Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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:	marie.ogrady1@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; Rachel Mc Carthy
Type of inspection	Unannounced
Number of residents on the date of inspection:	74
Number of vacancies on the date of inspection:	11

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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
13 October 2015 09:30	13 October 2015 18:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 14: End of Life Care	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Substantially Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

St. Patrick's Community Hospital is operated by the Health Service Executive (HSE) and situated near Carrick on Shannon Town.
It provides short and long-term nursing care and accommodation for residents with a range of needs such as; convalescence, respite care, assessment, rehabilitation, palliative care, continuing care and dementia care. At the time of this inspection, a total of 74 residents were being accommodated.

A registration inspection took place in St. Patrick's Hospital on the 24th of March 2015 Inspectors identified 6 compliant, 3 substantially compliant 4 major non

compliances, 5 moderate non-compliances, and issued twenty seven actions to the provider to address these non-compliances.
Following a review of the action plan response received from the provider, senior management in the Health Information and Quality Authority (HIQA) reviewed the evidence and issued a notice of proposal to refuse registration. The provider, the Health Service Executive (HSE) responded with a representation to the Authority of the actions it had taken or proposed to take to rectify the serious non compliances identified in the report. Following consideration of the representation submitted by the provider nominee, a further inspection took place to review the actions taken and to assess the provision of care provided to residents in the centre. This report outlines the findings of this follow-up inspection.

The inspectors found that considerable improvements had occurred in the centre and this was partially attributed to a change in the person in charge of the centre who was supported by the provider nominee. A new interim person in charge had been appointed to implement change and review care practices in the centre. This has occurred since September 2015 and actions taken by the person in charge to address the non compliances are discussed in most of the outcomes throughout the report. In addition; bed numbers were temporarily reduced, to implement change and since then a reduction in resident's falls had occurred, wound care management had significantly improved and staff training had significantly increased. However, some mandatory training was still not complete and required improvement.

The physical design and layout of the premises continued to be inadequate and not meet the assessed needs of residents'. Residents continued to be accommodated in a building that in part was over 150 years old which impacted of the quality of life of residents. The privacy and dignity of residents was not promoted due to the dormitory style bedrooms. In addition, bathrooms, toilets, sitting and dining rooms were inadequate. However, some actions were proposed to reduce bed numbers in the centre by 20 beds as a result of funding being allocated to open a newly built nursing home that had been vacant. In addition; plans were in place to improve some of the facilities in the hospital, such as sinks in the multi-occupancy bedrooms and additional bathrooms/toilet and visitors facilities.

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

Findings:
The Statement of Purpose for St. Patrick's Community Hospital described the aims, objectives and ethos of the service and the facilities and services provided in the centre. It has been updated to reflect the changes in the management structure since the last inspection 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There were three actions to be addressed following the last inspection. These related to Annual provider service reviews, Management of an inadequate premise, and the processing of Trust in care investigations. Two of the actions were complete and one action relating to premises remained active.

Since the last inspection the person in charge has changed and a new interim person in charge/ Director of Services has been appointed to manage the centre. In addition; a second vacant A/DON post has been advertised and was in the process of being appointed to manage the centre. This will ensure that the centre is governed by experienced, responsible and competent managers and that the delivery of care is in line with national policies and procedures and best practice.

On this inspection, inspectors found that the new person in charge had reviewed the organisations policies and procedures in each unit area and that staff working in each area were aware of the policies. Furthermore, the person in charge had commissioned external personnel to provide training on a weekly basis for healthcare staff working in the centre, in areas such as fire evacuation procedures, protection of vulnerable adults, wound management, falls prevention. This was to ensure that all staff were trained in the mandatory training required by the Older Person Regulations and the HSE policies. Training requirements are discussed in more detail under outcome 18. However, Residents' rights and social activities required review as they continued to be inadequately addressed. This was an action from the last inspection. This is discussed under outcome 16.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
There was one action issued following the last inspection relating to contracts of care. On this inspection, an inspector reviewed a sample of contracts and saw that they contained the requirements as outlined in the regulations, including the additional fees incurred by residents.

Judgment:
Compliant

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

the service.

Theme:
Governance, Leadership and Management

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

Findings:
Since the last inspection a new interim person in charge had been appointed as Director of Services on the 14/9/15. She had the relevant professional qualifications and experience in nursing older people to manage such a large nursing home. The person in charge was a registered General nurse and has an extensive range of professional experience as a Director of Services managing another large Community Hospital in Co. Sligo. Inspectors found that the new person in charge had made significant positive changes in the governance and management of the centre since her appointment. These changes are discussed in detail throughout this report.

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:
Previously inspectors had found that the schedules 4 and 5 were incomplete; Schedule 4 documents did not accurately show additional charges payable by residents and Schedule 5 policies and procedures were not up to date. On review of these documents on this inspection, all of the policies in the centre were updated and current and staff spoken to were aware of the organisations policies and procedures in relation to fire evacuation procedures, risk management and safeguarding and safety.

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:
There was one action issued relating to the lack of refresher training for staff in protecting vulnerable adults. The providers action plan response advised that the HSE "Protecting Vulnerable Adults" training was currently being devised and will be delivered to all staff by July 2015 on review, this was not yet complete: compliance as at the 31st August 2015 was 58.3%. Inspectors were told that mandatory training was ongoing and all staff were expected to be trained by December 2015.

Furthermore, Inspectors had also previously identified that there were not appropriate training measures in place to assist staff in supporting residents with behaviour that challenges. At the time of the last inspection, only few of the staff working in Monsignor Young unit, which is the dementia specific unit, had training in behaviours that challenge, on this inspection some staff had received training in non- violent crisis intervention, however, training was not fully complete for all front line staff and required refresher training.

Previously, inspectors had found the timeline for concluding Trust in Care investigations was extremely slow to finalise a conclusion on the matters. There was currently one Trust in Care investigation on-going and inspectors were assured by the provider nominee that the appropriate procedures were being followed to investigate and conclude this investigation in a timely manner. In addition; inspectors were assured by the provider nominee and the person in charge that there was a culture of open disclosure in the centre to ensure residents are safeguarded from abuse. Inspectors discussed the procedures in place for the protection of vulnerable adults in the centre with residents and they told inspectors that they were happy and well care for in the centre. Staff told inspectors that they would have no hesitation in reporting any concerns to the management team.

Previously there was a high number of residents using bedrails, all residents had been reassessed for the use of restraint and a restraint link nurse had been commissioned to support and train staff on assessing and recording restrictive practices in the centre.

Staff told inspectors that restrictive practices had been reduced as a result of this review.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
At the last inspection, inspectors found serious deficits in the managing risk in the centre and in response, inspectors issued six actions, these related to the management of clinical issues and staff training. For example; A high number of falls, including some residents receiving several falls were not adequately managed, there was inadequate storage of moving and handling equipment and emergency and first aid equipment. In addition Infection control issues were not managed and staff did not have adequate training on infections control, emergency evacuation procedures or fire safety training. Four of these actions were now complete and two were not complete.

Since the last inspection, the new interim person in Charge had taken responsibility for managing risks. The Quality and Safety (Q&S) committee meetings were held weekly and Health &Safety (H&S) audits were initiated to be completed twice daily. The H&S weekly meetings improved communication among the senior management team and the clinical nurse managers were responsible for the actions from the meetings that were now being implemented on the units.
In addition the Clinical Nurse Managers (CNM's) met weekly to discuss/ review the twice daily Quality & Safety management reports, including Shower audits, wound/tissue viability audits, Food and nutrition audits, Falls audits. Outcomes of these audit reviews have resulted in external experts being reassigned to train staff on best practice For example; in wound care, continence care, restrictive practice, falls management.

Since the last inspection a falls audit has been completed for period Jan-August 2015 which indicated 67 falls in total for all units, this showed a slight reduction in falls in the centre. Further training in relation to the Falls Policy and Post Fall Huddle assessments had commenced on 8th Sept. All residents falls risk assessments had been reviewed and a new falls policy was in place. A new initiative contained within the Falls Policy referred to as the "falls huddle" was introduced to all units. Training for staff in falls management and the recording of the "falls huddle" was in progress, control measures were in place to monitor residents that were frequent fallers. Twice daily Q&S audits were completed

on each unit and a Falls Audit was completed weekly. Weekly monitoring reports were completed and reviewed by senior management.

Inspectors also found that all of the residents' moving and handling assessments were reviewed by the nurses and physiotherapists. Staff had also 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.

A full review of the prevention of pressure wounds and pressure wound care management had taken place for all residents in St. Patricks Hospital. A CNS Tissue Viability expert was commissioned from another HSE Older persons centre to train nurses and Health Care Assistants (HCA's) in the identification and management of pressure and wound care. Staff received training on identifying early pressure areas, and there was evidence to show in the files reviewed that these measures were preventing pressure areas developing into serious pressure wounds. In addition; another tissue viability nurse was given protected time, to support staff identify and manage pressure wounds and new procedures were in place for reporting areas of concern. A care bundle for wound management had been implemented on each unit. Audits were completed by this expert. On the day of inspection nine residents were identified with wound/tissue viability issues in the centre and these wounds were appropriately treated.

A Health and Safety policy was updated. This was an action from the last inspection. The risk register was a live document and regularly updated. This register was reviewed at least every three months and included environmental risks within the centre.

Actions required relating to managing fire from the last inspection included; emergency evacuation plan to be put in place for each unit and all residents to have personal evacuations plans (PEEPS) in place in their file as well as up to date fire safety training for staff to be complete. Previously, six nurses and 14 HCA'S did not have up to date fire training, however, only 60% of staff had completed fire training, but the person in charge advised that a schedule of regular monthly training was in place for all staff.

Previously inspectors found in Dr. Mc Garry unit: the fire, doors were not connected to the fire alarm system and there was no magnetic door release to ensure they closed and compartmentalised in the event of a fire. This work was now complete. However, on this inspection, inspectors found that the fire doors in Monsignor Young unit were not connected to the emergency fire evacuation door release system and following discussion with the maintenance manager and external fire expert on site during the inspection, the inspector was told that this issue was in process of being changed.

Infection control measures continued to present difficulties 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. However, inspectors were advised in writing since this follow up inspection that funding had been sanctioned for the installation of hand washing facilities in all of the multi-occupancy bedrooms. In addition; inspectors found that hand hygiene training was ongoing.
Inspectors also found restraint assessments were reviewed 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. Previously, clinical equipment such as, oxygen cylinders were stored inappropriately along corridors and in bathrooms. This practice had ceased and clinical equipment was stored in locked clinical treatment or pharmacy rooms.
The organisation had implemented a new policy of no smoking in the premises and inspectors noticed 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
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 dose of PRN (as required medication) was recorded in the medication charts reviewed.

Safe storage of medications was complete since the last inspection. For example; medication stock were now stored in a locked presses in the clinic room and there was also a lock on the main clinic room door, that excluded unauthorised personnel from accessing the medications. Furthermore, storage facilities for the medicine trolleys had been adequately addressed since the last inspection, medication trolleys were secured in place to store medications.

Inspectors were told that pharmacists from Sligo General Hospital supervise the pharmacy technicians that visit St. Patrick's to generate stock requirements and review out of date stock. This service had been increased to twice weekly.

On this inspection, inspectors spoke with the pharmacist supplying medication to this centre, regarding the medication storage and stock control procedures in place in this centre. The pharmacist advised inspectors that a full review of medication ordering and stock control measures had been audited since the last inspection and following the audits findings, changes were made to reduce stock wastage and to ensure tighter

control measures were in place for ordering and returning discontinued medications. The pharmacy also advised that new procedures had been put in place to record controlled medications stock in each ward. However, Inspectors found in Monsignor Young unit that the nurses on duty on the day of inspection were unclear of the recording of controlled medications in the control medication register, as new recording procedures had been implemented and they had not received training. This is actioned under outcome 18

Medicines are provided by the Pharmacy in Sligo General Hospital, and previously inspectors had found that residents did not have a choice of pharmacists, should they wish to choose their own pharmacist. On this inspection, a nurse told the inspector that all residents had been given the opportunity to change from the pharmacy providing medications to the centre and no resident wanted to change to another pharmacy.

Nurse managers told inspectors that medication rounds had been reduced from four to three times a day, This was having a positive effect on residents, as it allowed the nurses more time to provide additional clinical care to residents

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
Since the last inspection, the new person in charge had completed a full review of notifiable incidents and found that some accidents and incidents that should have been reported to the Authority had not been notified. This is now complete.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
There were four actions issued following the last inspection. These actions related to access to bathing facilities and the number of bed dependent residents in the centre, and the management of falls and wound care management.

On the day of inspection the dependency levels of the residents in the centre were assessed as, 44 maximum, 16 high 14 medium dependencies. Residents had a mixture of age-related medical conditions and cognitive impairment.

Since the last inspection daily showering and bathing records were now maintained in each unit and a rationale was recorded for residents that did not receive a shower. All residents were now receiving a shower at least once a week, unless they were medically unfit. A recent audit dated 8/9/15 on showering showed that there was a 68.75% compliance across the hospital of residents receiving regular showers. There was also evidence in residents new bathing/shower records that they were offered a second opportunity to have a shower later in the day or the next day if they had refused a shower earlier. Some residents had taken up the opportunity, other residents had chosen not to. Nurses and managers told inspectors that staff attitude towards showering residents had changed and staff now saw it as an important element of the residents care needs.

On the last inspection Inspectors were told that at least twenty two residents in the centre were permanently bed dependent, on this inspection inspectors were told the Occupational Therapist (OT) and Physiotherapist had completed assessments for fifty one residents and eleven had been identified as "medically unfit" and were bed bound. This is a reduction of eleven residents being assessed as bed-bound since the last inspection. However, it was unclear in the files viewed what was the criteria for assessing residents as being "medically unfit" or what assessment tool was used to assess residents as being bed-bound 24 hrs. a day.

At the last inspection inspectors found that the preventative treatment for pressure wounds required review as there were 25 residents with wounds of a grade 2 or more treated in the centre in the past year. On this occasion, inspectors were told that a full review of the prevention of pressure wounds care management had taken place for all residents in St. Patrick's Hospital. One Clinical Nurse Specialist (CNS) in Tissue Viability was commissioned from another HSE older persons centre to train staff nurses and Healthcare Assistants (HCA's) on wound prevention and wound management and residents with pressure areas were assessed and treated by the tissue viability nurses. In response to the findings of a wound audits completed in the centre, one tissue viability nurse working on-site in the hospital was given protected time to support staff identified and manage pressure wounds. New procedures were also put in place for

reporting areas of concern. A tissue viability care bundle for wound management had been implemented on each unit. Audits completed by an expert found that 21 residents were identified with wound/tissue viability issues 6x Grade 2+ wounds, 7x Grade 1+ pressure areas, 8 x moisture associated skin damage. Weekly staff training on wound care management for all front line staff was provided and this had increased staff confidence and competence in preventing, assessing and treating pressure wounds in line with up to date evidence based practice.

At the last inspection, a new residents care plan system was being implemented in two of the units and care plans were in the process of being transferred onto the new care plan system. However, inspectors had found that care plans were very generic and lacked space to record individualised person centred care. On this inspection, the new interim Director of Services/PIC advised inspectors that she had piloted a new care plan system in the Sheemore unit and this system was working well. Inspectors reviewed this care plan and found it was person centred and identified residents care needs and was easily updated. Staff told inspectors they found the care plan system very easy to use and welcomed its implementation.

Since the last inspection the Clinical Nurse Managers (CNM's) met weekly to discuss/ review the twice daily Q&S management reports, including Shower audit, wound/tissue viability audit, Food and nutrition audit, Falls audit, Outcomes have resulted in external experts being reassigned to train staff on issues of concern. E.g. Wound care, continence care, restrictive practice, falls management.

Judgment:
Substantially Compliant

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

Theme:
Effective care and support

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

Findings:
There was one action issued regarding safe and suitable premises following the last registration inspection. Inspectors had found that the provider continued to fail in addressing 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 and premises issues were impacting negatively on residents privacy and dignity, personal hygiene facilities, and storage facilities in the centre.

Since then, the provider had returned an action plan response to the Authority stating that a new 20 bed nursing home already built in Ballinmore would be opened in 2016 and some residents from St. Patricks would be relocated to this new nursing home. This would assist in reducing the number of beds in St. Patricks by 20 to 65 beds to create more space to ensure residents privacy and dignity and storage facilities were enhanced. The reduction of bed numbers in the centre would also allow for better shower/toileting facilities and better infection control measures to be introduced; by the installation of hand washing sinks in all areas. Also the extra space created would allow for better facilities for patients and family members experiencing end of life care. The Authority has also been advise by the provider nominee that funding had been sanctioned to refurbish and upgrade the 1841 buildings including fire compliance issues.

However, despite, the provider nominee advising the Health Information and Quality that funding for a 90 bed purpose built facility in Carrick on Shannon has been submitted well over a year ago to the National Estates department of the Health Service Executive (HSE) however, to date no funding for this building has been sanctioned.

Judgment:
Non Compliant - Major

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

Theme:
Person-centred care and support

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

Findings:
At the last inspection, inspectors found that some resident did not have end of life care plans in place. On this occasion, inspectors reviewed a number of residents' files and end of life care plans and found that they complied with the centres operational policies and protocols in place for end-of-life care. Residents had access to specialist palliative care services when required. Family and friends were facilitated to be with the resident when they are dying, however, there continued to be privacy and dignity issues due to the inadequate premise. This has been discussed under Outcome 12 Safe and Suitable Premises.

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.

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:
There were three actions issued under this outcome following the last inspection. These related to inadequate facilities for occupation and recreation, institutional routines and practices that limited residents' choices and independence, and restricted visiting times.

In two of the units where the inspectors viewed residents social care plans they found that the residents had a social activity care plan that was regularly updated; however, the social activity programme was operated by the occupational therapist team consisting of four members and although they showed inspectors their weekly activity timetable of group and individualised person centred activities, it appeared that the same few residents were participating in the social activities when offered. The inspector found there were not sufficient daily recreational activities on each ward and training for ward staff on these activities was required. This was an action from the last inspection that was not adequately addressed. For example; when the inspector visited the dementia care unit mid morning there was no social programme in operation and residents were viewed sleeping in their chairs in the day room.

The facilities where residents meet with their visitors continued to be unsuitable in some units, as previously outlined under outcome 12 and 14. New arrangements in relation to visiting times have been put in place since the last inspection and discreet signage has been put in place to inform residents' relatives and visitors of the visiting times of the centre.

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

Findings:
An action from previous inspection required that additional storage facilities be provided to residents this was not yet complete. The inspector found that some residents clothes did not all fit in their wardrobes and that they were stored in containers in communal linen rooms on the units. The Authority was advised that a procurement process had been completed and the installation of wardrobes will commence on the 14th of September 2015 and expected to finish on the 16th September 2015.

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:
There were two actions issued following the last inspection of this centre. These related to staffing levels and skill mix and staff training in the centre. These were partially complete.

Since the last inspection a staffing review has been completed for St Patricks Community hospital. Some vacant staff nursing and healthcare assistant posts have been replaced. In addition interviews for Clinical Nurse Managers and a Assistant Director of Nursing post had occurred.

The new interim person in charge had reassigned some staff to different units to support staff and to implement changes in practices from institutional and task orientated practices in some units to person centred practices. Inspectors found that these changes had made a significant positive impact on residents' preferences and choice on the units and the care is more person centred rather than task focused as was previously the case.

However, there continued to be high levels of sick leave in this centre and agency staff continue to be a significant part of the staff team which may reduce continuity of care for residents.

Although manual handling training was complete at 100%; some mandatory training was still not complete. Fire safety training was 60.5% and managing behaviours that challenge was not fully completed, as well as training in the protection of the vulnerable adult at 58.3%.

Inspectors were told that there were planned training sessions each month to increase the level of compliance in staff training. In addition; the provider had sought external specialist trainers in care delivery areas such as: wound care management, falls prevention, restraint assessments, fire management, infection control management, and continence management. There was evidence that these training sessions were occurring daily/weekly in the centre to up skill the nursing and care staff on best practices in these areas to ensure a high standard of care. Inspectors found that these training sessions were having a positive effect on care delivery and from the documentation reviewed on managing patient wounds and post fall reviews; these training sessions had a positive effect on staff managing these risks.

Judgment:
Non Compliant - Moderate

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:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	St Patrick's Community Hospital
Centre ID:	OSV-0000661
Date of inspection:	13/10/2015
Date of response:	30/12/2015

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 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff working in the dementia care unit did not have the required training or knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

1. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour

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

that is challenging.

Please state the actions you have taken or are planning to take:
Training in the Newcastle Model - to understand people whose behaviour challenges in dementia care, is due to commence on the 12th January 2016. Training will take place over two days and will prioritise all staff on the Monsignor Young Unit (Dementia Care Unit). Further training is also due to take place on 19th and 20th January which will facilitate other units in the hospital in relation to dealing with responding to behaviours that are challenging. This training is being facilitated by the Nurse Specialist from the Old Age Psychiatry Team.

Person Responsible: PIC

Proposed Timescale: 26/02/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff did not have up to date training in the protection of vulnerable adults. This was an action from the last inspection.

2. 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:
19 Staff, four of these are Nursing staff, have not being trained in Recognising and responding to Elder Abuse. These staff will be trained before end January 2016. Safeguarding Vulnerable Adult Policy will be launched 4th January 2016 and all grades of staff to attend this training by 31st December 2016.

Person Responsible: PIC

Proposed Timescale: 31/01/2016

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:
In one unit a number of residents had fallen several times in the past few months and their falls prevention risks or post falls analysis was inadequate and required review.

3. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
The regional falls policy has been adopted by St Patrick's Community Hospital. A FRASE assessment is carried out for all residents and updated on a minimum three monthly basis. The Falls Huddle has been introduced as part of the Policy and takes place after every fall within the facility. Decisions made by the team are fully documented and any precaution not already in place, e.g. alert bracelet, bed sensor etc are introduced in order to lower the risk of further falls.

Recording of Falls is part of the twice daily quality and safety audit which is reviewed daily by Nursing Administration and weekly by the CNMII's & MDT. This will allow for close follow up and analysis of falls within the facility. A safety pause (twice daily) is being introduced from 1st January 2016. This will also support falls prevention. A further falls audit will be carried out in St Patricks and will be completed before 31st March 2016.

Person Responsible: PIC, ADON, CNMII's, MDT Members

Proposed Timescale: 01/01/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff had not yet completed fire training.

4. 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:
This action has been completed since 16th December 2015

Proposed Timescale: 16/12/2015

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:
In Monsignor Young unit the nurses on duty on the day of inspection were unclear of the recording of controlled medications in the control medication register, as new recording procedures had been implemented and they had not received training.

5. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
All nurses within the Hospital have full knowledge and are clear on the recording of Controlled Medications in the control medication register. The pharmacists will continue to provide updates to staff throughout 2016. A further review of the Medication Policy will be carried out and updated if necessary.

Person Responsible: PIC, ADON, CNM's

Proposed Timescale: 31/12/2015

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:
It was unclear what was the criteria for assessing residents as being "medically unfit" or what assessment tool was used to assess residents as being bedbound 24 hrs. a day. In addition; in the residents files viewed, there was no documentary evidence of the assessments maintained in the residents file.

6. 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:
Any decision in relation to whether a resident has to stay in bed (bed Bound continuously for 24 Hours) will be fully documented with a clearly documented professional assessment (including all physical and psychological factors) supporting this decision.

Person Responsible: Clinical Nurse Managers and MDT Members

Proposed Timescale: 08/01/2016

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:
Despite, the provider nominee advising the Health Information and Quality that funding for a 90 bed purpose built facility in Carrick on Shannon has been submitted well over a year ago to the National Estates department of the Health Service Executive (HSE) however, to date no funding for this building has been sanctioned.

7. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
Application for a new 90 bed purpose built facility remains with HSE National Estates Department. The provider nominee awaits the decision in relation to the provision of a new replacement Community Hospital. The Authority will be informed immediately when funding and a date of commencement is available.

Person Responsible: Nominated Provider

Proposed Timescale:

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was one action issued regarding safe and suitable premises following the last registration inspection. Inspectors had found that the provider continued to fail in addressing the premises issues, which were impacting negatively on residents privacy and dignity, personal hygiene facilities, and storage facilities in the centre.

8. 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:
The planned refurbishment for St Patrick's, as submitted to the Authority, has been authorised and will be carried out in 2016 with an expected completion date before end of third quarter 2016. This is reflected in the recently submitted Statement of Purpose.

20 beds will be reduced within St Patrick's in 2016 with the opening of the Ballinamore Unit date for completion by end March 2016. This bed reduction will provide more privacy and dignity for the remaining residents until the new build is completed.

Staff are currently being recruited for Ballinamore Unit and will become operational when recruitment process is completed.

Person Responsible: Nominated Provider

Proposed Timescale: 30th September 2016 for refurbishment within St. Patricks Hospital.

Proposed Timescale: 30/09/2016

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 not sufficient daily recreational activities on each ward and training for ward staff on social and occupational activities is required.

9. Action Required:
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
A health Care Assistant has commenced training with Age and Opportunity in the "Creative Exchange Programme" Fetac VI. This will be completed by 31st March 2016 and this staff member will lead out and support other staff to provide the essential social activities within the different units.

Recreational Activities have increased on each unit and these are recorded and monitored by the CNM's. This will be further strengthened by end February 2016.

Person Responsible: CNM's

Proposed Timescale: 31/03/2016

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:
Residents had additional clothes that did not fit in their wardrobes that were stored in containers in communal linen rooms on the units. The Authority was advised that a procurement process had been completed and the installation of wardrobes would commence on the 14th of September 2015.

10. 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:
Wardrobes have been installed since October 2015 which accommodates all residents clothing.

Proposed Timescale: 31/10/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some mandatory training was still not complete. Fire safety training was 60.5% and managing behaviours that challenge was not fully completed. Training in the protection of the vulnerable adult was at a total of 58.3% of staff and not complete.

11. 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:
Staff have been advised they have a responsibility to attend the training that is provided to fulfil their contractual obligations:
100%compliance with four out of five mandatory training topics for Nursing, HCA, Catering, Housekeeping, Clerical and Occupational Therapy staff achieved in 2015. It is expected to have 100% compliance in all mandatory training by 31 Jan2016

An extensive mandatory training programme has been introduced for ST Patrick's CHS:
Fire Safety
Hand Hygiene
Manual Handing
Safeguarding Vulnerable adults
Designated Officer training for Managers x 6 dates tbc
CPR
Open disclosure for all MDT and Clinical Nurse Managers by end June 2016
Tissue viability updates quarterly

Pharmacist updates x 4 topics and dates tbc 6th January 2016. Standard operating procedures for Infection Control HACCP for Catering staff Food hygiene training for Catering staff Continence management updates quarterly Physical restraint updates quarterly Newcastle model non chemical approaches to dealing with behaviours that challenge Further Dementia specific training to be sourced by end January 2016. Other training as deemed essential BY PIC:
Proposed Timescale: 31/12/2016