<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Patrick’s Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000595</td>
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<tr>
<td>Centre address:</td>
<td>John’s Hill, Waterford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>051 848 700</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:paula.french@hse.ie">paula.french@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Barbara Murphy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Caroline Connelly</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Ide Batan</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>89</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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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**

<table>
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<tr>
<th>From:</th>
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<tbody>
<tr>
<td>15 December 2014 09:50</td>
<td>15 December 2014 17:45</td>
</tr>
<tr>
<td>16 December 2014 09:00</td>
<td>16 December 2014 17:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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

This report set out the findings of an announced registration inspection of St. Patrick’s Hospital by the Health Information and Quality Authority’s Regulation Directorate that took place over two days on 15 December 2014 and 16 December 2014.

As part of the inspection the inspectors met with residents, the provider, person in charge, two Assistant Directors of Nursing (ADON), the Clinical Nurse Managers (CNM), nurses, relatives, resident advocate and numerous staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.
The centre is currently registered and the registration is due to expire on 4 April 2015 and the provider had applied for renewal of registration.

A number of questionnaires from residents and relatives were returned to the inspectors and the inspectors spoke to a number of residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Residents and relatives comments are reflected throughout this report.

Overall the inspectors found that the premises posed numerous challenges in the provision of care to residents due to the lack of private and communal space and facilities for residents. The majority of residents were accommodated in multi-bedded rooms and there was a lack of general storage for personal property and possessions. There were a number of actions required from the previous inspection in relation to the premises that remain outstanding and the provider continued to be non compliant in areas such as the suitability of the premises, multi-occupancy rooms and inadequate storage for residents' personal property and possessions. There was a major non compliance in relation to residents' privacy and dignity that required immediate attention. These issues are discussed throughout the report.

These improvements and others improvements were required to comply 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. Improvements required are described under each outcome statement and are set out in detail in the Action Plan at the end of this report.

These included improvements in the following areas:
- the premises
- provision of fire training for all staff
- staffing levels
- privacy and dignity
- medication management
- protection of residents finances
- restraint practices
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 centre had a comprehensive statement of purpose that accurately described the services provided. This contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**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):**
No actions were required from the previous inspection.

**Findings:**
The management team is made of the nominated registered provider, the person in charge and two ADON's. There is a clinical nurse manager 2 (CNM 2) in charge of each of the three units who are responsible for the day to day running of their respective units.
The registered provider is based on site and has responsibility for the operation of Health Service Executive (HSE) services in the Waterford Local Health Office area including management responsibility for Dungarvan Community Hospital and Dunabbey House. She has held this post since July 2012. General management meetings, chaired by the provider, were held bi-monthly and attended by the person in charge and all ADONs. The person in charge holds meetings with the ADONS and CNMs and the CNMs in turn hold unit meetings with the unit staff. Minutes of all these meetings were viewed by the inspectors which demonstrated ongoing communication of relevant issues.

The person in charge is in a full time post but she is the person in charge for two other units; Dungarvan Community Hospital and Dunabbey House in Dungarvan. The person in charge is based in Dungarvan and is only on site two days per week. Therefore the person in charge is in charge of three designated centres and spent only two days per week in this centre. The Authority was not satisfied that the person in charge is engaged in the effective governance, operational management and administration of the designated centres concerned due to the number of continual non compliances in the centres. The action for this is outlined under outcome 4.

There were systems to assess the quality of life and safety of care including committees to consider the review of audits on areas such as activities, pressure sores, falls, hand hygiene and medication. The inspectors viewed audits completed by the ADONs. Data was being collected on a number of key quality indicators such as medication management, accidents and incidents, hygiene, nebuliser cleanliness, care planning and the environment. The audits highlighted a number of issues and action plans were identified. There was evidence of ongoing improvements following the audit and action plans were followed up on the re-audit.

Inspectors noted a residents’ committee met regularly and minutes of these meetings indicated actions were taken in response to issues identified, such as meals and activities. Residents had access to advocacy services and nominated advocates had received appropriate training in this area. Advocates met with residents on a regular basis and mechanisms for feedback were in place. The inspectors met one of the advocates who was very active in one of the units and brought forward issues from residents to management.

Interviews were conducted with the provider nominee and person in charge and ADONs during the inspection and on previous inspections and they displayed a good knowledge of the standards and regulatory requirements in relation to their relevant roles.

There was appropriate assistive equipment available to meet residents’ needs such as electric beds, wheelchairs, hoists and pressure-relieving mattresses. The provider and person in charge outlined the plans to build a new 100-bedded community nursing unit to replace the existing centre and to address areas of major non compliances. This new build had been approved for capital funding from the HSE. However, finalised plans were not available at the time of the inspection.

**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 a policy on the provision of information to residents which included the residents’ guide. This guide was compliant with the regulations as it contained a summary of services and facilities, the terms and conditions of admission, a summary of the complaints process and the arrangements for visits.

The inspector reviewed a sample of residents' files and noted that one resident in the sample did not have a contract of care in place as required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Furthermore, two contracts viewed by the inspector did not set out the fee to be charged for the provision of care and services as also required by the Regulations.

**Judgment:**
Non Compliant - Moderate

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**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 the inspectors saw evidence that she was currently registered with the relevant nursing professional body. She holds a degree in nursing and a diploma in management. Training records confirmed she had kept her clinical knowledge current and showed that she had attended relevant training courses.

The inspectors formed the view that the person in charge was a suitably qualified and experienced nurse. She displayed a good knowledge of the Health Act 2007 (Care and
The person in charge held a full time post but is also the person in charge for two other designated centres, Dungarvan Community Hospital and Dunabbey House in Dungarvan. The person in charge stated that she was based in Dungarvan for three days each week and spent only two days in the centre in Waterford which is a 96 bedded centre. The Authority are not satisfied that the person in charge was engaged in the effective governance, operational management and administration of all the designated centres concerned due to continual non compliances found on inspection of the centres.

**Judgment:**
Non Compliant - Moderate

**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):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found that the records reviewed were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

The inspector reviewed a sample of staff files and found that they contained all information required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspector found that the system in place for maintaining files and records was very well organised with clear systems in place.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. However, the medication management policy, though centre-specific, did not outline the procedure for the prescription, administration and review of PRN medications.

The directory of residents in the centre contained most of the information required by Schedule 3 of the Regulations for all residents. However, if the resident died at the
centre, the date, time and cause of death when established were not consistently recorded.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the Regulations.

Judgment:
Non Compliant - Minor

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:
There had been no period of 28 days or more when the person in charge was absent from the centre and the provider demonstrated that she was aware of the obligation to inform the Chief Inspector if there is any proposed absence.

The person in charge is supported in her role by two assistant directors of nursing (ADONs), There is a clinical nurse manager 2 (CNM 2) in charge of each of the three units who are responsible for the day to day running of their respective units.

The ADONS were interviewed by the inspectors and was found to be experienced nurses with managerial experience. The inspectors were satisfied that they demonstrated an awareness of their responsibilities of being in charge of the centre under the legislation. The ADONS from Dungarvan Community Hospital will act up in the absence of the person in charge for the three centres for annual or other leave.

The person in charge and assistant directors of nursing are on call out-of-hours should a need for their assistance arise.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
Inspectors found that there were measures in place to protect residents from suffering harm or abuse. There was a generic HSE policy on the prevention, detection and response to elder abuse which had additional centre specific guidelines. Staff interviewed by the inspector demonstrated a good understanding of elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. The inspectors saw that elder abuse detection and prevention training was ongoing and training records confirmed staff had received this mandatory training. There was evidence that previous allegations of abuse had been recorded investigated and managed appropriately by the staff and management team.

Records of residents’ finances and invoicing for care were maintained in accordance with HSE policy and best practice guidelines which were also the subject of regular external audit. However, it was identified that the records maintained of money and valuables handed in by a resident/relative for safekeeping at the ward level in one unit was not sufficiently robust. Money was stored in a locked cupboard but transactions were signed and witnessed by resident/relative second staff member but only on the envelope which is then thrown away after use. It was also difficult to establish on the envelope when a number of transactions had taken place what the rolling balance was. This practice did not safeguard resident’s finances and a more robust system is required for the protection of residents and staff members.

There was a policy on challenging behaviour. There is a Clinical Nurse Specialist (CNS) in dementia care based in Dungarvan Community Hospital who provided training to staff in the centre on behaviours that challenge, medication management and monitoring and is available for advice and support. The ADON told the inspectors that the CNS had reviewed residents who presented with any behaviour that challenged and the inspectors saw evidence of positive behavioural strategies and practices implemented to prevent behaviours that challenged and that the CNS had advised on treatment and behavioural plans.

One of the ADON’s is a trainer in the area of restraint and is providing training to the staff. The inspectors saw that bedrail usage had been significantly reduced over the last number of years on all of the units. Restraint was the subject of audit and graphs were available to show the reduction in use. The inspectors saw that assessments for the use of bedrails were being completed on residents and some alternatives to restraint had been tried. These assessments were reviewed on a regular basis and there was evidence that residents were being checked and these checks were documented. However, on one resident's care plan it was stated that the resident was using bedrails.
on the family's request, there was no evidence that the assessment required the use of bedrails and there was also no evidence of consideration of least restrictive alternatives to bedrail usage. Residents' consent to treatment forms were viewed by the inspectors and were generally found to be completed by the resident wherever possible. There was also evidence of discussion with families as required.

**Judgment:**
Non Compliant - Moderate

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**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:**
The fire policies and procedures were centre-specific. The fire safety plan was viewed by the inspector and found to be very comprehensive. There were notices for residents and staff on “what to do in the case of a fire” throughout the building. The inspector viewed records which showed that fire training was provided to staff on various dates in 2014. However, although a very high percentage of staff had received training there were still a small number of staff outstanding this mandatory training. There was evidence of a contract in place for the maintenance of fire safety equipment and stickers on a sample of fire safety equipment viewed by inspectors indicated that maintenance was most recently carried out in March 2014. Certification was available to show that the fire alarm system was last checked in November 2014. Staff interviewed demonstrated an appropriate knowledge and understanding of what to do in the event of fire and that fire drills were being held on a regular basis - the last fire drill was undertaken in all units in December 2014. There was a fire safety register in each of the units with records of checks verifying that means of escape were free from obstruction these were completed on a weekly basis as scheduled. Emergency exits were seen to be free of obstruction on the days of inspection.

There was a centre-specific health and safety statement in place dated May 2014. There was also a risk management policy and a register of risks, detailing the precautions in place to control them. Arrangements were in place for investigating and learning from serious/adverse events involving residents. The risk management policy had been updated and given to the inspectors on the days of inspection which met the requirements of legislation.

Accidents and incidents were recorded on incident forms and were submitted to the HSE clinical incident reporting system and there was evidence of action in response to
individual incidents. There was a regional health and safety committee and one of the ADONs had specific responsibility for health and safety. Minutes of these meetings were seen by the inspectors and there was evidence of health and safety issues identified, action taken and closed off. There were reasonable measures in place to prevent accidents such as safe floor covering, grab rails in toilets and hand rails on corridors. There was a level of hazard identification and risk assessment that had been conducted in each unit. Staff to whom inspectors spoke confirmed that the identification and assessment of risks had occurred on the units. However, inspectors noted that radiators remained very hot to touch and could cause a burn injury to residents - this was also identified at the last inspection.

There was a centre-specific emergency plan that took into account all emergency situations and where residents could be relocated to in the event of being unable to return to the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, continence, moving and handling.

The provider has contracts in place for the regular servicing of all equipment and the inspectors viewed records of equipment serviced. Inspectors noted that there were a number of hoists available including ceiling hoists in some locations. There was evidence that staff were trained in moving and handling of residents. Inspectors observed staff generally using equipment to aid the transfer of residents in an appropriate manner. However, inspectors saw residents being transported in wheelchairs with no leg supports in use. The residents' legs were trailing on the ground and this practice could cause injury to the residents' legs and feet.

The environment was observed to be clean and personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Hand hygiene training was ongoing and staff demonstrated good hand hygiene practice as observed by inspectors.

The inspectors saw that there was a designated smoking room for residents who smoked. The designated smoking room was a small room located off a sitting room with a number of glass panels allowing for unobtrusive observation. The room had external ventilation and fire fighting equipment was available. The person in charge said staff supervision was in place for residents who smoked and individual risk assessments were seen in resident’s notes.

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):
No actions were required from the previous inspection.

Findings:
The inspectors observed nurses administering the medications, and this was carried out in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidelines 2007. There was evidence of good practice and evidence that staff on a daily basis endeavoured to implement procedures for the safe management of medications.

The medication management policy, though centre-specific, did not outline the procedure for the prescription, administration and review of PRN medications. The action for this is covered under documentation in outcome 5.

Medications were generally stored and disposed of appropriately in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Medication Management practices were subjected to audit, but based on a sample of prescriptions reviewed the inspector saw and staff agreed that:

- the dosage and maximum dosage of all medications prescribed on a PRN basis was not stated.
- Crushed medications were not consistently prescribed by the medical officer as is required by legislation.

There was a General Practitioner’s (GP’s) signature for each medication prescribed and discontinued. Each resident’s medication regime was routinely reviewed and prescribed on a quarterly basis by the medical officer. The prescription sheets for long stay residents were designed so that they had to be renewed every 12 weeks.

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. Nurses were checking the quantity of medications at the start of each shift. Staff spoken with and the inspection findings supported competency in medicines management practice.

The medication fridge stored medication at the appropriate temperature and there were suitable records available in relation to the regular temperature monitoring of these fridges. Medication management audits were completed on a quarterly basis. Medication-related incidents were reported and followed up appropriately with evidence of improvements implemented as a result of learning. A review of each resident’s medication regimen was undertaken and documented by the medical officer every three months.

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:**
A record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector. Quarterly notifications had been submitted to the Authority as required and within the appropriate timeframe.

**Judgment:**
Compliant

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**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:**
The centre had sufficient GP cover and an out of hour’s service was also provided by the local doctor on call service. Residents were seen by a GP within 24 hours of admission. Records confirmed that residents had timely access to GP services and were reviewed regularly by a GP which included regular medication reviews. The inspectors met one of the GP’s who was doing a ward round during the inspection.

Residents had access to a range of other health and social care services. Records were maintained of referrals and follow-up appointments. The centre had just employed the services of a dietician one day per week and the inspector met and spoke to the dietician during the inspection who confirmed she was commencing reviews of the resident’s individual dietary plans. Chiropody services were provided in the centre as required. There was a physiotherapy unit located in the centre and physiotherapy was available for assessment and the implementation of treatment plans. Occupational health and speech and language therapy were also available through community
services on site. Consultant geriatrician services were provided from consultants based in University Hospital Waterford as was access to the local mental health services and other specialist services.

Inspectors reviewed a selection of care plans on three different wards. Residents had assessments completed on admission which included; dependency level, moving and handling, falls risk, pressure sore risk assessment, nutrition, and mental test score examination. These assessments were generally repeated on a three-monthly basis or sooner if the residents’ condition had required it. The CNM and staff demonstrated an in-depth knowledge of the residents and their needs. There was evidence of ongoing monitoring of incidences involving residents including trips, slips and falls. Inspectors noted that residents’ weights were also monitored and recorded at a minimum each month and more often if required. There was evidence that the care plans were reviewed at least every three months and reflected any change to resident’s care and there was also some evidence in the care plans of residents having been consulted in relation to their care provision. The inspectors noted that while some care plans were comprehensive, further personalisation of care plans would ensure person-centred care was delivered.

There were centre-specific policies and procedures in relation to wound care and wound assessments were evident in care plans for residents with ulcers or wounds. There were also wound management plans available that included the monitoring of the healing of pressure ulcers by utilizing photographs and recording the care provided. These photographs/wound care plans assisted staff in obtaining precise information about the size, shape, colour and progress of these wounds and provided ongoing scientific assessment and measurement of the wound and wound bed. Therefore there was ongoing evidence of improvement or deterioration of the wound.

Residents and relatives said they were satisfied with the healthcare services provided. Documentation in place indicating that information about residents was provided and received when they were absent or returned from another care setting, home or hospital.

**Judgment:**
Non Compliant - Minor

**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 premises dates back to the 1950’s when it was first opened to provide long-term care services. The physical design and layout therefore remains predominately institutional in appearance and the physical design is consistent with the institutional style of that era. There are two single rooms used for end-of-life care and there are facilities for family or friends to be accommodated. The premises consisted of three wards/units: Our Lady’s, a 36-bedded unit, St Malachy’s a 34-bedded unit and St Patrick’s, a 26-bedded unit. Inspectors noted that while there were some single and two-bedded rooms available, accommodation consisted primarily of multi-occupancy rooms.

Inspectors noted that there was evidence that the premises was maintained with the standard of décor generally adequate and that efforts had been taken where possible in creating an atmosphere of comfort through the use of some suitable fittings and furnishings. There were spacious sitting rooms in two wards which had large windows providing plenty of natural light. These rooms were used for a number of functions including activities and dining and there was also the chapel which was used to provide mass for residents. There was one large central kitchen located off campus which delivered residents’ meals to small pantries in each ward. However, the premises consisted of ward-type accommodation and the physical environment was not suitable for the purpose of achieving the aims and objectives as set out in the statement of purpose and was not conducive to meeting the needs of residents.

The provider and the person in charge acknowledged this and stated that there were plans for the building of a new community nursing unit to replace the existing centre on the hospital grounds. Inspectors noted that the privacy of residents was respected as much as possible while they were being assisted with personal care - staff were observed closing curtains or screens between beds. However, the bedrooms consisted of hospital ward-type accommodation and apart from the six single rooms; the multi-occupancy bedrooms in each of the three wards were not suitable to meet residents’ needs. Due to the design and layout of these multi-occupancy wards, which accommodated up to six residents in ward bay type settings, there was inadequate private accommodation for residents to ensure that residents’ privacy and dignity was met on a daily basis. This was mainly due to the limited space provided in the areas surrounding the beds. Residents’ privacy and dignity was significantly compromised due to the close proximity of many of the beds. In these bedrooms, inspectors observed that residents were not able to undertake personal activities in private or meet with relatives in private. The option of a single room in the event of more than one resident requiring end of life care could not always be guaranteed for residents.

In addition, there were numerous challenges posed by the structure and layout of the physical environment in order to meet the individual needs of the residents. For example, one of the multi-occupancy bedrooms had a large ramp in place which made accessing this area very difficult for residents with reduced mobility and for staff in relation to manoeuvring and using assistive equipment such as hoists and assisted
chairs. Inspectors noted that some of the bedrooms had modern wardrobes provided and there was a laundry service which was available off site. Inspectors were informed that many relatives opted to manage residents’ clothing and laundry requirements. However, given the high dependency levels of the residents, inspectors formed the view that there were inadequate storage facilities available for residents’ personal belongings. The three units either had narrow bedside lockers and small wardrobes that were insufficient in size to hold an adequate number of personal belongings, clothing and mementos and/or in other instances, the wardrobe space alone was provided with no space for bedside lockers or chairs. In addition, inspectors observed that due to the lack of space residents displayed minimal personal effects which was also confirmed by staff to whom inspectors spoke.

Inspectors noted that some seating areas had been provided in a number of areas including a long corridor that had good views of the front grounds of the premises which improved the amount of suitable private areas which were separate from the residents’ own private rooms. However, the design and layout of the units did not provide adequate sitting, recreational and dining space separate from the residents’ private accommodation. In two of the units there were inadequate private areas apart from bedrooms to receive visitors and insufficient space for residents to spend quiet time alone. Inspectors noted that efforts had been made to ensure that all assistive equipment, when not in use, was stored away from living areas. However, there was inadequate storage space available for the storage of equipment such as hoists, wheelchairs and walking frames. For example, such equipment was stored in a sitting room, residents’ assisted shower rooms and sluice rooms. In addition, inspectors noted that there were no baths including assisted baths available for residents’ use in the centre.

All of the above issues were identified on the last and previous inspections and were identified as major non compliances.

The provider and person in charge showed the inspectors the agreement for the building of a new 100 bedded community nursing unit but finalised plans were not available to date.

**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):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
A centre-specific complaints policy was in place dated 2014 which identified the person in charge as the nominated complaints officer and also provided information on an independent appeals process and referral to the office of the Ombudsman. The complaints procedure was summarised in both the statement of purpose and the resident’s guide. Information for residents and visitors on how to make a complaint was clearly on display at the centre. Information was also available on the rights of residents and visitors and providing the contact details of advocacy agencies. Designated advocates were available at the centre who met with residents on a regular basis. The inspector also met with one of the advocates during the inspection who confirmed that there was a mechanism in place for the provision of feedback from their meetings with residents.

The centre referenced the Health Service Executive (HSE) national complaint document "Your Service Your Say" to support its procedures. Residents spoken with stated that they understood the process for raising concerns. When asked, residents regularly identified the CNMs or ADONs as the appropriate responsible person to go to with complaints.

The person in charge stated that as issues were identified they were addressed on an ongoing basis. The inspector reviewed the complaint log on different units and verified that generally where complaints had been recorded appropriate actions were taken and records of improvements implemented were maintained.

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):
No actions were required from the previous inspection.

Findings:
The inspector reviewed the self-assessment questionnaire and the overall self-assessment of compliance with Regulation 14 and Standard 16 End of Life Care. The person in charge had assessed the centre as being non-compliant: minor and outlined specific actions to ensure compliance.

These actions included:
• Review of policies, procedures and practices to ensure that any gaps between care provided/delivered is evident and reflected in the documentation

• Care plans to fully direct care to be delivered and to show same.

At the time of inspection the inspector was informed that there were no residents receiving end-of-life care. The inspector reviewed the centre's policy on end-of-life care and noted that the policy was up to date and comprehensive. It provided good guidance on the management of the period prior to death and the care of the body. It outlined procedures for end of life care and provided guidance for staff on care planning for end of life and how to provide support to relatives. There was an end of life committee in place and the inspector saw minutes from the previous meeting. The inspector saw evidence that an end of life resource folder had been developed and available in each unit.

There was evidence that residents received care at the end of his/her life which met his/her physical, emotional, social and spiritual needs. Residents who spoke to the inspector spoke in a positive manner with regard to their care. Some residents expressed that in the event of becoming unwell, they would like to go to the acute services while other residents stated that they would prefer to stay in the centre. This information was captured in the residents’ care plans. If a resident did require admission to hospital the inspector saw that there were transition documents available to support continuity of care between the hospital and the centre.

Questionnaires, asking relatives’ opinions regarding end-of-life care were sent to the relatives of deceased residents. All responses reflected a high level of satisfaction with the care received with the exception of one which referenced lack of communication with families. The inspector reviewed a sample residents’ care plans on a unit with regard to end-of-life care and noted that they comprehensively captured residents' preferences at this time. Care plans were reviewed when updating a care plan, following a medical review or when a resident’s condition changed.

Staff were knowledgeable in how to physically care for a resident at end of life. The inspector viewed a care plan of a deceased resident and noted that staff were with residents as they approached the end of their life. Care plans viewed indicated that residents had their end-of-life care needs addressed without the need for transfer to an acute hospital.

A clinical nurse manager told the inspector that residents had very good access to the specialist palliative care services. This was a nurse led service which provided on site visits to residents and also advice via telephone. Staff who spoke with the inspector were familiar with the use of a syringe driver (a mechanical pump used to administer medications) in symptom management. There was good access to medical services as evidenced by the medical and nursing records. Documentation such as care plans reviewed by the inspector indicated that symptom control was effective for residents to ensure adequate pain relief and comfort at end of life.

Religious and cultural practices were facilitated. Residents had the opportunity to attend
religious services held in the centre. There was a church on site and ministers from a range of religious denominations visited. Inspectors saw that residents were visited by the local priest who provided pastoral care. Family and friends were facilitated to be with the resident at end of life. There was a family room on the first floor for visitors who were facilitated to stay overnight if required which had a sofa and facilities to prepare drinks and snacks.

A remembrance event had taken place in November 2014. A bereavement leaflet for relatives ‘The Bereavement Journey’ had been developed. The leaflet offered practical information on what to do following a death, information on how to access bereavement/counselling services and how to register a death.

Staff had received training in end of life care. Two nurses had completed a post graduate diploma in palliative care. The inspector saw that further training by the Irish Hospice Foundation (IHF) programme ‘What matters to me’ was scheduled to take place following inspection.

There was a procedure for the return of personal possessions. The inspectors saw that all belongings are recorded and returned following the death of a resident. Staff outlined to the inspectors that designed canvas bags were used to return personal possessions. The inspector observed these and other symbols used by the centre when end of life care was being provided.

Inspectors noted that the privacy of residents was respected as much as possible. As described under Outcome 12 the bedrooms consisted of hospital ward type accommodation. The centre was registered to accommodate 96 residents. There were six single rooms throughout the centre in total. In a unit one of the single rooms was located some distance from the nurses station. The nurse manager told inspectors that it was too far away to be used as an end of life care room. The multi occupancy bedrooms in each of the three wards were not suitable to meet residents’ needs due to their design and layout in relation to maintaining privacy and dignity. These multi-occupancy rooms accommodated up to six residents in ward bay type setting. Therefore the option of a single room in the event of more than one resident requiring end of life care could not always be guaranteed for residents. This is actioned under Outcome 12.

Judgment:
Compliant

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

Theme:
Person-centred care and support
**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspector reviewed the person in charge’s self-assessment questionnaire and the overall self assessment of compliance with Regulation 18 and Standard 19. The person in charge had assessed the centre as being compliant: Based on the findings on the day of inspection the inspector did not concur with this.

There was an up to date policy on food and nutrition which was found to be comprehensive. There was a designated folder on nutrition available for staff.

The inspector observed that food and hydration needs were assessed on admission using the malnutrition universal screening tool (MUST) and this was repeated on a three monthly basis or more frequently if required. The inspector observed mealtimes including lunch, afternoon refreshments and tea. Snacks and hot and cold drinks and fresh drinking water were readily available throughout the day. The inspector noted that staffing levels were adequate to meet the needs of the residents during mealtimes.

All residents had a nutritional assessment on admission and with information on their food preferences care plans for nutrition and hydration were drawn up. Care, nursing and catering staff worked together to ensure that information on residents’ specialist needs were up to date and that appropriate food was available and prepared according to residents' requirements. Staff said that there were formal and informal arrangements in place such as regular team meetings to communicate changes in residents’ diets to catering staff who kept records of all individual requirements in the kitchen.

The inspector met with the chef who confirmed that he met with the residents on a weekly basis and he also attended the resident’s meetings. Up-to-date information with regard to any changes in residents’ dietary requirements was available on a white board in the kitchenettes on the units. The chef and staff who spoke with the inspector had in-depth knowledge of residents’ likes and dislikes.

There was evidence that the food available reflected choice. There were some residents who liked to have their meals in a quieter atmosphere away from the dining room. Some who had single rooms had their meals there and others had meals by their bed. However, the inspector saw that residents’ privacy and dignity was significantly compromised due to the close proximity of many of the beds. The inspector observed a resident having his breakfast whilst sitting in the centre of a six-bedded unit with his meal on a bed table.

Residents were observed to be appropriately assisted if they needed help to eat. Staff sat and chatted with them while the meal progressed. Some residents had specialist cutlery which helped them eat independently. Tables were generally set attractively however in one unit the inspectors observed that there were not enough dining chairs and residents sat to the table in the lounge chairs. A number of these chairs were noted to be too low making it difficult for some residents to be able to access the table correctly and fully enjoy their meal. The catering staff told an inspector that meals were kept refrigerated for residents if they were out and provided at times they wished to eat.
Snacks were available at all times for residents as observed by the inspector.

There were good working relationships with specialist services such as the dietician and speech and language therapist who were available on site. Nurses could make direct referrals for consultation to these services and from the records reviewed there was a timely response with regular and once off assessments undertaken. Access to diagnostic services was through the local hospital or outpatient department. Residents also had access to dental services as observed by the inspector. A sample of medication administration charts were reviewed by the inspector. These indicated that nutritional supplements were prescribed by the GP and administered by nursing staff accordingly.

The inspectors noted that the dietician had only recently taken up her post in the centre. However, there was no evidence available that the menus and nutritional content of the food met the dietary needs of residents as prescribed by healthcare or dietetic staff, based on nutritional assessments in accordance with the individual care plans of residents. The chef also confirmed this to the inspector. Resident meal satisfaction surveys had been completed in August 2014. A sample viewed by the inspector indicated that residents were very happy with the food and choices provided.

The complaints log was also reviewed and there was evidence that any complaints concerning food were acted on promptly and the complainant's satisfaction with the outcome recorded. The chef told the inspector that if there were issues raised by residents he would go and see the resident themselves.

Recent training that had been completed in relation to nutrition included:

- managing dysphagia
- MUST training
- food supplement training.

The catering staff had completed food hygiene training.

**Judgment:**
Non Compliant - Minor

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**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:
Residents who spoke to the inspector said that staff addressed them respectfully and that screening curtains were used in shared rooms when personal care was being delivered. However, the inspector found that residents did not have sufficient space and privacy. The size and layout of the multi occupancy rooms meant that there was very little space between some of the residents’ beds. Residents were unable to undertake personal activities in private. The inspectors observed that some residents were trying to rest while another resident was talking beside them.

Residents’ privacy and dignity was also not protected in one of the units. On the first day of the inspection the inspectors saw that doors into two shower rooms in multi occupancy rooms were quite transparent and definitely would not protect the privacy and dignity of a resident having a shower in the room. The shower rooms were positioned at the entrance to the multi occupancy rooms so all people entering would have to pass by doors. It was also noted that some of the toilets also did not protect privacy fully as curtains were outside the room and therefore could be moved if someone wanted to look in. These issues required immediate action and on the second day of the inspection the person in charge informed the inspectors that these had been rectified but when the inspectors went to view the issues remained the same. The inspectors requested reassurance that these shower rooms would not be used until residents’ privacy and dignity could be protected which the person in charge agreed to.

Staff to whom inspectors spoke outlined that all residents were orientated into the centre by the nurse on the day of admission and that all staff wore name badges. There were notice boards available in the premise providing information to residents and visitors. Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities.

The person in charge outlined that there were also arrangements in place to ensure that the centre was managed with due regard to the individual resident’s religious, racial, cultural and linguistic background. Inspectors noted that staff consulted residents in the participation in the organisation of the centre and there were residents’ council meetings held regularly to ascertain residents’ views. In addition, after each council meeting inspectors noted that a centre specific newsletter was published to inform all residents of issues that had been agreed at the council meetings and also outlined some local news that might be of interest to residents.

Inspectors noted that a survey had been completed in relation to residents’ satisfaction with services provided in the centre. Inspectors noted that the respondents to this survey reported significantly levels of satisfaction with the services provided.

As discussed previously there were external independent advocates available to residents or relatives should they wish to obtain help to make a complaint or require assistance to express their views. Inspectors reviewed records of advocate visits and the issues that had been raised with advocates during their visit. Inspectors noted from these records that action was taken to address any issues raised. The resident advocate
who spoke to the inspector confirmed this to be the case and said management were open to issues raised.

The centre was suitably resourced with adequate daily entertainment and leisure facilities such TV, radio, newspapers and magazines. A dedicated activities co-ordinator was available to the centre and a further part time staff member was also available and dedicated to undertaking activities with the residents. They initiated and supervised a range of activities and outings which the inspectors saw ongoing during the inspection.

The inspectors saw residents participating in and enjoying the various activities and residents told the inspectors how important and beneficial they were to them.

There was a good level of visitor activity throughout the days of inspection with visitors saying they generally felt welcome to visit. The inspectors met and spoke with a number of visitors who indicated that they had open access to visit their relative. Accommodation was available to receive visitors both communally and in private in some units, but in others there were not private space for visiting.

Judgment:
Non Compliant - Major

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:
There was a policy for the management of residents’ accounts and personal property. A sample of residents’ records indicated that records of residents’ property was created on admission. Residents’ clothing is appropriately labelled and sent externally to be laundered. There had been a number of complaints seen in the complaints log in relation to clothing going missing when sent to the main laundry so a second service has been made available for laundering of person clothing which residents have expressed satisfaction with.

As stated in Outcome 12, due to multi-occupancy rooms there was insufficient space for all residents to store their own clothes and some were stored centrally in the unit. In addition, inspectors observed that due to the lack of space, residents displayed minimal personal effects which was also confirmed by staff to whom inspectors spoke.
Judgment:
Non Compliant - Moderate

**Outcome 18: Suitable Staffing**

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

**Theme:**
Workforce

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

**Findings:**
Based on their observations and a review of the staff roster, inspectors were not satisfied that staffing levels and skill-mix were adequate to meet the assessed needs of the residents and other factors such as the layout of the building and the specifics of each unit. The management of the roster was devolved to each unit manager. There was a minimum of one registered nurse on duty at all times on two units and two nurses on the third unit. Staffing levels in the morning generally met the needs of the residents. However, the inspectors expressed concern to see a number of residents only getting up prior to lunch time. Staff said for some of the residents this was their choice but for others staffing levels dictated the inability for them to be up earlier.

Staffing levels decreased from 16.45hrs onwards in all units and two units operated with one nurse and two care staff for the evening and the night. The night nurse had to do the night time medication round and therefore this left only two members of staff to give out evening drinks and assist residents to bed and with other personal care needs. The inspectors found that these staffing levels were not adequate to ensure the nurse administered the medications safely without interruption and to ensure residents had a choice in bedtimes. The inspectors observed and were told by staff that the majority of residents were in bed before the night staff came on duty at 20.00hrs.

There was a clear organisational structure and reporting relationships in place. There were designated CNM posts of responsibility on each unit for the supervision of care and services to residents and the supervision and direction of staff. The inspector saw records of regular meetings between the CNMs and senior nursing management at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the regulations and standards.

Inspectors observed appropriate interactions between staff and residents and they
observed staff chatting easily with residents. Residents and relatives told the inspector that staff were very kind and caring.

There was a recently written policy for the recruitment, selection and Garda Síochána vetting of staff. The current registration details were maintained for all nursing staff. The inspectors viewed a sample of staff personnel files. These files were well organised contained all the documentation required under Schedule 2 of the Regulations.

Inspectors noted that there was a selection of healthcare reading materials and reference books stored in nurses’ offices along with copies of both the Regulations and the Authority’s Standards. Inspectors viewed the staff training records which also identified staff who were due training. Staff to whom inspectors spoke were familiar with the training programme and confirmed to inspectors training they had attended or training they were due to attend. The person in charge confirmed that staff education and personal development was facilitated and provided records of a staff training schedule which included the following:

- adult abuse training
- infection control training
- management of violence and aggression
- cardiac pulmonary resuscitation
- fire training and evacuation
- dementia care
- palliative and end of life care

As discussed under outcome 8 a small number of staff were overdue fire training.

Agency staff were employed in response to staffing contingencies and the inspector saw that service agreements were in place with the respective agencies.

**Judgment:**
Non Compliant - Moderate

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**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:**

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

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<tr>
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<td>15/12/2014</td>
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<tr>
<td>Date of response:</td>
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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 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents had contracts of care in place.

Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
Plan in place to ensure that all contracts are in place especially if client has not capacity and relative out of the country

Proposed Timescale: 19/12/2014

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all contracts reviewed by the inspector set out the basic fee to be charged for the provision of care and services.

Action Required:
Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

Please state the actions you have taken or are planning to take:
Plan in place to ensure that all contracts have fees detailed.

Proposed Timescale: 19/12/2014

Outcome 04: Suitable Person in Charge

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge is in charge of three designated centres and spent only two days per week in the centre. The Authority was not satisfied that the person in charge is engaged in the effective governance, operational management and administration of the designated centres concerned due to the number of continual non compliances in the centres.

Action Required:
Under Regulation 14(4) you are required to: If the person in charge is in charge of more than one designated centre provide evidence to the chief inspector that the person in charge is engaged in the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
This has been escalated to National Social Care Office where it will be discussed with HIQA nationally
Proposed Timescale: 20/01/2015

**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:
The medication management policy did not outline the procedure for the prescription, administration and review of PRN medications.

**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:**
Medication management policy updated and plan to roll out the same Medication management committee set up to ensure compliances and meeting held with General Practitioners to ensure compliance

Proposed Timescale: 23/01/2015

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
If the resident died at the centre, the date, time and cause of death were not consistently recorded which is a requirement of the regulations.

**Action Required:**
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

**Please state the actions you have taken or are planning to take:**
Education on the Attention to detail of forms has been rolled out

Proposed Timescale: 12/01/2015

**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:
On one residents care plan it was stated that the resident was using bed rails on the family’s request, there was no evidence that the assessment required the use of bed rails and there was also no evidence of consideration of least restrictive alternatives to bedrail usage.

Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
The centre will ensure compliance with Regulation 07(3)

Proposed Timescale: 12/01/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system in place to manage residents finances at unit level was not sufficiently robust.

Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Robust policy in place to protect clients finances

Proposed Timescale: 19/12/2014

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:
There were areas of risk in the centre that required review.
Inspectors saw residents being transported in wheelchairs with no leg supports in use. The residents legs were trailing on the ground and this practice could cause injury to the resident’s legs and feet.
Inspectors noted that radiators remained very hot to touch and could cause a burn injury to residents this was also identified at the last inspection.
Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
All wheelchairs have been assessed to ensure that they are compliant to use.

Plan in place to ensure that radiators are not accessible to clients

Proposed Timescale: 28/02/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were a small number of staff who had not received 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 plan in process to train the 5 people not trained in fire

Proposed Timescale: 28/02/2015

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:
Based on a sample of prescriptions reviewed the inspector saw and staff agreed that:

• the dosage and maximum dosage of all medications prescribed on a PRN basis was not stated.
• Crushed medications were not consistently prescribed by the medical officer as is required by legislation.

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:**
Meeting held to discuss the issues with General Practitioner has taken place and the same will be carried out in accordance with Regulation 29(5)

**Proposed Timescale:** 20/01/2015

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### 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:
The inspectors noted that while some care plans were comprehensive, further personalisation of care plans would ensure person-centred care was delivered.

**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:**
There is process in place to ensure total compliance under Regulation 05(1)

**Proposed Timescale:** 12/01/2015

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### 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 environment was not suitable for the purpose of achieving the aims and objectives as set out in the statement of purpose and was not conducive to meeting the needs of residents.

**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:**
A design team has been appointed and work is under way on design and preparation of application for planning permission. It is estimated that this process should be completed later in 2015 (subject to stage approvals and no significant planning permission issues).

**Proposed Timescale:** 31/12/2015

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The premises posed numerous difficulties in the provision of care due to the lack of private and communal space and facilities for residents. The inspectors found that the centre required a large number of actions to ensure it met the requirements of legislation as outlined in schedule 6 of the Care and Welfare regulations 2013.

**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:**
A design team has been appointed and work is under way on design and preparation of application for planning permission. It is estimated that this process should be completed later in 2015 (subject to stage approvals and no significant planning permission issues).

**Proposed Timescale:** 31/12/2014

**Outcome 15: Food and Nutrition**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence available that the menus and nutritional content of the food met the dietary needs of residents as prescribed by healthcare or dietetic staff, based on nutritional assessments in accordance with the individual care plans of residents.

**Action Required:**
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.
Please state the actions you have taken or are planning to take:
A process is in place to ensure that nutritional assessment is in accordance with individual care plan

Proposed Timescale: 19/01/2015

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:
The size and layout of the multi occupancy rooms meant that there was very little space between some of the residents’ beds. Residents were unable to undertake personal activities in private.
Residents’ privacy and dignity was also not protected in one of the units doors into two shower rooms in multi occupancy rooms were quiet see through and definitely would not protect the privacy and dignity of a resident having a shower in the room.

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:
Shower doors have been replaced

Proposed Timescale: 23/12/2014

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Private facilities to receive visitors was not available in all units

Action Required:
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident’s room, if required.

Please state the actions you have taken or are planning to take:
There are 2 extra rooms available within centre for clients to use to meet visitors in private.

This will be addressed thoroughly through the new building
Proposed Timescale: 12/01/2015

**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:**
Due to multi-occupancy rooms there was insufficient space for all residents to store their own clothes and some were stored centrally in the unit. In addition, inspectors observed that due to the lack of space residents displayed minimal personal effects.

**Action Required:**
Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

**Please state the actions you have taken or are planning to take:**
All efforts are made to ensure that clients has access and retains control over the property and possessions and finances and choice is given to display their effects.

This will be addressed thoroughly through the new building.

Proposed Timescale: 19/01/2015

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Based on their observations and a review of the staff roster, inspectors were not satisfied that staffing levels and skill-mix were adequate to meet the assessed needs of the residents and other factors such as the layout of the building and the specifics of each unit.

**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:**
Roster review in place to address the skill mix where needed.
Proposed Timescale: 26/01/2015