### Centre name:
St Patrick’s Hospital

### Centre ID:
OSV-0000595

### Centre address:
John’s Hill, Waterford.

### Telephone number:
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### Email address:
bridget.kearns@hse.ie

### Type of centre:
The Health Service Executive

### Registered provider:
Health Service Executive

### Provider Nominee:
Barbara Murphy

### Lead inspector:
Catherine Rose Connolly Gargan

### Support inspector(s):
Ide Cronin

### Type of inspection:
Unannounced Dementia Care Thematic Inspections

### Number of residents on the date of inspection:
85

### Number of vacancies on the date of inspection:
11
About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 23 March 2016 09:00  To: 23 March 2016 17:30
24 March 2016 08:00  24 March 2016 12:00

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

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**Summary of findings from this inspection**

This report sets out the findings of an unannounced dementia thematic inspection by the Health Information and Quality Authority (HIQA). This inspection focused on specific outcomes relevant to dementia care in the centre. The inspection also followed up on progress with completion of the action plan from the last inspection of the centre in May 2015, self-assessment documentation, notifications and other relevant information. There were five actions for completion detailed in the action plan from the last inspection. The findings supported satisfactory completion of one action on medication management. The other four actions referencing regulatory non-compliances with the premises and residents' rights and dignity were not completed, but progressed by the provider with confirmation of approval of funding for a new 100-bed premises.

As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the provider nominee completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Inspectors met with residents and staff members during the inspection. They tracked the journey of four residents with dementia within the service and reviewed aspects of the care for others. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined the relevant policies including those submitted prior to inspection. Day-to-day management responsibilities are with the clinical nurse managers on each unit, who work closely with the person in charge.

Residents' accommodation in the centre comprises of three areas referred to as wards; St Malachy's, St Patrick's and Our Lady's. Residents with dementia were integrated with the other residents in the centre. Overall the inspectors found that the premises posed numerous challenges in the provision of care to residents with dementia due to limited private space and the standard of communal facilities for residents. The majority of residents were accommodated in multiple-occupancy bedrooms and there was insufficient storage for personal property and possessions. Inspectors found that the design and layout in all three areas of resident accommodation did not meet their stated purpose and did not provide a therapeutic or comfortable environment for residents with dementia. A regulatory improvement notice was issued on 13 April 2015 and inspectors
observed that no substantial action had been taken to address major regulatory non-
compliances with the current premises and residents' quality of life therein, since the
registration renewal inspection in December 2014. In fact, many of the previously
identified non-compliances found to be satisfactorily addressed in the follow-up
inspection in May 2015 have not resulted in sustained improvement. Inspectors
found on this dementia thematic inspection that the design and layout of the
premises in addition to staffing arrangements had a significant impact on the quality
of life for residents in the centre. These findings are discussed throughout the report.

The Action Plan at the end of this report identifies areas where improvements are
required to comply with the Health Act 2007 (Care and Welfare of Residents in
Designated Centre's for Older People) Regulations 2013 and the National Quality
Standards for Residential Care Settings for Older People in Ireland.

The response forwarded to HIQA by the provider to actions required numbers 5, 10
and 16 detailed in the Action Plan at the end of this report do not satisfactorily
address non compliance with the regulations.

### 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: Health and Social Care Needs

**Theme:**
Safe care and support

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

**Findings:**
This outcome sets out the inspection findings relating to healthcare, nursing
assessments and care planning. Findings regarding the social care of residents with
dementia are comprehensively covered in Outcome 3.

There were 85 residents in the centre on the day of this inspection of whom; 67
residents were admitted on a long-stay basis, three for respite care and 15 for
rehabilitation care. 50 (75%) residents had assessed maximum dependency needs. 28
(42%) residents had a formal diagnosis of dementia and a further three residents had
symptoms of dementia.

Inspectors focused on the experience of residents with dementia in St Patrick's and St
Malachy's wards. They tracked the journey of four residents with dementia and also
reviewed specific aspects of care such as nutrition, wound care and end-of-life care in
relation to other residents.
Inspectors found that there were systems in place to optimise communications between the resident/families, the acute hospital and the centre. All residents admitted under ‘Fair Deal’ had a Common Summary Assessment (CSARs) completed, which detailed the pre-admission assessments undertaken by the multidisciplinary team. Inspectors observed that residents transferred to hospital from the centre had appropriate information about their health, medications and their specific communication needs included with their transfer letter. Additional information to support residents, with behaviours that challenge was also included.

Comprehensive nursing assessments, using validated assessment tools were carried out on admission of all residents including those with dementia. Each resident had a care plan developed to address their individual needs. Residents' care plans were reviewed and updated if necessary every four months or more frequently in response to changing needs. However, there was inconsistent documentation referencing residents' and or their families' involvement in the development of care plans. Although inspectors were told that residents and or their relatives were consulted when care plans were reviews, this was not documented. Inspectors also found that some residents' needs were not informed by a comprehensive care plan. For example, end of life care, management of behaviours that challenges and management of pain care plans.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents’ weights were monitored on a monthly basis or more often when unintentional weight loss or gain was identified. Residents were appropriately referred and reviewed by a dietician and or speech and language therapy services. Recommendations made were recorded in care plan interventions and were observed to be implemented. Inspectors observed the lunchtime meal in one resident area on the day of inspection. Residents had a good choice of menu. Menus were displayed on dining tables and text included photographs of the various dishes available to support residents with making informed choices about their food and fluid intake. Staff were observed discussing menu choices with residents whilst referencing the menu to give them opportunity to change their choice if they wished. Modified consistency meals were presented to a high standard.

While residents’ nutrition and hydration needs were generally met, their mealtime experiences were negatively impacted on by the environment. The dining area was crowded and the environment was very warm. Not all residents had opportunity to eat their meals from a table. Residents needing assistance with eating and using specialist seating were seated around the perimeter of the dining area. As insufficient tables, including mobile tables were available, staff held resident's food receptacles in one hand whilst providing assistance with the other hand. This finding did not promote residents with dementia to eat independently and to maintain their dignity. The meal was not a social occasion and whilst most staff providing assistance, paced the meal appropriately and talked with residents, some were observed to engage in no conversation and to rush residents with eating their food.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and were implemented for the residents whom inspectors case-tracked. The inspectors reviewed a sample of residents' medication
prescription and administration records. Findings confirmed residents were protected by safe medication policies and procedures. An action plan from the last inspection of the centre in May 2015 referencing prescription of medications in 'crushed' format was found to be satisfactorily completed. However, improvement was required in the management of behaviour that challenges with administration of PRN (as required) psychotropic medications to ensure they were documented as a de-escalation intervention of last resort in behavioural intervention care plans. This finding is also discussed in outcome 2.

Residents had a choice of GPs who attended the centre at least weekly. They also had access to allied healthcare professionals including physiotherapy, occupational therapy, dietetic, speech and language therapy, dental and podiatry services. Residents also had access to mental health of later life and palliative care services.

Staff provided end-of-life care to residents with the support of their medical practitioner and community palliative care services. Single rooms were available for end of life care and relatives were accommodated in the centre's family room. Relatives of a resident in receipt of end of life care, spoken to by an inspector were complimentary of the care provided to their relative and the support they received. Staff outlined how residents' religious and cultural practices were facilitated within the centre. Residents had access to a large church which was also available to them for funeral services. Palliative care services were available to support residents and staff with symptom control, including pain management. Residents' 'end of life' preferences and wishes were reviewed as part of their comprehensive assessment on admission. However, care plans that outlined residents' physical, psychological and spiritual needs, including their preferences regarding their preferred setting for delivery of their end of life care were not in place for some residents. Advanced directives were not supported with documented multidisciplinary input including the involvement of the resident concerned.

The Health Information and Quality Authority (HIQA) was notified of one resident with a pressure-related skin ulcer since 01 January 2015, this skin ulcer was present on the resident's admission and was managed in line with evidence-based best practice. Wound management records were informative regarding care procedures and photography was used to track wound healing. Tissue viability nurse specialist advice was available to support staff with care of residents' wounds in the centre if required. Inspectors reviewed pressure ulcer preventative care and found residents at risk of developing pressure ulcers had appropriate assessments and care plans completed. Pressure-relieving equipment such as, mattresses and cushions to prevent ulcers developing was available and observed in use. However, the inspector observed that some incidents of pressure ulcers were not notified as required to the Authority in 2015. This finding is discussed and actioned in outcome 8. In addition, there was some evidence that pressure-ulcer classification was not in line with contemporary evidence-based nursing.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised and care plans were updated to include interventions to mitigate risk of further falls. A National Incident Management System (NIMS) was populated with this information. Falls audits were completed and included action plans that informed falls management. There was evidence that a recent
increase in staffing in one ward area from 16:00 to 20:00hrs addressed a notable increase in falls identified on an audit completed for the period - October to December 2015. However, inspectors found that staffing levels required further review to address findings of increased accidents and incidents including medication errors from 20:00 to 08:00hrs from 01 January to 21 March 2016. Inspectors also found improvement was required in staff supervision of residents, especially in the morning time periods. This finding is discussed and actioned in outcome 5 and 7.

Frequency of audits by the pharmacy service required improvement to ensure their completion on a quarterly basis. While residents’ medications were dispensed as needed, improvement was required to ensure the pharmacy service was facilitated to meet their obligations as required by the regulations.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
There were measures in place to ensure residents were safeguarded and protected from abuse. However, some improvements were required regarding investigation of incidents of unexplained bruising and appropriately responding to some incidents of residents requesting attention from some staff. Improvement was also required in management of behaviours that challenges. The inspectors observed that allegations of abuse were investigated and arrangements were put in place to ensure residents were safeguarded during the investigation process.

The safeguarding policy had been updated to reference the National Policy. Staff training was underway on the revised procedures. Staff training records indicated that all staff had attended or were scheduled to attend annual training on the prevention, detection and response to suspicions or allegations of abuse. Staff spoken with confirmed to inspectors that they had received this training and were aware of what to do if they suspected or were informed of an allegation of abuse. The inspectors followed up on two notifications to HIQA of alleged peer to peer abuse and observed both were managed in line with the centre's policy. There was also a small number of incidents of bruising to residents skin, for which a cause was not confirmed to outrule abuse.

Some staff had attended training on dementia care, which included managing behaviours that challenge. From a review of the incident log for 2016, the inspectors observed that there were a number of residents with frequent episodes of significant
behaviours that challenge. Residents experiencing episodes of behaviours that challenge were regularly reviewed by their GP, and referred to mental health of later life for further specialist input. Staff were knowledgeable regarding triggers to individual resident’s behaviours that challenges and effective interventions for their de-escalation. However, individual behaviour management care plans did not contain sufficient detail to guide the care of residents with behaviours that challenge including the use of PRN psychotropic medications as an intervention of last resort.

Restraint use such as bedrails, lap-belts and alert bracelets were appropriately notified to HIQA. However, use of PRN psychotropic medications was not included on notification information. This finding is discussed and actioned in outcome 8. Inspectors found that efforts were being made to promote a restraint-free environment. There was evidence of alternative use of less restrictive devices, such as low-low beds, floor mattresses, alarm mats and half-rails to enable residents' independent mobility while in bed. These measures achieved goals of care without restricting residents’ freedom.

**Judgment:**
Non Compliant - Moderate

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**Outcome 03: Residents’ Rights, Dignity and Consultation**

**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 systems in place to support residents to exercise their religious, civil and political rights. However the premises did not support staff to respect the privacy and dignity of residents. There were notice boards available in the centre 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. External independent advocates were 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. There was a residents’ forum in place and meetings took place on a monthly basis.

Residents were facilitated to exercise their civil, political and religious rights. Residents told the inspector that religious services were held regularly and the inspectors observed the church located on-site. Inspectors were told that residents were enabled to vote in national referenda and elections with the centre registered to enable polling. In one unit five residents had voted in recent elections and a staff member told an inspector that two of the five residents had a cognitive impairment.
Inspectors observed that staff made all efforts to maintain privacy of residents as much as possible, whilst assisting with personal care, by closing bed-screen curtains and bedroom doors. However, the findings of this inspection confirmed that the privacy and dignity needs of residents with dementia were not adequately met on this inspection.

Inspectors found;
- that residents did not have sufficient space and privacy.
- the design and layout of multiple occupancy bedrooms meant that there was limited space between most of the residents’ beds. -- residents could not undertake personal activities in private in their bedroom.
- residents were unable to rest in a chair within in their personal bed-space due to restricted space available to them.

The inspectors observed that the environment was generally hot, stuffy and in some areas contained malodours. Some residents with dementia were disturbed by the noisy, crowded environment, other residents shouting, inadvertently entering their private space and exposure to residents who had behaviours that challenges. These findings were informed by inspectors’ observation, discussions with residents, review of a quality of service evaluation survey done in February 2016, review of residents' documentation records and review of the centre’s accident and incident log. As discussed in outcome 2, there were a number of significant incidents of behaviour that challenges. There were also incidents of attempted self-harm, behaviours that challenge and residents entering other residents bedrooms.

Inspectors’ observations and review of residents’ documentation did not support findings that residents with dementia were provided with adequate and appropriate activation to meet their needs, Residents did not have access to a safe and secure external area. The feedback from the service evaluation survey completed in February 2016 confirmed residents' expressed wishes to go on outings and out around the grounds more often to 'breath fresh air'. Residents also stated they had difficulty sleeping due to noise levels in the ward.

Inspectors observed and reviewed the activation service provided to residents. Findings did not confirm that residents with dementia were given opportunities for participation in meaningful, purposeful and age-appropriate activities to suit their assessed and documented activation needs, preferences and capacities. Inspectors found that particular consideration was not given to residents with dementia. There was one activity co-ordinator available to meet the activation needs of all residents in the centre. Healthcare assistant staff were busy with meeting the care needs of residents and did not have a defined role in providing activities. The activity coordinator told inspectors that the Sonas programme had not been facilitated for over three weeks as transition year students were not available to assist her. Inspectors observed that there was limited use of other techniques such as reminiscence, reality orientation or use of sensory equipment for residents with dementia.

Inspectors observed that there were prolonged periods of time when a staff member was not present with residents in the communal sitting/dining rooms and multiple-occupancy bedrooms. Some staff were observed to be busy and rushed and did not engage with some residents seeking their attention. One resident said she would love a “cup of tea but the staff take so long”. Another resident told an inspector that “she was
bored and there was nothing to do all day”.

Inspectors used a validated tool to observe staff-resident interactions for four 30 minute periods during the early morning, prior to, during and after lunch and in the afternoon. These observations took place in communal areas/dining areas on two units in the centre. Although there were some instances of person-centred care observed, overall, inspectors observed that care was primarily task oriented. Some staff were observed to make eye contact, use touch and gentle encouragement in low key moderate and supportive tones of voice. However, inspectors also observed that many staff did not engage residents in conversation except for the purpose of performing a task.

Although staff seemed familiar with residents' basic physical care needs and some of their family background, efforts to connect on a personal level and chat about their family, previous interests or working life were limited. Overall staff did not avail of opportunities to engage with residents in manner which might enhance their emotional or psychological wellbeing. Overall observations of the quality of interactions between residents and staff in the communal area of each unit for selected periods of time indicated that the majority of interactions were of a neutral nature. In that, for the majority of the residents in these communal areas, there were no therapeutic person-centred interactions with staff and most residents were disengaged or asleep in their chairs with no stimulation for considerable periods of time. Inspectors formed the judgement that meaningful self expression was not facilitated by occupational, recreational physical or sensory stimulation.

There was a good level of visitor activity throughout the day of inspection with visitors saying they generally felt welcome to visit. Visitors met their relatives in the communal room or in their bedrooms. There was a room available between two of the three wards where residents could meet their visitors in private.

**Judgment:**
Non Compliant - Major

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**Outcome 04: Complaints procedures**

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

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

**Findings:**
There were systems in place to ensure that the complaints of residents with dementia or their representative were listened to and acted upon. There was access to an appeals procedure.

There was a complaints policy in place. The complaints procedure was summarised in
both the statement of purpose and the resident’s guide documents. Information for residents and visitors on how to make a complaint was clearly on display in the centre.

Verbal complaints were documented and inspectors were told this information was used to inform service improvements. The person in charge advised inspectors that most complaints were managed at a local level. Complaints that could not be resolved locally were escalated up to the person in charge as the designated complaints officer. Some residents spoken to could tell inspectors who they would bring a complaint to. Records viewed on one unit indicated that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded.

The inspectors reviewed the documentation referencing three complaints received since January 2015 as recorded in the complaints log. The documentation recorded details of the complaint, investigation details and whether or not the complainant was satisfied with the outcome.

Three independent advocates supported residents with dementia and their families to raise issues of concern. Relatives spoken to by inspectors were satisfied that issues raised on behalf of residents were addressed. Information was also available on the rights of residents and visitors and provided the contact details of advocacy agencies.

**Judgment:**
Compliant

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**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

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

**Findings:**
The findings of this inspection did not confirm that adequate staffing resources were in place to meet the needs of residents including residents with dementia. Inspectors’ observations on the days of inspection and review of the staff rosters did not provide assurances that staffing levels and skill-mix was adequate to meet the assessed needs of residents. Management of the staffing rosters were devolved to each unit manager.

There was a clear organisational structure and specified 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 inspectors saw records of regular meetings between the CNMs and senior nursing management at which operational and staffing issues were discussed. The inspectors also saw that staff had copies of the regulations and standards available to them.
The staffing arrangements did not support the safe care of residents due to the following findings;
- availability of staff who were familiar with the centre from the external agency was not assured on a consistent basis
- arrangements for induction and supervision of new staff to the centre from the external agency was not robust
- the clinical nurse managers were unable to fulfil their clinical leadership role, as they were required to work as nurses providing care.
- nurses who acted up for the assistant director of nursing, who was on leave, were not always replaced at ward level.
- there were prolonged periods where residents were not supervised in the communal sitting/dining rooms and multiple occupancy bedrooms
- residents' activation needs were not met.
- Night duty staffing arrangements needed review, as 55% (32) resident fall incidents in the centre from 01 January to 21 March 2016. 32 (55%) occurred between 20:00hrs and 08:00hrs.
- staff reported to inspectors that their ability to engage in person-centred care at all times was compromised due to the volume of work that needed to be completed.

Inspectors found that on an ongoing basis, high numbers of contracted staff from an external staff agency to replace staff on leave and to fill vacant positions. There were efforts demonstrated to ensure staffing levels and skills met the needs of residents. On the week previous to the inspection, approximately 12 whole-time equivalent (WTE) staff hours were provided by contracted staff. However this arrangement did not offer continuity of care or support the provision person centred care for people with dementia.

Staff training records confirmed attendance at mandatory and professional development training. While many staff had attended training provided in pressure ulcer classification, behaviours that challenge, person-centred care and activation of residents with dementia, the inspection findings confirmed that all staff would benefit from attending this training. Inspectors held the view that the culture of care and staffing levels did not support the implementation of new learning to enhance the care of residents with dementia.

The inspector read a sample of staff files, which were in line with the requirements of the regulations and contained the required information, such as photographic identification, two references and Garda Síochána vetting. There was a staff recruitment policy in place.

**Judgment:**
Non Compliant - Major

**Outcome 06: Safe and Suitable Premises**

**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:
Residents' accommodation in the centre is located on ground floor level and comprises three wards/units: Our Lady’s, a 36-bedded unit of which 15 beds were assigned for residents admitted for rehabilitation care, St Malachy’s is a 34-bedded unit and St Patrick’s is a 26-bedded unit. Inspectors observed that while there were some single and two-bedded rooms available, accommodation consisted primarily of multiple-occupancy bedrooms with 4 to 12 beds in each.

Residents with dementia were integrated with other residents in the centre. 26 of the 28 residents with a formal diagnosis of dementia were accommodated in multiple occupancy bedrooms. The design and layout of the multiple occupancy bedrooms and the communal dining/sitting rooms did not meet their stated purpose. These areas did not provide a therapeutic or comfortable environment for residents with dementia in any of the three wards in the centre.

St Malachy’s Ward provides accommodation for 34 residents. 17 (50%) residents with dementia resided in this area on the days of this inspection. Residents were accommodated in two single bedrooms, one twin bedroom; two bedrooms with five beds in each, two bedrooms with ten beds in each. The bedrooms with ten beds were sub-divided into three bays. There was insufficient space in all multiple occupancy bedrooms to meet the needs of residents, including residents with dementia. One of the two bedrooms with ten beds was subdivided into three bays. A bathroom with toilet facilities was located within the confines of this bedroom. The second bedroom with ten beds was arranged into two separate rooms – one room led into another by means of a doorway. Six residents were accommodated in two bays in the first room. There was no toilet or washing facilities in this room. Residents who wished to avail of these facilities were required to pass through the second room which accommodated three residents. There was one communal sitting/dining room available that did not provide adequate space for all 34 residents to dine or rest comfortably together. There was no alternative space available for residents to meet with their visitors, for residents with dementia who were disturbed by noise levels to rest quietly or to undertake dementia –specific sensory therapies. Storage of personal clothing was limited with many residents provided with narrow wardrobe space. There was also limited or no suitable space to display photographs or personal items.

St Patrick’s Ward provided accommodation for 26 residents. Eight residents with dementia and three residents with symptoms of dementia resided in this area. Residents were accommodated in two single bedrooms, two bedrooms with six beds in each, and a bedroom with 12 beds, which was sub-divided into three bays with four-beds in each. There were three windows located in one bedroom accommodating six residents, two windows opened into a corridor and the third window was located at an inaccessible height. It was not operational and was covered by a closed roller-blind. A resident’s bed was pushed against a built-in wardrobe on one side of this room rendering the built in
wardrobe storing five residents’ clothing inaccessible. The room was confined, hot and stuffy due to the absence of adequate ventilation. A toilet and bathroom was located outside this bedroom. Beds were placed closely together and there was limited space between beds and bed-screens. A similar layout was observed in the second bedroom with six beds. An en-suite toilet and shower was available in this bedroom. The bedroom accommodating 12 beds was found by inspectors to be hot, stuffy and the environment contained malodours. The windows in the three bays in this room were located at an inaccessible height and did not facilitate residents with a view through them or access to open them for ventilation. Two en-suite toilet/washing facilities were available to residents in this room. Due to the layout of the bays, residents could not easily view televisions and the inspectors observed there were a total of six televisions located in this bedroom. The beds were placed closely together with limited space between beds and bed-screens. The communal sitting/dining room in this ward did not provide adequate space for 26 residents to dine or rest comfortably together. The room was noisy, hot and confined. An area with glass walls on three sides was located between St Patrick’s and Our Lady's ward and was available for residents or meet their visitors in private if they wished. This room was functional, however, was not decorated to reflect a familiar homely environment, which would benefit residents with dementia.

Our Lady's Ward was observed to be of a better standard in terms of space available to residents. This area provided accommodation for 36 residents. Twenty four beds were assigned as accommodation for residents with rehabilitation/respite care needs. Three residents with dementia or symptoms of dementia resided in this area. Residents with long-term care needs were accommodated in two bedrooms with six beds in each. Both these bedrooms had en-suite toilet and shower facilities. However, although these bedrooms provided more space for residents, their privacy and dignity needs could not be met. Screen curtains did not satisfactorily contain noise and odours or afford residents privacy to converse with visitors or others if they wished. There was limited personalisation of bed-spaces by residents. The design and layout of these bedrooms did not provide a therapeutic environment for residents with dementia.

The inspectors observed that the fabric of the premises was maintained to a generally adequate standard of décor in that areas where residents resided were painted and furniture and fittings were in working order. However, none of the resident areas were homely or decorated to a standard that reflected best practice in dementia care. All areas were crowded, busy and noisy. Residents’ accommodation was institutional in style throughout. Most of the residents' toilets had only one or no grab-rails fitted. The inspectors observed that a disposal unit in the sluice in one ward area was leaking. The leak was collected in a receptacle fitted underneath. There was evidence that some efforts had been taken where possible in creating a more familiar environment for residents with photographs and pictures on the walls in communal areas. The communal rooms in two wards had large windows that provided plenty of natural light. There was a central kitchen located off-site, from which residents’ meals were transported to small pantries in each ward.

The provider and person in charge acknowledged the inspection findings and confirmation of funding for a new community nursing unit to replace the existing centre on the hospital grounds for completion by December 2019 was forwarded to HIQA. This information has been also forwarded as part of the renewal of registration of the centre.
Given the numbers of maximum and high dependency levels of residents, many were observed to use assistive equipment to support their needs. Inspectors observed 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 storage of residents' equipment. Inspectors also observed that due to lack of personal space, residents displayed minimal personal effects and many residents' beds- spaces were not personalised. There was insufficient space for residents to have a chair by their bedside and therefore bedrooms were used as a functional space for sleeping in. As many residents needed large assistive wheelchairs, the lack of adequate communal space also negatively impacted on their quality of life.

Inspectors noted that some seating had been provided in some areas outside the wards including a long corridor between St Patrick's ward and Our lady's ward. There were garden areas around the centre, however residents with dementia did not have access to a safe and secure external area. All of the above issues were identified on all previous inspections and were identified as a major non-compliance with the regulations.

**Judgment:**
Non Compliant - Major

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**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The management team comprises the nominated registered provider, the person in charge and two assistant directors of nursing. There is a clinical nurse manager 2 (CNM 2) in charge, responsible for the day to day running of each of the three units. Records were available of minutes of meetings held at each level within the team.

There were systems to in place to monitor the quality and safety of care including established forums to consider the findings of audits on areas such as falls, hand hygiene, residents' satisfaction and medication management procedures among others. The inspectors saw that the findings of the audits were clearly analysed and action plans were developed to address areas requiring improvement. While there was evidence that actions were completed, completion timescales were not established in all cases.

There was appropriate assistive equipment available to meet residents’ needs such as electric beds, wheelchairs, hoists and pressure-relieving mattresses. HIQA was forwarded confirmation of funding approval from the Health Service Executive on 01 April 2016 for construction of the new facility as planned. However, inspectors observed
that no substantial or tangible action had been taken since the last inspection to address
the current premises which does not meet its stated purpose and has been in ongoing
major non-compliance with the regulations as outlined in all previous inspection reports.

Inspectors found there were insufficient staffing resources provided to meet the needs
of residents including residents with dementia. These findings are discussed in outcome
5.

**Judgment:**
Non Compliant - Moderate

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**Outcome 12: Notification of Incidents**

**Theme:**
Effective 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. However,
notification of use of PRN (as required) psychotropic medications used to de-escalate
behaviours that challenges were not included in quarterly notifications forwarded to
HIQA. There were incidents of residents admitted with pressure ulcers and pressure
ulcers that occurred in the centre in 2015 that were not notified to HIQA as required.
Although unharmed, there were three unnotified instances since 01 January 2016,
where two vulnerable residents left the centre unaccompanied, one resident was located
outside the designated centre in an area on the first floor of the building and the other
resident left unnoticed through a fire exit on two occasions. These incidents were also
not notified to HIQA

**Judgment:**
Non Compliant - Major
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Patrick's Hospital</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000595</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>23/03/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>10/05/2016</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 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inconsistent documentation referencing residents' and or their families' involvement in the development of care plans.

1. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
it, after consultation with the resident concerned and where appropriate that resident’s family.

Please state the actions you have taken or are planning to take:
All residents Care plans are in the process of been audited and reviewed to ensure residents who have capacity have been consulted and relatives are also invited to participate in the planning of care.

**Proposed Timescale:** 29/04/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents’ needs were not informed by a comprehensive care plan.

2. **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:
All care plans are been audited and process in place to address non compliance

**Proposed Timescale:** 29/04/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was some evidence that pressure-ulcer classification was not in line with contemporary evidence-based nursing.

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

Please state the actions you have taken or are planning to take:
Pressure sore to zero information (HSE Quality Improvement Division) is been disseminated to all areas to ensure evidence based practice is carried out by all nurses in this area. This will be subject to ongoing review.

**Proposed Timescale:** 25/04/2016

**Theme:**
Safe care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans that outlined residents' physical, psychological and spiritual needs, including their preferences regarding their preferred setting for delivery of their end of life care were not in place for some residents.

Advanced directives were not supported with documented multidisciplinary input including the involvement of the resident concerned.

4. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
Staff meetings have been held to ensure that staff are aware of the need for appropriate care planning when residents are approaching end life and to take cognisance of the fact that many residents do not have capacity. Advanced directives are in place and are currently being audited for multidisciplinary input

Introduction of the “Think Ahead Forms” has commenced for all residents who choose to participate

**Proposed Timescale:** 13/05/2016

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents did not have access to a table to promote independent dining and dignity

5. Action Required:
Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

Please state the actions you have taken or are planning to take:
PIC has ensured that all staff are fully aware of the requirement to ensure residents have access to a bed table during mealtimes. This will be subject to ongoing observation by nursing management.
Re organisation of dayrooms has occurred to facilitate more space and discussion with residents about providing a 2nd sitting in the dining areas has commenced

**Proposed Timescale:** 05/05/2016
Outcome 02: 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:
Behaviour management care plans did not include details of triggers and de-escalation management interventions including administration of PRN (as required) psychotropic medications

6. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
Evaluation of all Antecedent Behaviour Charts is to take place to ensure all staff are aware of triggers and de-escalation interventions. To ensure the management of residents with behaviour that challenge has consistent approach a comprehensive care plan is put in place to ensure all details are documented in the managed of the residents

Proposed Timescale: 03/05/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Incidents of bruising of unknown origin to vulnerable residents’ skin that were not investigated to out rule abuse

Some residents' requests for attention from staff were not appropriately responded to.

7. 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:
Local policy is been developed to ensure staff are aware of the need to investigate all bruising of unknown origin to out rule abuse. Training in the National Policy and procedures of SafeGuarding of Vulnerable Persons at Risk of abuse has commenced and will be ongoing on 2 weekly basis

Proposed Timescale: 09/05/2016
### Outcome 03: 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:**
Findings did not confirm that residents were given opportunities for participation in meaningful, purposeful and age-appropriate activities to suit their assessed and documented activation needs, preferences and capacities.

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

**Please state the actions you have taken or are planning to take:**
Activation has been given priority by management and from 18th April there are now 2.3 WTE working in the area covering from 10am to 7pm to ensure residents can participate in meaningful and appropriate activities.

**Proposed Timescale:** 18/04/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was inadequate facilities to provide residents with adequate occupation and recreation including a safe accessible outdoor space.

**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:**
Plans are been developed to provide a secure area for the residents of St Patrick’s ward to access a garden to the front of the building.

All other wards have access to secure gardens.

**Proposed Timescale:** 30/06/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents’ were unable to undertake personal activities in private in multiple occupancy.
### 10. 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:
There are current limitations however all beds have screens and are always used by staff to ensure privacy and dignity. On completion of the new 100 bed CNU, there will be single rooms available for all residents.

**Proposed Timescale:** 01/05/2019  
**Theme:**  
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
Residents did not have access to facilities to meet their visitors in private if they wished in one ward in the centre.

### 11. 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 three rooms available for residents to meet visitors in private. One is located on the ground floor and two are located on the second floor (which is accessible by a lift). All residents and relatives are made aware of same on admission. In the new build all areas will have private seating areas available.

**Proposed Timescale:** 25/03/2016  
**Theme:**  
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
Some residents could not access their wardrobes due to layout arrangements of beds in multiple occupancy bedrooms.

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

Please state the actions you have taken or are planning to take:
There is a limitation to the size of the wardrobes available to residents at present however the layout of wardrobes has been organised to ensure that there is space for
patients clothes and that all clients can access their clothes.

**Proposed Timescale:** 27/04/2016

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Many residents in multiple occupancy bedrooms did not have suitable space for displaying their photographs and personal items.

**13. Action Required:**
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

**Please state the actions you have taken or are planning to take:**
Even though there is limited space there has been consultation with all residents and relatives for the preference to personalise their area and if further shelving is required the same will be provided

**Proposed Timescale:** 30/03/2016

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The numbers and skill mix of staff did not adequately meet the needs of residents including residents with dementia.

**14. 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:**
Local recruitment campaigns are underway in order to populate vacant posts staff both nursing and healthcare assistant in effort to reduce the dependency on agency. HCA interviews on 12th 13th 17th and 18th May. Nursing interviews have been completed and HR issuing contracts. The skill mix within the unit is at normal limits for that of 96 beds.
Meeting held with agency on 29th April 2016 to discuss the provision of same staff to allow continuity within the hospital. Team nursing is encouraged and support staff are supervised by the leader of the team. Each agency is inducted on their first day and policies and procedures are explained. All agency staff are educated to Fetac level 5/6.
Proposed Timescale: 01/07/2016

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The findings of this inspection confirmed training was required in pressure ulcer classification, behaviour that challenges, person-centred care and activation of residents with dementia was required.

15. 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:
Training is been put in place for staff
- Wound Management 31st May and 13th June 2016
- Person centred training 25th May 2016
- Behaviours that challenge 3rd May 2016
- Training in activation for dementia April 2016 and 25th May 2016

Proposed Timescale: 30/06/2016

Outcome 06: 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 design and layout of the multiple occupancy bedrooms and the communal dining/sitting rooms did not meet their stated purpose. These areas did not provide a therapeutic or comfortable environment for residents with dementia in any of the three wards in the centre.

16. 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:
In the new 100 bed community nursing unit there will be single rooms access to gardens, activation rooms, quiet rooms, separate dining and sitting room areas

Proposed Timescale: 01/05/2019

Theme: Effective care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Areas of the premises did not conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre as follows:
- there was inadequate ventilation in some multiple occupancy bedrooms. Windows were at an inaccessible height.
- most residents' toilets had only one or no grab-rails fitted.
- a waste disposal unit in the sluice in one ward area was leaking.
- there was inadequate storage space available for storage of residents' equipment.

17. 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:
All maintenance has been completed on waste disposal system on 24/03/2016.
Assessment of the need for grab rails will be undertaken by Occupational therapist and completed by 10/05/2016. Commencement of installing will commence on week of the 16th May 2016 and completed within 3 working days
Space for the storage of non appropriate equipment is provided in area on First Floor which is accessible by lift.

Proposed Timescale: 18/05/2016

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there was evidence that some improvement actions were completed as an outcome of audits, completion timescales were not established in all cases.

An effective system was not in place to ensure improvements made following previous inspections were sustained.

18. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
Evaluation System has been put in place to review all audits and action plans. This system will be carried out on a monthly basis. The findings will be an agenda item at the monthly governance meetings chaired by the registered provider.
Proposed Timescale: 05/05/2016

Outcome 12: Notification of Incidents

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were incidents of residents admitted with pressure ulcers and pressure ulcers that occurred in the centre in 2015 that were not notified to HIQA as required.

There were three unnotified instances since 01 January 2016, where two vulnerable residents left the centre unaccompanied.

19. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
All notifications have been submitted in accordance regulatory requirement

Proposed Timescale: 09/05/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Notification of use of chemical restraint were not included in quarterly notifications forwarded to HIQA

20. Action Required:
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

Please state the actions you have taken or are planning to take:
Use of chemical restraint will be notified in accordance with regulatory requirement

Proposed Timescale: 31/03/2016