

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	St Patrick's Community Hospital
Centre ID:	OSV-0000661
Centre address:	Summerhill, Carrick on Shannon, Leitrim.
Telephone number:	071 962 0011
Email address:	anthony.wadd@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Frank Morrison
Lead inspector:	Thelma O'Neill
Support inspector(s):	Damien Woods;
Type of inspection	Announced
Number of residents on the date of inspection:	82
Number of vacancies on the date of inspection:	3

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.

Compliance 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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
24 March 2015 10:30	24 March 2015 18:30
25 March 2015 08:00	25 March 2015 13:30

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

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

Summary of findings from this inspection

The centre is operated by the Health Service Executive (HSE) and situated a short drive from the shops and business premises of Carrick on Shannon Town.

St. Patrick's Hospital provides short and long-term care accommodation for residents with a range of needs including convalescence, respite care, assessment, rehabilitation, palliative care, continuing care and dementia care. At the time of this inspection, a total of 82 residents were being accommodated.

St. Patrick's Hospital currently comprises of four units accommodating a mixture of male and female residents over the age of 65 years. The centre also provides

Physiotherapy, Occupational Therapy, Speech and language therapy, Dental Treatment and Palliative care services. Other facilities include a church, a relaxation room and the main catering kitchen and laundry. In addition, a day care centre that provides a service for up to 25 people daily was available on site.

On this inspection the inspectors assessed 18 outcomes and found six compliant, four non-compliant Major, five non-compliant Moderate and three substantially Compliant. Twenty seven non-compliances are actioned at the end of this report. Inspectors found that the provider and person in charge had not taken appropriate action to address the non-compliances identified in the previous inspection to ensure the care and welfare of residents were protected. Of the 23 actions reviewed inspectors found that 11 actions were complete, one action was partially addressed, and 11 actions remained active.

Inspectors were concerned that there continued to be major non-compliances in Governance and Management, Premises, Healthcare and Staffing. These were found to be consistently impacting on the quality of life and care provided to the residents living in the centre.

The lack of effective management, responsibility and accountability for the delivery of supervision and training for staff and poor delivery of care resulted in major non-compliance in the governance and management of this centre. The provider and person in charge had failed to ensure that residents were adequately protected and many staff had not up to-date training in fire, protection of vulnerable adults, managing behaviours that challenge and infection control training to ensure safe practices. In addition, the annual review of the quality and safety of care did not identify the care and welfare issues identified by the inspectors, or actions required to address the issues in a specific, timely and efficient manner.

The physical design and layout of the premises did not meet the assessed needs of residents', which impacted on the quality of life of residents. The privacy and dignity of residents was not promoted due to the dormitory style bedrooms, with the smallest having 4 beds and largest having 6 beds. Staff, residents and relatives have to walk through these rooms to access communal areas. Furthermore, there were inadequate toilets/ showering facilities and personal care was inadequate due to the lack of opportunities and choice for regular showers/baths. The provider had failed to address this non-compliance which had been identified on the previous inspection.

The inspectors found there was insufficient staffing to meet the needs of the residents and current staff were not deployed in a manner that met the needs of residents.

Organisational policies and procedures had not been reviewed in line with stated dates for review.

Inspectors found that the provider had consistently failed to address the fire management non-compliances from previous inspections.

Inspectors also found medication practices were not adequately supervised by the

person in charge to ensure safe administration and storage practices. Inspectors found that there were significant improvements in the quality of food and nutrition provided to residents. In addition; staffing rosters had been restructured and the person in charge had introduced a new resident's care plans system. While progress and improvement in some outcomes were evident since the last inspection; further improvements were required.

While residents and family members told inspectors (verbally and in questionnaires) that they were happy with the services provided by this hospital, they were concerned about the inadequate staffing in the centre.

The Action Plan at the end of this report highlights those areas where improvements are still required to comply with the Regulations and the Standards.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The Statement of Purpose for St. Patrick's described the aims, objectives and ethos of the service, the facilities and services provided in the centre and all the information required by Schedule 1 of the Regulations.

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):

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

Findings:

There was a clearly defined management structure in place in the centre. The registered provider nominee is the acting General Manager HSE Sligo/ Leitrim Services. The Director of Nursing is also the Person in Charge; he works full-time in the centre. He manages the centre with the support of one Assistant Director of Nursing and a nine

Clinical Nurse Managers (CNMs) who are responsible for supervising and managing the delivery of care. They are supported by thirty- nine full-time staff nurses, and forty-one health care assistants as well as administrative, clerical and ancillary staff. In addition; there was a multidisciplinary team of physiotherapists and occupational therapists and a medical officer working in this centre.

Residents, relatives and staff were very familiar with the management team and were heard addressing them by their names. Residents, relatives and staff told the inspectors that they were very happy living in the nursing home and that staff were kind to them, and this was evident from the observations of the inspectors.

Inspectors found that the Provider/PIC continued to fail to address the requirements of the Health Act 2007(Care and Welfare of Residents for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland, for example; premises issues were impacting negatively on many of the residents lives. Also there were limited opportunities for personal care; such as, regular showers/baths as per the assessed needs or wishes of the residents. Risks such as fire evacuation and personal evacuation plans were not in place and fire safety equipment had not been installed as per provider's response to previous actions. Furthermore, there were a significant number of falls in this centre and some residents had fallen repeatedly and were not adequately protected from further injury.

The inspectors found that the person in charge had failed to ensure that the organisations policies and procedures were adequately reviewed or updated in each unit area. For example; the risk management policy was due to be reviewed in 2012. There was inadequate training for staff in every unit; for example; in fire management and the protection of vulnerable adults. Resident's rights and social activities were not adequately addressed and inspectors were told that an annual safety review had taken place by the provider; however, the review was not available on the day of inspection.

Resident's contracts of care did not adequately show the additional costs being charged to residents and this required review to ensure compliance with the regulations , Also, medication management practices was not adequately supervised.

In May 2014, the Authority was notified of an that a Trust in care investigation had been commenced; however, the inspector found that there was poor time management of this investigation, as over a year has passed and the investigation has still not been commenced.

The role and responsibilities that were previously held by a retired Assistant Director of Nursing (ADON) were being divided between the person in charge and existing assistant Director of Nursing (ADON). The person in charge and ADON told inspectors that this had impacted on delivery of staff training and implementing social activities for the residents as well as extending their responsibility to cover the centre out of hours. Both managers now work opposite each other to ensure that a senior staff member was on duty during the day/weekends, however, this had limited opportunities for joint management meetings between the Person in Charge an Assistant Director of Nursing.

Judgment:
Non Compliant - Major

--

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:
All residents have a signed contract of care in place; however; some residents have no capacity to sign their contract. The residents' next of kin pay's the maintenance charges and sign's on behalf of the resident. An inspector reviewed a sample of contracts and saw that they contained most the requirements as outlined in the regulations. However, additional charges were not clearly identified in the contracts of care.

There was a residents' guide that an inspector reviewed and noted that it met the requirements of the Regulation

Judgment:
Substantially 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 person in charge is a registered nurse and has an extensive range of professional and relevant qualifications and experience in nursing older people. Throughout the inspection, he demonstrated knowledge of the regulations and his professional and legal responsibility. He acknowledged that some improvements had been made; however, more were required in the structure and operational management and administration of the designated centre. Non- compliances are actioned under Governance and Management in outcome 2.

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:

Inspectors reviewed the actions from the last inspection and found that instructions regarding medications that were required to be crushed were now recorded on each medication prescription sheet. In addition; medication administration records also contained the dose or route to be administered to the resident. Medication administration sheets were completed at the correct time and these had all been reviewed since the last inspection.

Nutritional assessments and swallowing diagnosis, recommendations and treatments were now recorded in the resident's food and nutritional care plans. Also, residents nutritional or swallowing difficulties were risk rated and were also documented in the residents care plans. These had been actions that had been achieved from the last thematic inspection in October 2014.

Inspectors found improvements in maintaining records listed in Schedules 1, 2, and 3 that previously were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval of information in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. However, inspectors found that the schedules 4 and 5 were incomplete on this inspection. Schedule 4 did not accurately show additional charges payable by residents and Schedule 5 policies and procedures were not reviewed within the policies review dates. For example; the risk management policy, was not reviewed since 2012 and the protection of vulnerable adults' policy review date was due in June 2014. Also, the records policy review date was January 2014. All of the policies in the centre required review to ensure they are current.

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:

The provider was aware of the requirement to notify the Chief Inspector should the person in charge be absent for more than 28 days.
From discussion with the provider, the person in charge and PPIM the inspectors were assured that the deputising arrangement in place were adequate to provide continued governance in the centre.

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):

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

Findings:

The inspectors discussed the procedures in place for the protection of vulnerable adults the centre with residents, relatives and staff, and all said they would have confidence in reporting any concerns to the management team. This was also evidenced by the completed responses in the residents and relatives questionnaires returned to the Health Information and Quality Authority. An inspector spent time in one of the day rooms and heard and observed the staff interacting with residents in a respectful manner.

Inspectors found that most staff had not up to date training on the protection of

vulnerable adults. A copy of the proposed refresher training was given to the inspectors. However, it was found to be inadequate and it did not specify the organisations policies on "Safeguarding Vulnerable Persons at Risk"

There were no residents displaying aggressive behaviour on the day of inspection. Although inspectors found a calm atmosphere in the centre, inspectors found that there were not appropriate training measures in place to assist staff in supporting residents with behaviour that challenges. At the time of the inspection, only few of the staff working in Monsignor Young unit, which is the dementia specific unit, had training in behaviours that challenge. The person in charge informed inspectors that he had secured training in non- violent crisis intervention for all staff working in this unit over the coming months. This is actioned under training in outcome 18.

In addition the person in charge informed inspectors that eight staff members were booked to attend training in Dementia care, commencing on the 9th of April for eight staff working in the unit.

An action from the previous inspection found that chemical restraint was not in line with national policy. Since the last inspection, inspectors found that a record of the assessment by the nurse and any adverse events resulting from the chemical restraint including details of the records of each chemical restraint was recorded.

An inspector reviewed the system in place for the management of residents' finances. There was a policy in place that provided adequate guidance and appropriate records were maintained.

Judgment:

Non Compliant - Moderate

***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 reviewed the number of falls in the centre. A falls audit had been completed by the person in charge. The audit showed that there were 110 falls in the centre in 2014, 47 falls in the first six months of the year and 63 in the last six months. During the inspection, the inspectors followed up on a number of notifications of serious injuries to residents' following a number of falls in the centre. One resident had fallen seven times in a four month period and another resident had fallen six times in a six month period. One of these resident's received a fractured hip; the other person received

fractured vertebrae following a fall out of bed. A request for further information was sent to the Person in Charge requesting information on falls management practices and staffing allocation, this information was provided to the Authority as requested.

As part of this inspection the inspectors followed up on a number of these residents that had repeated falls and the residents that were identified as a high falls risk in the centre. While the residents with previous histories of falls had up to date falls risk assessments completed and post fall assessments and care plans in place. Inspectors found that a staffing needs analysis was required to ensure that appropriate supervision of residents at high risk of falls was completed. This is actioned under Outcome 18 Staffing.

Inspectors found that in all of the resident's files viewed a moving and handling assessment was completed, which was documented in resident's files. Staff had completed training in safe moving and handling and further training was on-going. There were a number of manual hoists available for safe moving and handling; however, storage of the manual hoists continued to be an issue in some areas due to lack of storage space. This is actioned under premises in outcome 12

A Health and Safety policy was reviewed by inspectors. The safety policy was found to be comprehensive and centre specific dealing with a range of issues including manual handling, behaviour challenging and infection control. However, it requires review as it had not been reviewed since 2012. This has been actioned under documentation in outcome 5. There was a risk register in place. This register was reviewed every three months and included environmental risks within the centre.

In 2014 a certificate of fire compliance was sent into the Health Information and Quality Authority by a suitable qualified person to confirm that all the requirements under the building regulations were in compliance with this centre. Fire extinguishers and emergency lighting checks were documented. A recent fire drill had been completed in the centre that was recorded in the fire records. Fire exits were observed to be unobstructed by inspectors. An emergency plan was on display throughout the centre. However, they were unclear as they did not clearly show the emergency evacuation plan. In addition; not all residents had personal evacuations plans (PEEPS) and this required review. Furthermore, the required fire safety training for staff had not been completed. Six nurses and 14 HCA'S did not have up to date fire training.

In Dr. Mc Garry unit: the fire, doors were not connected to the fire alarm system and there was no magnetic door release them to ensure they closed and compartmentalised in the event of a fire. In addition; there were gaps in-between some fire doors that had existed since previous inspection, despite assurances that they would be addressed.

There was an infection control policy in place and staff were aware of the precautionary measures required to prevent healthcare related infections. The Authority was notified of an influenza outbreak in the centre in February 2015 and the management of the outbreak was implemented as per the organisational policy and procedures. However, managing outbreaks in the centre was difficult due to the lack of hand washing facilities. For example; in most of the multi-occupancy rooms, there was no hand washing facilities available in these areas for staff or residents to wash their hands.

The installation of hand washing facilities was an agreed action plan response to a previous inspection that had not been implemented. Inspectors reviewed the hand hygiene training records of all staff and although some staff had training in 2014 not all staff had up to date training.

Inspectors also reviewed the restraints used for residents living in this centre. 70% of the residents were using bed rails. Inspectors found that restraint assessments were documented for residents who used bed rails/restraint and these were included in the centres restraint register.

Storage space remains limited for assistive devices, specialised/modified chairs and clinical equipment. Clinical equipment such as, oxygen cylinders were stored inappropriately along corridors and in bathrooms. This created a health and safety risk in the centre. This is actioned under outcome 12.

A smoking room were available for residents to use, however the organisation was introducing a new policy of no smoking in the premises and inspectors read notices displayed around the premises notifying the residents and visitors of the new restrictions.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

There were written operation policies and procedures relating to the ordering, prescribing, storing and administration of medicines to residents. An inspector observed one of the nursing staff during the medication round and found that medication was administered in accordance with the policy and An Bord Altranais agus Cnaimhseachais na hEireann (Nursing and Midwifery Board of Ireland) guidelines. Medication and Prescription sheets included the appropriate information such as the resident's name and address, any allergies, and a photo of the resident and the General Practitioner's signature. Maximum does of PRN (as required medication) was recorded in the medication charts reviewed.

Inspectors reviewed the actions from the last inspection and found that medications that were required to be crushed were now recorded for each medication on the prescription

sheet. In addition; medication administration records also contained the dose or route to be administered. Medication administration sheets were completed at the correct time when a medication was due to be administered and these had all been reviewed since the last inspection.

Storage of medications were not adequately addressed since the last inspection. For example; medications were not stored in a locked press in the clinic room and although there was a keypad on the main clinic room door, there was a risk that unauthorised personnel could access the medications. Oxygen cylinders were also found stored in the residents' bathrooms, corridors, and general areas throughout the hospital. They were left unsecured and unsupervised, and this created a risk to residents. Inspectors brought this to the attention of the person in charge immediately. Furthermore, storage facilities for the medicine trolleys had not been adequately addressed since the last inspection. In Dr. Mc Garry's ward, the medication trolley was secured to a wall in the six bedroom ward, and this was an inappropriate place to store medications.

Inspectors were told that there was a new more robust system in place for ordering, reviewing and monitoring stock controls and safe medication management practices. However, Inspectors found that the processes for the managing controlled drugs were incomplete and required review to ensure compliance with current guidelines and legislation. Inspectors found there were inconsistencies in the recording of the administration of control medication to residents in the control drugs register. This was a result of poor stock control practices as controlled medication had to be borrowed from another unit due to stock shortages. This practice was not in keeping with the organisations medication management policy and required review.

Medicines are provided by the Pharmacy in Sligo General Hospital, and inspectors found that residents did not have a choice of a pharmacist, should they wish to choose their own pharmacist.

Senior pharmacists from Sligo General Hospital supervise the pharmacy technicians that visit St. Patrick's hospital twice a week to generate stock requirements and review out of date stock. This service had been increased to twice weekly following an action from the last inspection. While inspectors found that stock controls were monitored more regularly, there continued to be excessive medication stock in some of the medication stock rooms.

Judgment:

Non Compliant - Moderate

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:

The inspector reviewed records of accidents and incidents that had occurred in the designated centre. On review of these incidents and cross referencing with notifications submitted the inspector found that the centre adheres to the legislative requirement to submit relevant notifications 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):

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

Findings:

On the day of inspection the dependency levels of the residents in the centre were assessed as, 48 maximum, 15 high 14 medium and five low dependencies. Residents had a mixture of age-related medical conditions and cognitive impairment.

The Inspectors reviewed the actions from the previous inspection. Previously inspectors found that personal care such as showers/baths were not frequently offered to residents in accordance with their care plan. On this inspection; Inspectors found a similar practice where residents were offered a shower once every two weeks. Inspectors found that on occasions when residents had declined the offer of a bath/shower, or if there was no staff available on that particular day, residents had not received a shower/bath for a month or more.

Inspectors noted that at least 22 residents in the centre were permanently bed dependent, in Sheemore ward that 10 of the 22 residents were in bed all day, similar practices were observed in Rivermeade unit. Inspectors were told that some residents were too frail to get out of bed and other residents did not have the appropriate seating equipment to ensure that they could sit out comfortably in a suitable chair during the day. This lack of equipment had resulted in some residents being bed bound. Also, some of these residents did not have up to date mobility assessments or equipment

assessments required to identify their seating needs. Inspectors found that the lack of assessments and equipment had negatively impacted on residents ability to choose to get out of bed and sit in a chair, if they so wished and this needed to be addressed.

Inspectors reviewed the actions from the last monitoring inspection and found that the Dietician and Speech and Language Therapist (SALT) assessments, diagnosis and recommendations were now recorded in the resident's food and nutritional care plans. Residents nutritional or swallowing difficulties were risk rated and were also recorded in the residents care plans in accordance with the policies and procedures and good practice guidelines. In addition; residents' up to date weights and BMI's were recorded. Inspectors noted a significant improvement since the last inspection in referrals to members of the multi-disciplinary teams and regular assessments in monitoring residents' nutritional needs. Resident's weights were being monitored, and there was good evidence that regular nutritional review. For example, one resident had a weigh loss of 3kg and had been referred to the G.P. the Dietician and the Speech and Language Therapist for assessment. A nutritional assessment had been completed and a fluid balance chart and supplements were being administered to the resident following the assessment. Meals were being strictly supervised, and various food options were being offered to encourage the resident to eat and drink.

Inspectors found that residents' medical care needs were achieved through timely access to the General Practitioners. The hospital had access to a large General Practitioners (G.P's) practice of five GP's in conjunction with the NOWDOC out of hour's service. Each of the GP's. were on call for a month at a time to the centre. Staff nurses told inspectors that the doctors were all familiar with the residents and undertook continual assessments of the residents: This occurred both in an acute phase of the resident's illness as well as reviewing the resident's general well-being on a long term basis. Each resident had been assessed immediately before or on admission to identify his/her individual needs and choices.

There was a wide range of allied health professionals such as; Dieticians, Speech and Language therapists, Dentists, Ophthalmology and Podiatry available. Evidence of these reviews was viewed by an inspector in the residents' files. Residents malnutrition universal screening tool scores had been reassessed in the care plans inspected.

There were 25 residents with wounds of a grade 2 or more treated in the centre in the past year. The Health Information and Quality Authority had been notified as required under the Health Act 2007. Inspectors found that nine of these residents were admitted with pressure wounds received while admitted in an acute hospitals. Although the treatment of the pressure wounds were in line with evidence based practice, inspectors found that the preventative measures required review and in particular for long stay residents that were immobile and bed bound.

Each resident has a personalised care plan prepared within 48 hours of their admission that details their needs and choices. Inspectors found that following the last inspection a new care planning system was implemented in two of the units and resident's care plans were in the process of being implemented onto the new care plan system. However, inspectors found that they were very generic and lacked space on the care plan sheet to document individualised person centred care.

Nurses told inspectors that they were finding this new system very time-consuming and on occasions it was taking their time away from the residents. These findings were discussed with the person in charge on the day of inspection and he stated that training for the first twenty-five nurses was being provided on the 25th of June on the care planning to ensure the new system would be implemented correctly.

The care and support provided generally reflected the nature and extent of residents' dependency needs. In addition; since the last inspection, some improvements had been made, for example; in two of the units staffing levels had been increased so that adequate staffing was available at the high support need times.

Judgment:

Non Compliant - Major

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 centre was built in 1841 and has been used as a care facility since 1928 and extended in the 1970's and 1998. It is a two-storey building and in addition to the residential centre the building accommodates the day hospital, outpatient departments and an attic conversion which are not used by residents of the centre. The age and layout of the building presented significant challenges to supporting resident's needs. Inspectors found that the physical environment continued not to comply with the specifications of the National Quality Standards for Residential Care Settings for Older People in Ireland. The premise consisted mainly of ward-type accommodation and was not fit for the purpose of achieving the aims and objectives as set out in the statement of purpose. The premises did not meet the requirements of regulations.

The reception area, which has a coffee shop and seating area, is located in the entrance foyer, visitor's toilets, a conference room and administration offices. The main kitchen and chapel located are accessed through the staff dining room. The external grounds are available to all residents including those using wheelchairs via ramps, which provide access to the surrounding paths and a lovely open and enclosed wheelchair user sensory garden. There is ample car parking space for visitors.

The residential accommodation referred to as wards or units, consists of the following;

Ground floor - Sheemore Ward accommodates 22 female residents; Dr McGarry Ward accommodates 20 male residents, and Monsignor Young Unit accommodates 18 male and female residents with dementia-specific needs. First floor: Rivermeade unit-accommodating up to 25 maximum/high dependency residents.

Bedroom Accommodation

In the main, residents were accommodated in multi-occupancy bedrooms configured in three and four, five and six bedded rooms. There were fourteen single rooms available in the centre; seven of these are located in the Monsignor Young Unit.

Residents' accommodation in each unit/ward is outlined below:

Sheemore Unit:

This unit accommodated up to 22 maximum/high dependency female residents. Access to this ward is through the combined Day sitting/dining room area that was located immediately on entering the ward. Bedroom accommodation was made up of five four-bedded areas and two single bedrooms. There were two wheelchair accessible shower rooms and toilets. There were also three toilets cubicles for independent residents/staff located towards the end of the ward. Auxiliary rooms include a staff toilet, housekeeping store, and sluice room.

Dr McGarry Ward

On entering this unit: There was one six bedded area and a smoking room located off the units corridor, access to the main area of the unit was further down a long corridor which contains a combined Day room and dining room. Following on from these rooms there were three four-bedded areas and two single rooms. There were one shower room and two cubicle type toilets suitable for independent residents located opposite the entrance to the ward. There was also one bathroom and three toilet areas located outside of the ward area on another corridor to facilitate the residents sleeping in the six bedded ward. Other rooms in this unit included medication store room, linen, sluice, a quiet room used by visitors and a kitchenette.

Areas to be address were:

- There were no hand washing facilities in the multi-occupancy bedroom areas.
- There was no door to the entrance of the toilets; a shower curtain was used to screen the area from the corridor for privacy.
- Toilet facilities for the six bedded area were located off the ward and across the corridor from the bedroom areas.
- A large water storage tank was installed high over the shower and was exposed in the shower room.
- The radiator in the shower room was hot, and there was a risk residents could touch the radiator and get burned.
- Clinical equipment was stored in bathroom areas e.g. Oxygen cylinders and this created a risk of unauthorised personnel gaining access or tampering with the cylinders.
- There were inadequate communal and bedroom facilities.
- There was inadequate storage of the drug trolley in the six bedroom area.

Monsignor Young Unit

The Unit is developed around an internal courtyard. Communal space includes a day room/activity room, spiritual area, reception area, dining room and adjoining kitchen. Bedroom accommodation consists of seven single bedrooms, one four-bedded room with en-suite shower, toilet and wash-hand basin and two two bedded rooms with en-suite toilet and wash-hand basin and one three bedroom ward. There are two independent toilets, a male toilet/shower and a female toilet/shower and one bathroom and one wheelchair accessible toilet. A variety of other rooms was available such as designated smoking room, visitors' room and bathroom, linen, cleaning/housekeeping, sluicing facilities and staff room. Some of the walls were painted in colours to aid residents with dementia to locate their bedroom areas.

Rivermeade Unit is located on the First floor;

A main stairway from reception leads to the entrance of Rivermeade Unit on the first floor. The male and female accommodation is separated to the left and right of the entrance area where the, nurse's office and kitchenette and passenger lift are centrally located. This 25 bedded ward was divided into two areas, a Male Ward for 12 residents and a Female Ward for up to 13 residents. Generally respite residents were accommodated on the first floor.

Male Ward Area:

Bedroom accommodation was located directly inside the entrance to the ward. Staff residents and visitors have to walk through the bedroom area to access communal areas. There is one six bedded area, and one five bedded area. There were two single bedrooms (one was a inner bedroom). The privacy and dignity of residents were not promoted due to the dormitory style bedrooms. Furthermore there were inadequate toilets/showering facilities for personal care. There were two communal sitting areas at the end of the ward, one of which was also used for dining. Other facilities include a linen, smoking, store and visitors room.

Areas to be address were:

- There was only one shower and toilet facility for the whole ward.
- There were two separate toilets and a urinal for independently mobile residents, located near the day/dining room area. However, these toilets were not wheelchair accessible.
- Inspectors found there was a strong unpleasant smell from the toilet area.
- There was a radiator that was excessively hot to touch and required to be covered.
- Water temperature was excessively hot in the sinks at 49 degrees.
- Dining and sitting rooms space was combined For example; there were only three dining room tables and five chairs available for the twelve residents. Inspectors found and many residents had their meals in/at their bedside. There was no evidence that this was personal choice, or due to a lack of dining/sitting room facilities.
- There were hoists and wheelchairs stored in the dining room and sitting room areas. Three wheelchairs were stored in the sitting room area and a hoist was stored in the dining room area.

Female Unit: – the layout of the female accommodation is similar to the male side. Bedroom accommodation is located directly inside the entrance to the ward. Staff residents and visitors have to walk through the bedroom area to access communal areas. The bedroom accommodation comprises of one five bedded areas with three

beds on one side of the ward and two beds on the other side and the walkway was directly through the middle of the ward. There were also two single bedroom areas, one was an inner bedroom the other was open plan design.

The privacy and dignity of residents were not promoted due to the dormitory style bedrooms. Furthermore there were inadequate toilets/showering facilities for personal care. There were two communal sitting areas at the end of the ward, one of which was also used for dining. Other facilities include a linen, smoking, store and visitors room.

Areas to be address were:

- There was only one bathroom containing a wheelchair accessible shower, wash-hand basin facility and three toilets for independently mobile residents. There were limited sitting and dining room facilities.
- The partitions separating the multi-occupancy rooms did not reach the ceilings and the noise and odours in the ward impacted on the all of the residents living in the unit.
- All residents in Rivermeade Unit shared their allocated personal space with up to four/five other residents.
- Staff members and visitors had to pass through the middle of multi-occupancy bedrooms areas to access the communal areas of the unit.
- There was limited space that resulted in an inability to facilitate individual items such as double wardrobes and reclining chairs at each bed area.
- Furniture was not kept in a good state of repair. A damaged wardrobe was stored in the visitor's room and was missing half a door.
- Due to the lack of space in the multi-occupancy rooms, residents that required the support of assistive devices such as a hoist was impacting on the rights and dignity of their room mates. Beds and tables in shared areas required altering to facilitate the moving and handling procedure.
- Sitting, recreational and dining space was limited and inadequate for the number of residents and located at the opposite of the ward end to the entrance of the unit.
- There were an insufficient number of appropriately located toilets, baths and showers, including facilities designed to provide access for residents in wheelchairs.
- The only privacy for residents living in this long term care facility was curtains around their bed and this did not prevent residents from the noise our unpleasant odours in and around their personal space.

Judgment:

Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there was an effective appeals procedure. There were policies and procedures for the management of complaints. The complaints process is user-friendly, accessible to all residents and displayed in a prominent place. Residents were aware of the complaints process and are also supported to make complaints. There was a nominated person to deal with all complaints, and all complaints were fully investigated. There is appeals process that is fair and objective. Residents were made aware promptly of the outcome of any complaint.

The inspector discussed the procedure for managing verbal complaints and the manager stated that they were dealt with immediately. However, there was no record kept of verbal complaints or the management of same. The person in charge told inspectors that he would implement a complaints log in each of the units following this inspection and this action has been confirmed to the inspector since the inspection.

Judgment:

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):

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

Findings:

There were written operational policies and protocols in place for end-of-life care which staff were familiar. Residents' had access to specialist palliative care services when required. The end-of-life policy recorded the multi- denominational spiritual needs of residents and the policy provided guidance to staff on the appropriate procedures to follow when caring for the residents from other religious denominations. Family and friends were facilitated to be with the resident when they are dying. All religious and cultural practices were facilitated. Residents viewed Mass daily via video link from the on-site chapel. The priest also visited residents when near end-of-life, and residents were offered and received the sacrament of the sick and dying.

Inspectors reviewed the actions from the previous inspection and found that the actions had not been achieved. Residents near end of life continued to be cared for in multi-occupancy bedrooms, which did not provide them or their families with privacy or

dignity near end of life. The premise was completely inadequate to meet the needs of residents receiving end-of-life care. This was due to the poor environmental conditions in the centre. Inspectors found that there was limited space around beds, and a lack of privacy and dignity for the residents due to the multi-occupancy rooms and open plan design. Inspectors observed that the only privacy provided to resident's near end of life was a light curtain around their bed and this did not exclude the noise and odours from others around the ward.

In addition; visitors and staff had full view of all residents, including residents near end of life and their family members, as they walked through resident's wards. In most wards residents that shared multi occupancy bedrooms were offered a single room (if available) when near end of life; however, this option was not always available due to the lack of single rooms in the long stay wards in the centre. The non-compliance in Premise is actioned under outcome 12

Relatives were facilitated to stay with their family members when they were near end of life; In some units there was a visitor's room that included reclining chairs, a television, some reading material and facilities to make tea and coffee. However, in the Rivermeade unit, the visitor's room was unwelcoming and there were inadequate tea/coffee making facilities. An old wardrobe was stored in this room and half the door was missing and it was very unsightly.

Although staff were aware of the procedures to follow at end of life for residents living in the centre, all residents did not have an end of life care plan in place. Some residents files reviewed had no end of life care plans completed. The person in charge told inspectors that documentation in relation to end-of-life care for residents was on-going and some residents had completed assessments, care plans and nursing evaluations that were in date and regularly reviewed. The inspector noted that meetings were held with the resident, their family members and their General Practitioner's, (GPs) to discuss end of life care with the resident and these resident's assessments reflected the resident's death and dying preferences/wishes.

Arrangements for the removal of remains occurred in consultation with deceased resident's family. There was an onsite mortuary and local funeral parlour available for non-family members to visit and pay their last respects.

Judgment:

Substantially 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):

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

Findings:

Inspectors viewed the actions completed following the last thematic inspection. A significant amount of progress had been made in relation to auditing resident's opinions and offering them food choices at their meal times. For example; a meal time questionnaire was given to all residents and 58% participated in the questionnaire. Over all the comments were positive, however the questionnaires captured valuable personal preferences which highlighted the need to ask individuals regularly about their food likes and dislikes. Inspectors found that this information had been documented into the residents care plans, and it was also communicated to the catering staff on receipt of this information. There was a food menu choice of two main courses each day. The menu has since been revised and there was now a hot meal option each evening for the residents. Residents on pureed diets had their choices of meals increase since the last inspection and all meals are labelled. Alternatives could be arranged for residents who wanted something else to eat.

Residents who spoke with the inspector were very satisfied with the standard of catering and confirmed that they were offered more choices at mealtimes now. In addition staff roster changes have improved the availability of staff to support residents with their meals. In the Sheemore unit inspectors saw at dinner time six staff sitting beside residents assisting them to eat their dinner. Staff were aware of residents' special dietary requirements and were knowledgeable of how these meals should be served to meet the resident's individual needs. Some residents required special diets or a modified consistency diet, and this was provided for them. The inspectors noted that they had the same choices as other residents, and the food was suitably presented. The inspector noted that residents were offered a variety of snacks throughout the day, including drinks, soup, fruit and baked goods

Evening meal times have been extended up to 5pm and this had improved the quality of service being provided to residents living in this centre. Inspectors viewed the contents of the fridge in Sheemore unit and it contained adequate choice of food to offer a resident something to eat should they wish to eat outside the normal meal times.

Inspectors were shown a Food and Nutritional Audit that had also been completed in Sheemore ward and a record of resident's weight, nutritional assessment score, a record if the resident was referred to the Dietician and if a Food Diary was maintained was all recorded about each resident in the unit. The person in charge had also organised for staff to attend 3 day nutritional assessment training in April 2015 to help support this process.

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):

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

Findings:

Inspectors observed residents being treated with dignity and respect and noted friendships and familiarity between residents. Staff were seen providing individualised supports to residents. Residents' civil and religious rights were respected. Residents attended or listened to the daily morning mass in the hospital church if they so wish.

Although there were some activity groups held during the week such as music therapy, and cookery on the dementia specific unit. There were limited social activities organised for residents that were unit bound. There was no activities coordinator available to organise activities for residents. There were inadequate facilities for occupation and recreation including the opportunity to have personal conversations in private. For example; residents had limited private space to hold a conversation in private on the telephone.

There was some evidence that residents were consulted about how the centre is planned and run. However, residents that had high dependency needs and cognitive impairment were unable to communicate their wishes either verbally or in writing and many were dependent on staff or family members to advocate on their behalf. This had not been adequately addressed.

The facilities where residents can meet with their visitors were often unsuitable as previously outlined under outcome 12 and 14. Visiting times are restricted visiting at four times each day, at each of the three meal times and in the evening after 9.30pm. Exceptions were made for relatives of residents near end of life. Routines and practices and facilities do not maximize each resident's wishes. Practice was led by the routine and resources of the service, not the residents' wishes.

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:

Personal wardrobes and lockers had been provided but all residents did not have adequate personal storage facilities. A list of resident's personal items was kept in the residents file. Each residents' personal clothing was stored in their wardrobes at their bedside and all clothes were labelled. Residents that had additional clothes that did not fit in the residents wardrobes were stored in containers in communal linen rooms on Rivermeade Unit, Dr McGarry and Sheemore Wards. Lockable storage was available to residents. The person in charge did arrange for residents of the centre to have their laundry attended to as required. Residents and relatives expressed satisfaction with the laundry service provided.

There was a policy in place for residents' property; that was inclusive of the process for logging and recording residents' personal possessions in line with the Regulations.

Judgment:

Substantially 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):

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

Findings:

Inspectors found that there were not sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents. Staffing levels have not taken into account the statement of purpose and size and poor layout and facilities in the premises. On the day of inspection, there were eighty two residents living in the centre.

There were 42 male residents and 40 female residents. The inspector found that 77% of the resident's dependency levels in this centre were maximum/high dependency residents. A significant number of residents in this centre were bedbound and required additional staffing to meet their needs. A staffing needs analysis was required to assess whether the current staffing ratios were impacting on residents ability to actively engage in meaningful activities of daily living.

There was some evidence that staffing levels during the day had improved since the last inspection through changes in staff rosters and additional staff were being recruited for the centre. However, inspectors found that the allocation of staffing, particularly in the evening and at night, was inadequate to meet the needs of all residents. Inspectors found that additional staffing was required to ensure that the health and social needs for all of the residents in this centre would be met. This was also the finding following all previous inspections and has not been adequately addressed to-date.

An inspector viewed the returned completed satisfaction questionnaires to the Authority by the resident's families/relative and all of the returned questionnaires of the residents/family members commented that there was inadequate staffing in the centre. They stated "nurses have little time for anything apart from basic nursing care, because they are so short staffed" "Staff are ran off their feet, should be more staff " I feel the staff are run off their feet yet they still try to give of their time to visitors"

An inspector reviewed the staff rosters for each of the four units and found that it reflected the staff on duty on the day of inspection. However; Inspectors reviewed the staff numbers and skill mix in two of the units and there were inconsistencies found on the staffing levels on duty in the mornings on different days of the week. In Sheemore unit: there was only one nurse and one care staff on duty after 10pm at night to care for 22 maximum / high dependent residents. 19 of these residents were assessed as having maximum/ high dependency needs.

A review of the staffing levels was required based on the dependency levels on the ward. The morning and evening staffing rosters also require review, as inspectors found that early morning and evening staffing levels are inadequate to meet the resident's needs. For example; in the morning there were staggered starting times and in the evenings there was only one nurse and two care assistants from 5pm until 20.30 pm to care for the 22 high dependency residents. Taking into account staff evening breaks, staff numbers on the ward were reduced further, resulting in reduced staff support for residents in the evening.

The inspector reviewed the records of recruitment and they contained all of the documents required for Schedule 2 in the regulations. There was a recruitment policy and an induction programme was in place and it there was evidence to show the policy and procedures were being implemented from reviewing the staff files.

There was a need to develop a comprehensive training and education schedule which demonstrated a programme of commitment to on-going improvement and staff training in this centre. In particular training in the protection of vulnerable adults, managing behaviours that challenge, fire, wound care management, infection control.

Judgment:

Non Compliant - Major

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:

Thelma O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St Patrick's Community Hospital
Centre ID:	OSV-0000661
Date of inspection:	24/03/2015 and 25/03/2015
Date of response:	22/06/2015

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The annual review of the quality and safety of care delivered to residents was not available on the day of inspection. The person in charge stated that the audit was complete but there was no evidence of actions being taken as a response to the findings of the annual review.

Action Required:

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

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:

A copy of the Annual review on quality and safety was forwarded to the authority and the person in charge will continue to review all identified actions in relation to the audit

Proposed Timescale: 31/10/2015

Theme:

Governance, Leadership and Management

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

Premises issues need to be addressed as a matter of priority as they are impacting negatively on many of the outcome inspected.

Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:

It is very important to the staff of St Patrick's that residents, their families and friends are happy with the care provided within the hospital and that the respect, dignity and choice of the residents is maintained. St Patrick's Hospital is a very old building and would find it difficult to meet modern day environmental standards. Therefore we can confirm that a Development Control Plan for a new Community Hospital on an already identified site within Leitrim have been put forward to the HSE National Capital office for approval and these plans are presently being considered. Copies of the plans were presented to the authority with costing and time frames for implementation

Proposed Timescale: October 2015 to commence pending capital funding

Proposed Timescale: 31/10/2015

Theme:

Governance, Leadership and Management

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

Trust in care investigations were not completed in an appropriate timeframe.

Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

The provider has commissioned the investigation under the Trust in Care Policy and has selected investigators to carry out the required work.

Proposed Timescale: 31/07/2015

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

Each resident has a contract but it does not clearly set out the additional fees being charged.

Action Required:

Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

Please state the actions you have taken or are planning to take:

The contract of care will now outline the charges for hairdressing that the residents will be required to pay.

Proposed Timescale: 19/06/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Schedule 5 policies and procedures were not reviewed within the policies recommended review dates. For example; Risk management, in one of the wards was not reviewed since 2012 and the policy on the protection of vulnerable adults had not been reviewed within the appropriate time frame and expired in June 2014.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:

The person in charge will review all of the policies outlined in the report and update these in a timely manner taking into account both national and regional policies that are presented. This process will involve all stakeholders and is expected to be completed before the end of 2015

Proposed Timescale: 31/05/2015

Outcome 07: Safeguarding and Safety**Theme:**

Safe care and support

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

Staff had no up to date training on how to protect vulnerable adults.

Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:

All staff in St Patricks Community Hospital has received training from the Health Service Executive in "Recognising and Responding to Elder Abuse" up to 2013.

A new educational programme in relation to the latest HSE policy "Protecting Vulnerable Adults" is currently being devised and will be delivered to all staff. Elements in both training course share similar themes.

Current sessions to staff in 2015 are refreshing knowledge and information on the present processes.

Staff within the hospital are aware of whom to report abusive situations too and would have the confidence to do so if required

Proposed Timescale: 01/07/2015

Outcome 08: Health and Safety and Risk Management**Theme:**

Safe care and support

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

Clinical equipment was stored inappropriately along corridors and in bathrooms for example; oxygen cylinders and hoists in communal areas.

Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:

A review of the location of oxygen cylinders has been undertaken and the safe appropriate storage of these cylinders in public areas particularly for emergency situations has been done.

Environmental factors regarding the premises has meant that the issue of storage continues to be an issue prior to the movement to another location

Proposed Timescale: 31/07/2015**Theme:**

Safe care and support

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

The annual falls audit showed that there were 110 incidences of residents falling in the centre in 2014. Appropriate prevention actions were not taken to protect residents with mobility problems and to keep them safe while mobilising.

Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:

The Person in charge will continue to monitor and audit all falls in the centre and provide context to the situations in which residents fall. Balancing risk and independence and encouragement around mobilisation continues to be carried out by staff in all units. Residents with a previous history of falls or a high falls risk, have up to date falls risk assessments and care plans in place. In addition they have post falls assessments in place. Residents whose primary diagnosis is predominately Dementia experience the highest number of falls and the supervision that is required in these situations is constantly being reviewed. The Person in charge has worked with staff to address training around the restraint free environment and also to provide equipment and resources to be available to prevent injury to residents and allow independence. 5 Low/Low beds were provided in 2015 in the Monsignor Young Unit.

Proposed Timescale: 30/06/2015**Theme:**

Safe care and support

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

There were inadequate hand washing facilities for residents and staff. In addition; all staff had not received training in prevention of infections.

Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:

St Patricks Community Hospital has two hand hygiene coordinators and a third to be assessed for competencies in the next two months. A plan of education for the third and fourth quarter of 2015 has been implemented –updates for the five moments of hand hygiene will be delivered to staff .Those staff who have completed the online – Hand Hygiene training will be exempt from the formal training.

Therefore planned training includes;

Rivermead – All staff completed by end of July 2015

Dr McGarry –All staff completed by the end of August 2015

Sheemore- All staff completed by the end of August 2015

Monsignor Young Unit- All staff completed by the end of August 2015

For all other staff who have not received training in other areas for e.g. catering, household, allied health professionals within the past two years will be addressed in quarter 4 of 2015

The provision of hand washing facilities will be part of the new development control plan and in the meantime there will be the provision of alcohol gel dispensers at the residents bed and adjacent to their living area.

Proposed Timescale: 31/12/2015

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The emergency evacuation plans displayed in the centre did not clearly show the layout for evacuating the building and required review.

Action Required:

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

Please state the actions you have taken or are planning to take:

Evacuation Plans are to be updated with the relevant stakeholders

Fire/Health and Safety Officer ,Fire trainer and the estates department

Proposed Timescale: 30/09/2015

Theme:

Safe care and support

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

Not all residents had personal evacuations plans (PEEPS) and this required review.

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:

In conjunction with the fire officer and approved trainers the person in charge will ensure that all residents in St Patricks Community have a personalised (PEEP) evacuation plan. These will be stored in their care plans and copies will be kept by the fire board in main reception and will be available for the for the Manager on duty in the event of a fire occurring

Proposed Timescale: 31/08/2015

Theme:

Safe care and support

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

The annual fire safety training for staff had not been completed. Six nurses and 14 HCA'S did not have up to date fire training.

Action Required:

Under Regulation 28(1)(d) you are required to: 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 fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:

A review of training records has been undertaken. Those staff requiring an update will attend at the next available session on the 9th July 2015.

This will involve 1 nurse and 2 Health care assistants(the remaining staff requiring update are on extended absence and unable to attend at present)

We continue to deliver a programme of training that addresses the theory, practical and management of fire prevention and evacuation.

Proposed Timescale: 09/07/2015

Outcome 09: Medication Management

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There were inconsistencies in the recording of the administration of controlled medication to residents in the controlled drugs register. A staff nurse had borrowed controlled medications from another unit; however, there was no record of nurses receiving the medication or from which unit the medication was borrowed. This practice was not in keeping with the organisations medication management policy.

Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:

The process of utilising controlled medication from a different unit has been practiced safely and all checks and balances in the relevant documents were correct. No medication was missing or misappropriated.

However the person in charge will review this process with the relevant stakeholders including the pharmacy department and staff to review this practice and amend the policy accordingly.

Proposed Timescale: 31/07/2015

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Medications were not stored in a locked press in the clinic room and although there was a keypad on the main clinic room door, there was a risk of unauthorised personnel could access the medications. There continued to be excessive medication stock provided to the hospital.

In Dr. Mc Garry's ward, the medication trolley was secured to a wall in the six bedroom ward.

Oxygen cylinders were also found stored in the residents' bathrooms, corridors, and general areas throughout the hospital left unsecured and unsupervised.

Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:

1) Medications were not stored in a locked press in the clinic room and although there was a keypad on the main clinic room door, there was a risk of unauthorised personnel could access the medications. There continued to be excessive medication stock provided to the hospital.

Response

The person in charge will review each of the four clinic rooms and discuss with the relevant stakeholders including pharmacy, and estates to provide safe storage of medication in a locked room. The keys to the clinic rooms are kept on the person by a registered nurse which complies with the guidelines of the Nursing and Midwifery Board of Ireland.

2) In Dr. Mc Garry's ward, the medication trolley was secured to a wall in the six bedroom ward.

Response:

The person in charge in discussion with the Clinical Nurse Managers will review the storage of the drugs trolley

3) Oxygen cylinders were also found stored in the residents' bathrooms, corridors, and general areas throughout the hospital left unsecured and unsupervised.

Response

A review of the location of the oxygen cylinders has been undertaken and the safe appropriate storage of these cylinders in public areas particularly for emergency situations has been carried out.

Proposed Timescale: 30/09/2015

Theme:

Safe care and support

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

Residents did not have the opportunity to choose their pharmacist as the medication was provided from a central pharmacy in Sligo.

Action Required:

Under Regulation 29(1) you are required to: Make available to the resident a pharmacist of the resident's choice or who is acceptable to the resident.

Please state the actions you have taken or are planning to take:

We continue to provide a safe comprehensive pharmacy service to the residents. The PIC will undertake an audit into the present service and ascertain the views of the residents, and also taking into account the complexities, governance and safety issues involved with medication management from a number of different pharmacies. This practice would introduce a risk not present in the current pharmacy system within the hospital.

Proposed Timescale: 31/07/2015

Outcome 11: Health and Social Care Needs**Theme:**

Effective care and support

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

Residents were not provided with regular opportunities to access showers/ bathing facilities as per care plans.

Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:

The person in charge continues to ensure that the quality and safety of the residents is monitored and that they have the opportunity to receive a regular shower in a safe and proper location. Personal hygiene continues to be attended to on a daily basis. Further recruitment of staff is currently with the National Recruitment Service (NRS) and should assist with the provision of this essential care for the residents.

Proposed Timescale: 31/07/2015

Theme:

Effective care and support

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

22 residents were bed dependent and on review of some of their nursing notes, some residents did not have up to date mobility reviews or equipment assessments.

Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:

The person in charge will with all relevant stakeholders including nursing and allied health professionals will review residents care plans to ensure that mobility reviews are documented. The Occupational Therapists when requested assess for the equipment that enhances the resident's ability to sit out of bed comfortably. Significant numbers of special seating have been purchased in 2014/2015 to enable residents with specific needs to sit out and be cared for appropriately.

Proposed Timescale: Ongoing

Proposed Timescale:

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There were a significant number of falls in the centre and residents were not adequately protected against falls in this centre.

Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:

The Person in charge will continue to monitor and audit all falls in the centre and provide context to the situations in which they fall. Balancing risk and independence and encouragement around mobilisation continue to be the work that the staffs undertake. Residents with previous history of falls or a high falls risks have up to date falls risk assessments and care plans in place. In addition they have post falls assessments in place. Residents whose primary diagnosis is predominately Dementia experience the highest number of falls and also the supervision that is required in these situations is constantly being reviewed. The Person in charge has worked with staff to address training around the restraint free environment and also to provide equipment and resources to be available to prevent injury to residents and allow independence. 5 Low/Low beds provided in 2015 in the Monsignor Young Unit.

Proposed Timescale: 30/06/2015

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The prevention of pressure wounds required review and particularly for residents that were immobile and bed bound.

Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:

The person in charge is satisfied that the prevention and treatment of tissue viability issues is being carried out appropriately. There are agreed referral processes including local tissue viability nurses and also access to regional tissue viability expert knowledge. Treatment issues are utilising evidence based practice. We continue to review all preventative measures including assessment and treatment and also continue to ensure that the provision of equipment and resources are available for the resident.

Proposed Timescale: 31/07/2015

Outcome 12: Safe and Suitable Premises**Theme:**

Effective care and support

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

The physical premise was inadequate and did not meet the Regulations or the National Standard's for older people living in Ireland. Resident's privacy, dignity, personal hygiene facilities and personal storage facilities were all negatively impacted due to the premises.

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:

It is very important to the staff that residents, their families and friends are happy with the care provided within the hospital and that the respect dignity and choice of the residents is maintained. We accept that St Patrick's Hospital is a very old building and would find it difficult to meet modern day environmental standards. Therefore we can confirm that a development control plan for a new Community Hospital on an already identified site within Leitrim have been put forward to the HSE National Capital office for approval and these plans are presently being considered.

Proposed Timescale: 2015 pending capital funding

Proposed Timescale: 31/12/2015

Outcome 14: End of Life Care

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents did not have end of life care plans in place.

Action Required:

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

Please state the actions you have taken or are planning to take:

The person in charge will ensure that all residents have an end of life care plan in place

Proposed Timescale: 31/07/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

There were inadequate facilities for occupation and recreation including the opportunity to undertake personal activities in private.

Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:

It is very important to the staff that residents, their families and friends are happy with the care provided within the hospital and that the respect dignity and choice of the residents is maintained. There are a number of groups held during the week offering, Sonas- utilising music therapy on Dementia Specific unit, Cookery group in occupational therapy kitchen, relaxation and sensory therapy utilising the Snoozlan room, reminiscence and news discussion groups on each unit. Bed dependent exercise groups on Sheemore and Rivermead unit. The Occupational Therapy staffs also undertake one to one activity with residents resulting in identified residents having one to one trips out

to the sensory garden, walks outside and trips to local hotels for afternoon tea in their localities utilising our minibus.

Proposed Timescale: 31/07/2015

Theme:

Person-centred care and support

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

Routines and practices and facilities do not maximize each resident's independence and choice.

Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:

Residents within the hospital continue to be the number one priority. All efforts will be made to ensure that each resident's independence will be maximised. Further communication with the residents / Consumer groups will take place in order to identify further activities that will suite the residents' needs. The provision of a new build / facility will also assist with maximising independence and choice.

Proposed Timescale: 31/07/2015

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There were restricted visiting four times a day, at each of the three meal times and in the evening after 9.30pm.

Action Required:

Under Regulation 11(2)(a) you are required to: Ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident, or the resident concerned has requested the restriction of visits.

Please state the actions you have taken or are planning to take:

The Person in Charge (PIC) will continue to review the visiting times to the resident and to the centre. It is very important to the staff that residents, their families and friends are happy with the care provided within the hospital and that the respect dignity and choice of the residents is maintained. Meal and mealtimes and protected mealtimes have enhanced the resident experience at this important time. Resident's families and significant people in their lives are encouraged to be present and participate in the

mealtime experience.

Proposed Timescale: 31/07/2015

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

All residents did not have adequate personal storage facilities. Residents' personal clothing were stored in labelled containers in a communal linen room on Rivermeade Unit, Dr McGarry and Sheemore Wards.

Action Required:

Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

Please state the actions you have taken or are planning to take:

There are individual lockable wardrobes / units on all units. Further individual space is provided in each ward. This is clearly identified as belonging to individual residents.

Proposed Timescale: 31/07/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The allocation of staffing particularly in the evening and at night was inadequate to meet the needs of all residents and additional staffing was required to ensure that the health and social needs for all of the residents in this centre would be met. This was also the finding following all previous inspections and has not been adequately addressed to-date.

Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

Nationally work is ongoing in relation to staffing levels/skill mix for residential services with the HSE and Unions. St Patrick's Hospital awaits the outcome of this review and will be guided by the agreed staffing level throughout the country.

Similar to other Community Hospitals / Nursing Units within Sligo Leitrim, St Patrick's monitors its staffing level and skill mix on a day by day basis and replaces staff accordingly.

Two Health Care Assistants (HCA's) commenced employment on 01.11.2014 and two commenced employment on the 09.03.2015 with a further two HCA posts waiting to be filled.

Currently the National Recruitment Service are processing the following posts, Staff Nurse, replacement post for Clinical Nurse Manager and replacement post for Assistant Director of Nursing at St Patrick's.

These vacant posts are due to recent retirements from within the hospital and staff that have left to pursue other careers etc.

Proposed Timescale: During quarter 3-4 2015

Proposed Timescale:

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff working in the centre did not have up to-date training in the protection of vulnerable adults, fire prevention management, managing behaviours that challenge, wound care management and infection control. There was not a comprehensive training and education schedule which demonstrated a commitment to regular on-going staff training in the centre.

Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:

1. Protection of vulnerable adults

A further eight refresher sessions for all staff will continue on recognising and responding to elder abuse until the training programme which includes "Protecting Vulnerable adults" will be launched

2. Fire prevention management

There are twelve further planned sessions in 2015

3. Managing behaviours that challenge

Training programme on Non Violent intervention to be delivered in September 2015

4. Wound care management

The PIC will continue to liaise with the Regional Tissue Viability Specialist to provide further training and development in detection, prevention and treatment options for frontline staff.

5. Infection control

Hand Hygiene training will be undertaken

Rivermead – All staff completed by end of July 2015

Dr McGarry –All staff completed by the end of August 2015

Sheemore- All staff completed by the end of August 2015

Monsignor Young Unit- All staff completed by the end of August 2015

For all other staff who have not received training in other areas catering,household,allied health professionals in the past two years these will be addressed in quarter 4 of 2015

The PIC will liaise with the Infection Control Specialist on her return from Leave in Quarter 3/4 of 2015 and devise a programme of training that addresses standard precautions, management of outbreaks and environmental hygiene assessments.

Proposed Timescale: 3 and 4th quarter 2015

Proposed Timescale: