will carry out weekly fire walk around to ensure all fire precautions are in place.</p>	
Regulation 21: Records	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p> <p>All Staff records/files are currently under review &amp; a system will be put in place to ensure that all items required under schedule 2 will be easily accessible.</p>	

Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Person in charge has arranged fire training for all staff &amp; has implemented a comprehensive fire evacuation drill education program.</p> <p>There is a maintenance program in place to renovate the premises &amp; work in Clyda Ward &amp; Avondhu ward is currently taking place.</p> <p>The Person in charge will ensure that an activity coordinator will be put in place &amp; a program of meaningful activity will be implemented with immediate effect.</p> <p>The registered provider has submitted the application to renew the registration of the centre.</p> <p>The Person in charge has submitted the notification of the Incident that was not reported to HIQA.</p>	
Regulation 31: Notification of incidents	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 31: Notification of incidents:</p> <p>The Person in charge has submitted the notification of the incident that was not reported &amp; will give an undertaking to report all further reportable incidents within the required time frame.</p>	
Regulation 34: Complaints procedure	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <p>A review of the complaints policy &amp; complaints log has been undertaken .All complaints are under review to bring them in line with the correct procedures.</p>	
Registration Regulation 4: Application for registration or renewal of	Not Compliant

registration	
<p>Outline how you are going to come into compliance with Registration Regulation 4:  Application for registration or renewal of registration:  The registered provider has submitted the application for registration renewal.</p>	
Regulation 12: Personal possessions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 12: Personal possessions:  A review of the standard of the bedrooms in Clyda ward &amp; Avondhu ward has been undertaken .We are awaiting a delivery of new bedside lockers &amp; chairs for the bedrooms. Wardrobes &amp; required furniture will be purchased to bring the bedrooms up to the required standard .The person in charge will ensure that the standard is met &amp; maintained in all areas.</p>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:  The person in charge will appoint an activity coordinator &amp; outside access for the residents in Avondhu ward will be worked into their meaningful activity program .It must be noted that our focus for 2020 was infection prevention &amp; the residents in Avondhu ward are the most vulnerable residents in Mt Alvernia &amp; during level 5 restrictions our focus was infection prevention. I acknowledge that improvements can be made with regard to outside access. This will be worked into the activity program.  Redecoration is currently underway in the hospital &amp; all maintenance issues will be resolved.  Clinical Items such as syringes, nebulizers &amp; dressings have been removed from the presses in the dining rooms .Locks are being fitted to all presses to ensure that they can be locked .  A supply of chairs for bedrooms has been ordered .We are waiting delivery of same. The person in charge will ensure that all bedrooms meet the required standard.</p>	
Regulation 27: Infection control	Not Compliant

<p>Outline how you are going to come into compliance with Regulation 27: Infection control:</p> <p>Social Distancing among staff &amp; residents has been discussed with all staff .It is not always possible in residential services to maintain social distance .This risk is addressed by staff wearing surgical masks at all times &amp; adhering to good hand hygiene techniques &amp; the wearing of PPE when required. All Staff have a COVID swab every 2 weeks &amp; are actively encouraged not to come to work if they feel unwell. Residents &amp; Staff have received the Pfizer bio tech vaccine .All COVID guidelines from HSPC have been implemented as per guidelines &amp; staff will ensure that where possible social distance is maintained. A review of the Dirty Utility in Clyda ward has been undertaken. Only essential equipment will be stored in this area. Extra equipment not necessary has been removed &amp; is being held in storage. This will ensure access to the Bedpan washer &amp; sink. All signage will be Laminated to ensure it can be easily cleaned.</p> <p>A review of the Multi task role has been undertaken in both Avondhu ward &amp; Clyda ward. The Multi task attendants will not be involved in the catering service on the wards. They will accept the food trolley from the Main Kitchen &amp; the Nurse in Charge will serve the food to the residents.</p> <p>Currently the Laundry is delivered to the floors through the service lift .The delivery of clean linen is limited to Wednesday morning at 11am &amp; Thursday morning at 11am .A cleaning schedule will be put in place for the lift following delivery of the linen .The Person in charge will order a closed trolley for the delivery of the linen to the wards .All food is delivered in closed containers to the floors on a trolley or in a food trolley .Food is not sent to the floors in trays.</p>	
Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>Staff training has been arranged for the 23/4/21 &amp; 26/4/21 for Fire Evacuation training &amp; fire extinguisher training has been arranged for 11/5/21 7 12/5/21 .A comprehensive fire drill program has been implemented &amp; will be carried out weekly until all staff are up to date with fire training &amp; are confident in what to do in the event of a fire .The frequency of fire drills will then be fortnightly on each ward.</p> <p>Fire evacuation floor plans have been replaced with maps that can be easily read &amp; they are displayed in the front hall &amp; on each floor.</p> <p>The trolleys have been removed from the fire exit in the laundry. The Laundry Supervisor will ensure that this area remains clear. The Person in charge will do a weekly fire walk around to ensure all areas meet the required standard &amp; that all fire exits are clear of obstructions.</p> <p>The Residents smoking area will be highlighted with a yellow box to ensure that it is clearly marked as a no parking zone.</p> <p>New High Visibility jackets have been received from Mallow Garda station &amp; Staff will ensure that the residents use them when they go out walking.</p> <p>Smoking Aprons have been provided for the residents who smoke &amp; they will be</p>	

encouraged by the staff on each ward to use them.

Regulation 9: Residents' rights

Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:  
The person in charge will appoint an activity coordinator & a person centered activity program will be implemented. Following our previous inspection an activity coordinator was appointed but she is currently out on sick leave. COVID 19 has significantly impacted the ability of the facility to implement a meaningful activity program .All outside activity programs have been restricted due to level 5 restrictions .Also with restrictions & HSPC guidelines it has been a challenge to provide meaningful activity to meet all residents requirements .However all residents & staff are now vaccinated & the serial staff swabs for staff every 2 weeks are still taking place this will allow further freedom with regards to the implementation of a meaningful activity program.

## 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).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Not Compliant	Orange	19/04/2021
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	01/06/2021

	and other personal possessions.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	12/05/2021
Regulation 17(1)	The registered provider shall 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.	Not Compliant	Orange	01/06/2021
Regulation 17(2)	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.	Not Compliant		31/08/2021
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	17/05/2021
Regulation 23(c)	The registered provider shall ensure that management	Not Compliant	Orange	12/05/2021

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	01/06/2021
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	12/05/2021
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire	Not Compliant	Orange	12/05/2021

	fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	23/04/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	24/03/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated	Substantially Compliant	Yellow	24/03/2021

	person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	17/05/2021