Health Information and Quality Authority

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:	St Doolagh's Park Care and Rehabilitation Centre
Name of provider:	Costern Unlimited Company
Address of centre:	Malahide Road, Dublin 17
Type of inspection:	Announced
Date of inspection:	24 July 2024
Centre ID:	OSV-0004042
Fieldwork ID:	MON-0040035

About the designated centre

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

St Doolagh's Park Care and Rehabilitation Centre is a purpose-built facility located in a rural setting, within close proximity to Malahide. The centre is registered to provide residential care to 72 male and female residents over the age of 18 years. The centre provides specialist care for adults with acquired brain injury (ABI) once they are discharged from hospital and medically stable. It provides long-term care and a secondary slow stream rehabilitation programme. Residents are accommodated in single en-suite bedrooms, on two floors. This modern building has its own inner courtyard and secure landscaped gardens designed to meet the needs of residents. The centre is close to hotels, restaurants, pubs, local parklands and shopping centres. There is an established bus service to and from the Malahide road.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	72

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 24 July 2024	09:15hrs to 16:45hrs	Sheila McKevitt	Lead

What residents told us and what inspectors observed

Residents spoken with were positive about the way they were looked after and the efforts that staff made to ensure that they had everything they needed. A comfortable familiarity was seen to exist between residents and members of staff.

The inspector walked around the centre meeting residents, staff and relatives. The inspector observed that residents privacy and dignity was consistently maintained when morning care was being delivered to residents. The staff were knowledgeable regarding the residents complex needs, call bells were answered promptly and residents were appropriately supervised in communal areas.

The inspector spoke with a number of visitors and relatives visiting residents who had been in the centre for a number of years, they said they were extremely satisfied with the standard of care delivered to their loved one. They also said that staff kept them informed of resident's progress and that they were involved in developing their care plan.

The visitors spoken with said staff supported the residents to enjoy as a good quality of life as possible in the centre. Residents went out a lot in the centre's bus to different places. One relative explained how they brought the resident to the family home for weekend visits as the residents large wheelchair would not fit in the family car, they described this as an excellent service, 'going that extra mile for the resident'. None of the visitors expressed any concerns and were very complimentary about the service provided.

There were no restrictions on visitors, which visitors were happy about. They said they signed the visitors book on entry into the centre and explained how they could visit their loved one in the privacy of their bedroom, the sitting room or in the visitors room.

Residents confirmed they had adequate storage for their personal belongings including a lockable storage area within their personal private space. Residents and their relatives said the laundry service was good, however, one resident said that sometimes there was an issue with clothes shrinking. The inspector noted that this had been brought to the attention of the person in charge at the last residents meeting and they had addressed it with laundry staff.

The inspector observed that residents were empowered to raise any concerns they might have and residents who communicated with the inspector confirmed that their feedback was appropriately responded to. Feedback from residents was documented and records from resident meetings showed that follow up actions were implemented that addressed residents' issues. The inspector read the centres quarterly news letter which contained information and updates about the centre, activities and residents, copies were available throughout the centre.

Residents were happy with the choice of food on offer, one resident described the food as 'delicious' and said that they had independent access to a variety of snacks in the dining room.

In the morning, the inspector spoke with a number of residents who were leaving to attend day services. When they returned in the afternoon, they were involved in in-house activities which they confirmed were good. Some said they enjoyed the occupational therapy and physiotherapy sessions other preferred the trips out in the centre's bus or trips to the local parks.

Residents told the inspector how much they had enjoyed the summer barbecue which had occurred the previous weekend, they said the food and music were just brilliant and the staff were good fun.

Residents reported that they had no complaints and that when they had, they reported them and they got dealt with promptly to their satisfaction.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

Overall, this was a good, well-resourced centre which ensured residents were supported to enjoy a good quality of life and receive safe quality care and supports. Notwithstanding this, the findings of this inspection are that the governance structures and oversight required to be strengthened to ensure a consistent and safe service continued to be provided to the residents living in the centre. This was an announced inspection which took place over one day, to monitor ongoing compliance with the regulations.

St. Doolagh's Park Care and Rehabilitation Centre is operated by Costern Unlimited Company, which is part of the wider Trinity Care group. There had been a change to the senior management structure since the last inspection with the removal of a clinical operations manager since April 2024, which had been notified to the Chief Inspector. This position remained vacant at the time of inspection. The inspector was informed that another clinical operations manager belonging to the Trinity group was available to support the centre, however this person did not have a formal role in the governance and management arrangements for this registered provider. Such arrangement required review.

The provider has continuously had a good level of regulatory compliance and the inspector noted that the governance oversight and the level of compliance was beginning to slip as evidenced in this report. This centre accommodates a high profile of young residents with complex needs and therefore the person in charge

needs the consistent support from the senior management team and clear and well-established reporting structures.

There was a defined management structure in place within the Nursing Home, however in the absence of a clinical operations manager in the role of a person participating in management, the lines of authority and accountability were not in accordance with the reporting structures outlined in the provider's statement of purpose and condition of registration. On the day of inspection the person in charge was supported by an assistant director of nursing (ADON), a clinical nurse manager (CNM), a team of nurses, healthcare assistants, therapy technicians, an occupational therapist, physiotherapists, psychologists, housekeeping, catering, laundry, maintenance and administrative staff. The person in charge was supported by the provider and there was evidence of fortnightly governance meetings and weekly analysis of key performance indicators. However, as outlined under Regulation 23; Governance and management a strengthening of the oversight of some areas of practice was required.

An annual review was available and reported the standard of services delivered throughout 2023 and included a quality improvement plan for 2024. It also included feedback from residents and relatives.

The registered provider had ensured that the number and skill-mix of staff was appropriate, having regard to the needs of residents and the size and layout of the centre.

There was a complaints policy and procedure in place in the centre, however it was not consistent throughout. The complaints register showed there were no open complaints on the day of inspection . Documents reviewed such as the certificate of insurance and statement of purpose met the legislative requirements however, Schedule 5 policies and the directory of residents did not meet the legislative requirements and theses required further review.

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Regulation 15: Staffing

There were adequate numbers of staff on duty with appropriate skill-mix to meet the needs of the 72 residents and taking into account the size and layout of the designated centre.

Judgment: Compliant

Regulation 19: Directory of residents

The residents directory was reviewed and was found not to contain all the required information outlined in part 3 of Schedule 3. For example:

- There was no address entered for two of five residents cross-referenced in the directory of residents.
- The general practitioner (GP) address and telephone number was not included for two of five residents cross-referenced in the directory of residents.
- The next of kin address was not included for two of five residents cross - referenced in the directory of residents.

Judgment: Substantially compliant

Regulation 22: Insurance

A contract of insurance was available for review. The certificate included cover for public indemnity against injury to residents and other risks including loss and damage of resident's property.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the good governance structure in place a strengthening of the oversight of the following was required to ensure that ;

- the Schedule 5 policies were reviewed within three years, were available, dated and met the legislative requirements.
- the service records kept within the centre were comprehensive.

- documents such as the directory of residents and the complaints policy met the legislative requirements.
- residents who smoked had smoking risk assessments and care plans in place.
- the premises was kept in a good state of repair throughout.
- the signage on communal bathroom and toilet doors required review to ensure they respected the residents' abilities.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed in within the past year. The contents met the regulatory requirements and reflected the number and makeup of the beds in the centre. It reflected that there was no person currently in the role of person participating in management.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints policy had been reviewed, however it was not aligned with the legislative requirements. For example, the complaints reviewer was not consistent in the master complaints policy with the copies on display throughout the centre.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A number of Schedule 5 policies had not been updated in the past three years, the following are a sample of those policies;

- Residents' property, personal finances and possessions policy.
- Staff training and development policy.
- Provision of information to residents.

The following Schedule 5 policy was not available for review;

- The creation of, access to, retention of, maintenance of and destruction of records.

The recruitment, selection and Garda vetting of staff did not mention the need for a full employment history together with satisfactory history of any gaps in employment.

- The fire safety policy and risk assessment was not dated, therefore it was not possible to determine if it had been updated since the inspection in September 2022 post which the provider had committed to updating it by 30 April 2023

Judgment: Not compliant

Quality and safety

Overall, the residents in this centre were receiving good-quality, person-centred care. Residents told the inspector that they felt safe living in the centre.

The facilities and premises were observed to be clean, tidy and adequate for the needs of the residents. Some areas were identified as requiring upgrading as further mentioned under Regulation 17; Premises.

There were records indicating that preventive maintenance of fire safety equipment was conducted at appropriate intervals and staff had received fire safety training. However, not all areas of fire safety risks were appropriately identified, risk assessed and mitigated. For example, some issues were found in relation to residents who smoked not having risk assessment completed, as mentioned under Regulation 28; Fire precautions.

Residents' rights were protected and promoted. Residents could choose from a variety of activities, such as gym workouts, social gatherings, and where to spend their day. Residents were generally consulted about their care needs and about the overall service being delivered and had access to independent advocacy if they wished.

There was open visiting and the receptionist welcomed all visitors into the centre. At the weekend, one of the residents did this job, as a paid employee. The centre was welcoming and one where residents and visitors reiterated to the inspector that they were well cared for and enjoyed living in the centre.

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were observed meeting visitors

in private and in the communal spaces throughout the centre, including the front garden.

Judgment: Compliant

Regulation 12: Personal possessions

There was adequate storage in the residents' rooms for their clothing and personal belongings including a lockable unit for safekeeping. The laundry service provided met the residents' needs.

Judgment: Compliant

Regulation 20: Information for residents

A residents guide was available and included a summary of services available, terms and conditions, the complaints procedure and visiting arrangements.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The inspector saw evidence that all relevant information which accompanied residents transferred out of the centre such as, nursing and doctors transfer letters were available for review. The national transfer letter was in use and a copy was available for review. For residents transferred into the service, a copy of their transfer letters were also available for review.

Judgment: Compliant

Regulation 28: Fire precautions

The records of the quarterly fire alarm checks completed by an external company were not comprehensive. From the records available it was not clear if any faults were identified on the dates the alarm system was serviced and it was not clearly stated if the fire alarm system was left in working order.

The safety of residents' who smoked required review;

- Residents who smoked did not have a smoking risk assessment in place and did not have a smoking care plan in place.
- The outdoor smoking shelters did not have call bells in place.
- One outdoor smoking area did not have a smokers' protection apron in place.

Judgment: Substantially compliant

Regulation 8: Protection

All reasonable measures were taken to protect residents from abuse. This included having appropriate policies and procedures which staff understood and implemented.

The provider was a pension-agent for a small number of residents. The inspector saw that monies collected on behalf of residents were being lodged into a residents' account, in line with the Social Protection Department guidance.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were upheld. There were opportunities for recreation and activities. Residents were encouraged to participate in activities in accordance with their interests and capacities. Residents were viewed participating in activities as outlined in the activity programme displayed in each unit. Residents were supported by staff to join in group activities in smaller groups or individual activities relevant to their interests and abilities.

Residents were registered to vote and their religious needs were met.

Judgment: Compliant

Regulation 17: Premises

The inspector observed the following issues in relation to the premises, which did not meet the requirement of Schedule 6:

- The wall in one of the sluice room was damaged.

• The floor covering in the laundry required repair to ensure it could be cleaned thoroughly. • The walls of some bedrooms were heavily scuffed.
Judgment: Substantially 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
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 17: Premises	Substantially compliant

Compliance Plan for St Doolagh's Park Care and Rehabilitation Centre OSV-0004042

Inspection ID: MON-0040035

Date of inspection: 24/07/2024

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The directory was reviewed by the PIC in full and the required information residents that was missing has been included. A follow-up audit was also carried out to ensure all areas were compliant in line with the regulations and best practice, including the General Data Protection Regulation. The most recent up to date copy of regulation 19 guidance was attached to the directory as well for reference	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: St Doolaghs policies are essential for the delivery of service. All policies folders that were in use were reviewed and updated in line with the requirements. The folders with older versions were archived and removed from the floors. Schedule 5 policies are now available for all staff on Epicare with a view to extending all policies to the electronic system. The policy folders are also accessible on the two floors and any updates communicated to staff to read and sign. The PIC and Maintenance staff contacted the fire contractors. They were notified of the lack of a comprehensive reporting post service identified at the inspection. The contractor has since reissued comprehensive reports on 7th August. The reports have all been filed accordingly. Servicing is scheduled for the third week of September 2024, and they have confirmed the reports that follow will correlate with their certificates. PIC and Maintenance team will	

be sent copies of the final reports.

The signage on the toilets was changed to 'accessible toilet' on 24th July to ensure inclusive language. The new signage was discussed with residents in the residents committee on 21st August and they are aware of the new changes and reassured that it is still designed to accommodate them but maintains their dignity.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints signage was updated to ensure it was consistent throughout the home and in line with the legislative requirement. The changes were communicated to staff during handovers to ensure they were disseminated to all. The complaints procedure and advocacy supports are discussed in all residents committee meetings and was further highlighted in the committee meeting on 21st August which the PIC attended.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
St Doolaghs policies are essential for the delivery of service. All policies folders that were in use were reviewed and updated in line with the requirements. The folders with older versions were archived and removed from the floors. Schedule 5 policies are now available for all staff on EpicCare. The policy folders are also accessible on the two floors and any updates communicated to staff to read and sign. The recruitment policy is under review by the Human Resource team to ensure its comprehensive. This is due completion on the 26th August.

The fire safety policy and risk assessment version was checked to ensure it was the most up to date version. The date of issue and review date have now been included in all copies.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC and Maintenance staff contacted the contractors. The PIC and Maintenance staff contacted the contractors. They were notified of the lack of a comprehensive reporting post service. One contractor was able to review and completed and reissued comprehensive reports on 7th August. The reports have all been filed accordingly.

A review of the residents who smoke was carried out and an assessment and care plans were reviewed and completed appropiately. Capacity assessments were carried out in relation to restrictive measures in place.

Additional aprons were procured and delivered on 8th August 2024. Each external smoking shed now has one each. The outdoor smoking shelters were also fitted with a temporary call bell on 14th August. A more permanent system is under review and is expected to be completed by November 2024. Communication was sent out to all staff of the new call bell system and signage in place to inform all residents.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The sluice room wall was repaired and painted on the 24th July 2024. Whiterock cladding was put in to prevent damage when trolleys are being pushed in and out of the room.

A room checklist audit was completed by the head housekeeper and maintenance team 29th July. An action plan has been carried out, and estimated completion of works by October 2024. Monthly room checklist are carried out to identify areas that need to be refurbished due to damage from wheelchairs and equipment.

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
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.	Substantially Compliant	Yellow	10/10/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	24/07/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	10/10/2024

Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	05/11/2024
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	05/11/2024
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Substantially Compliant	Yellow	21/08/2024

Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	26/08/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	26/08/2024