

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Patrick's Hospital
Centre ID:	OSV-0000589
Centre address:	Cahir Road, Cashel, Tipperary.
Telephone number:	062 611 00
Email address:	joanf.brosnan@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Breeda Desmond
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	95
Number of vacancies on the date of inspection:	7

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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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:	To:
23 July 2018 10:30	23 July 2018 17:30
24 July 2018 08:30	24 July 2018 16:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Major
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an unannounced thematic inspection that focused on six specific outcomes of dementia care. In addition, the inspector followed up on progress of the action plan from the last inspection.

The inspector noted that the provider representative and the person in charge were committed to providing a quality service for all residents including people with a diagnosis of dementia. The person in charge completed the self-assessment on dementia care and the judgments of the self-assessment and the inspection findings are stated in the table above. The centre did not have a dementia specific unit and at the time of the inspection there were 41 people living in the centre with a formal diagnosis of dementia.

Care practices and interactions between staff and residents who had dementia were observed using a validated observational tool. The inspector viewed that some residents required a high level of support and attention due to their individual communication needs and dependencies. While all care staff had responsibility to help residents exhibiting aspects of responsive behaviours, observations demonstrated that some staff did not actively engage in a positive connective way to enhance their quality of life.

There were three staff on the activities team and activities were varied and activities staff showed good insight regarding promoting individualised activities to enhance peoples' quality of life.

Observation and discussion with staff demonstrated that not all staff understood or provided person centred care. Consequently, institutional practices, with rigid daily routines were evident, which resulted in significant negative outcomes for some residents. The inspector observed that there was inadequate staff supervision to ensure that appropriate care was delivered that enabled quality of life and safe care for residents.

The inspector met with residents and staff. She reviewed the documentation relating to the assessed care needs of residents and tracked the journey of a sample of residents with a diagnosis of dementia within the service. Validated tools to support staff to recognise and support residents with responsive behaviours were not used appropriately, consequently, poor outcomes for residents were demonstrated.

The inspector found that residents' healthcare needs were met. Residents had access to general practitioners (GPs) and support services such as advanced nurse practitioner (ANP) candidate for dementia care, living well with dementia project and memory technology library, memory clinic, neural psychologist, geriatrician, psychiatry, physiotherapy, pharmacist, speech and language therapists and community health services were also available.

As identified in all previous inspection reports, the design and layout of the centre was not fit for purpose and could not meet the needs of residents due to lack of communal and private space, multi-occupancy bedrooms, inadequate storage for residents' personal property and possessions, and lack of storage for equipment.

A sample of staff files reviewed demonstrated that staff files did not contain a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Forms in place were titled 'HSE Garda vetting liaison office reporting confirmation form'. While it was reported that all staff had been re-vetted, there was no documentary evidence of this in the sample of staff files examined.

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 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):

No actions were required from the previous inspection.

Findings:

The inspector was satisfied that each resident had appropriate access to the medical and healthcare services including specialist nursing services. Some improvement was required in care planning and assessments, particularly the assessments of residents who presented with responsive behaviours. Rigid institutional practices observed by the inspector did not support a person-centred approach and this warranted urgent review as it impacted the welfare and wellbeing of residents.

The inspector tracked the journey of residents with dementia and also reviewed specific documentation of care such as nutrition, medication management, end-of-life care and management of responsive behaviours. Pre-admission assessments were completed and documentary evidence showed that residents and their families were involved in planning care and assessing care needs. Some residents had a booklet 'Getting to Know Me' with forget-me-not flowers and the caption 'Don't Forget to Remember Me' as part of the information of their life and times, their interests and important people in their lives; the activities team updated this and used it as part of their one-to-one and group sessions.

Assessments were carried out on admission of all residents, including those people with a diagnosis of dementia. While validated assessment tools were used to support assessments and care, these were not always timely or comprehensively completed in accordance with the regulations. The evidence-based direct observation behavioural tool Antecedent-Behaviour-Consequence (ABC) comprised part of residents' care plans. The ABC records demonstrated that the antecedents to behaviours were not recorded, consequently, a pattern was not established to the possible cause of someone's responsive behaviour. When this was discussed during the inspection and it was realised that some rigid institutional routines and practices had a negative impact on residents and may have triggered or contributed to some behaviours. This, in turn, negatively impacted nutritional intake and medication management. This resulted in poor outcomes for some residents.

Following review of healthcare records and residents' feedback, residents had timely

access to health care services including GP services, advanced nurse practitioner (ANP) candidate for dementia care, memory clinic, neural psychology, geriatrician, psychiatry, physiotherapy, occupational therapy, speech and language, dental, ophthalmology and chiropody. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, that relevant information and appropriate information was readily available and shared between services.

The inspector reviewed practices and documentation relating to medicines management in the centre. Best practice was observed and described by nurses during a medication round. A multi-disciplinary team (comprised the nurse prescriber, pharmacist and GP) completed medication reviews every three months to ensure medication optimisation. Nonetheless, photographic identification was not in place for all residents as part of their medication management to minimise the risk of medication errors. Documentation associated with medication administration was not in keeping with best practice professional guidelines. While medication audits were completed, an audit of practice was not included to ensure safety and minimise risk.

Activities were observed and the activities programme was discussed with the coordinator. There were three in the activities team who work over six days from 09:00hrs - 20:30hrs. This enabled one-to-one sessions as well as group sessions. The programme varied and group activities included items such as imagination gym, call-to-mind, go-for-life exercises, sewing, baking, art classes and poetry reading. These positively influenced the well-being, relaxation and mood of residents including people with a diagnosis of dementia. The service had access to two buses that accommodated wheelchairs and ambulant people. Bru Bru was a local theatre and residents were invited to a show annually; on the day of inspection twenty residents were going there for the afternoon show and refreshments afterwards. One-to-one sessions were facilitated and these included hand massage, listening to music, reading or chatting with residents. Local musicians visited the centre once a month to entertain the residents; pupils from the local schools come to the centre for occasions to play music; family members were welcomed to play music for residents when they visit the centre.

Meals and mealtimes were observed including breakfast, snacks, lunch and tea. While some staff positively engaged with residents and provided appropriate discreet assistance which respected peoples' dignity, not all residents had such a positive experience. For example, tables were cleared away while residents were still having their meal. In one unit, breakfast was served by a member of the catering staff; while choice was offered to each resident, breakfast was given without a care staff being present to provide assistance. The care staff were located on a different floor. It appeared that some daily routines did not adequately consider the experience of the residents.

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:

Policies were in place for safeguarding vulnerable adults including information relating to responsive behaviours and restrictive practice. They included assessment tools, behavioural support charts and restraint recording charts and these formed part of residents' initial assessments and on-going assessments. As discussed in Outcome 1, these were not effectively implemented so safeguarding residents was not assured. Institutional practises of rigid routines were observed relating to meals and meal times, and personal care-giving times which resulted in poor outcomes for residents.

The person in charge and unit clinical nurse managers were well known to residents and residents reported that they could raise concerns or issues. The inspector observed respect and kindness shown to residents. While training records indicated that all staff had up-to-date training related to protection and managing behaviours that challenge, staff did not view some of the institutional practices as a form of abuse. In addition there was inadequate supervision of staff to ensure the service provided was safe, appropriate, consistent and effectively monitored. This, together with the lack of insight into institutional practices suggested that residents were not adequately protected.

A risk assessment was completed prior to using bedrails. Signed consent was obtained from the resident and there was documentary evidence in the restraint register to show that the person in charge and GP discussed restraint with relatives in the event that the resident was unable to discuss it. There was evidence of trialling alternatives prior to using bedrails. Records were maintained of checks when bedrails were in use.

To enhance the positive findings related to residents' finances, dual signatures upon receipt of cash would better safeguard staff.

Judgment:

Non Compliant - Moderate

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:

Appropriate arrangements were not in place to ensure that the rights of residents were respected in relation to privacy, dignity and their ability to exercise choice due to the unsuitable premises. Residents' privacy and dignity could not be assured due to lack of communal and private space, multi-occupancy bedrooms, inadequate storage space for personal possessions and less than optimal location of some toilet facilities. This limited residents in the extent they could exercise choice around activities in their personal space, such as watching television or listening to the radio or receiving visitors in private, without adversely impacting other residents. In addition, there was additional available communal space but this was underutilised and not identified as an area for development for residents' benefit. The impact of the physical environment on the privacy and dignity of residents warranted a judgment of major non compliance for this outcome.

In addition, personal information on signage displayed on wardrobes, bed headrests and walls was not respectful of residents', consequently, privacy and dignity of residents could not be assured.

There was a daily programme of activities as well as special events, outings and celebrations. People participate if they wished and their right to not participate was respected and this was observed on inspection. There was a church on site where mass was said every day and residents could listen to it over the radio if they wished.

The residents' committee met every two months and it was facilitated by the activities coordinator. Minutes of meetings demonstrated that it was well attended and residents were vocal in their feedback. Issues raised were documented and followed up in subsequent meetings.

The inspector used a validated observational tool to rate and record, at five minute intervals, the quality of interactions between staff and residents in the centre. The observational tool was the quality of interaction schedule (QUIS). These observations took place in day rooms, dining rooms, verandas and garden. Each observation lasted 30 minutes. A variety of interactions were observed: some were positive and kind, where staff positively engaged with residents and adapted their approach to reflect the individuality of each resident, others were task-oriented, while more did not avail of opportunities to engage with residents.

Judgment:

Non Compliant - Major

Outcome 04: Complaints procedures**Theme:**

Person-centred care and support

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

Findings:

A complaints policy was in place and a summary of the procedure was displayed throughout the centre. It reflected the HSE 'Your Service Your Say' procedure with internal and independent appeals process detailed as well as providing contact information for advocacy services and the office of the Ombudsman. Complaints were recorded and responded to in a timely fashion in one unit, however, while there were complaints logged for 2017 in another unit, there were no complaints logged for 2018.

Judgment:

Substantially Compliant

Outcome 05: Suitable Staffing**Theme:**

Workforce

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

No actions were required from the previous inspection.

Findings:

The person in charge was the interim director of nursing who took up the post of person in charge in February 2018. She worked full time and had the relevant experience and qualifications for the position of person in charge. She was involved in the governance, operational management and administration of the centre. The assistant director of nursing was newly appointed and was in the process of submitting the appropriate documentation to the HIQA. The inspector observed that residents were familiar with the person in charge, deputy person in charge and clinical nurse managers and conversed freely with them.

Not all staff had access to or were familiar with regulations and standards appropriate to their role and responsibility.

A sample of staff files were reviewed. While most of the requirements as listed in the Regulations were in place in the sample of staff files reviewed, vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were not on file.

Judgment:

Non Compliant - Moderate

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:

St Patrick's Hospital currently provides residential accommodation to residents in four continuing care wards. Two of these wards St. Ann's/St. Bernadette's Ward and St. Benedict's Ward were located on the main campus of St. Patrick's Hospital. St. Anthony's unit was located in Clonmel approximately 14 miles from Cashel and St. Claire's Ward was located on the grounds of Our Lady's Hospital in Cashel. In addition there were 21 rehabilitation and three respite beds located on the main campus of St. Patrick's Hospital.

Each unit had a defined complement of residents who were accommodated in shared facilities of two, three, four, five and six bedded rooms. As identified in all previous inspection reports, the premises was not fit for purpose. It could not meet the individual or collective needs of residents due to lack of communal and private space, multi-occupancy bedrooms, inadequate equipment storage space, and less than optimal location of some toilet facilities.

Nonetheless, there were three secure walled gardens for people to sit out or walk around. A gazebo and canopy gave welcome shade to residents and seating areas around the gardens enabled people to sit and relax and enjoy the fresh air. There was ramp access to the garden so people using specialist wheelchairs could access the area. The newly constructed smoking area was a lovely expansive sheltered unit with decking, located outside the veranda. There was a church on site and mass was held there every day.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Breeda Desmond
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St Patrick's Hospital
Centre ID:	OSV-0000589
Date of inspection:	23/07/2018 and 24/07/2018
Date of response:	07/09/2018

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:

While validated assessment tools were used to support assessments and care, these were not always appropriately completed. The ABC records demonstrated that the antecedents to behaviours were not recorded, consequently, a pattern was not established to the possible cause of someone's responsive behaviour.

1. Action Required:

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

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

All patients will have a pre placement assessment carried out prior to admission and this will be kept on the patient's medical notes.

Staff retraining will commence on the week beginning 27th August on the correct procedures for the completion of the ABC of Behaviour Management to include all necessary information and within the appropriate timeframe.

Proposed Timescale: 22/10/2018

Theme:

Safe care and support

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

While validated assessment tools were used to support assessments and care, these were not always timely or comprehensively completed in accordance with the regulations.

2. Action Required:

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

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

All nursing staff members are to reminded of the fundamental value in completing the care plans in a timely and comprehensive manner. Ongoing documentation training is being carried out throughout the year. While this training has always included care planning for residents with challenging behaviours, additional emphasis will be placed on it going forward.

Nursing staff are to be advised that care plans are to be prepared within 48 hours of admission. (Completed)

Proposed Timescale: 07/09/2018

Theme:

Safe care and support

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

Photographic identification was not in place for all residents as part of their medication

management to minimise the risk of medication errors.

Documentation associated with medication administration was not in keeping with best practice professional guidelines.

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:

Immediate intervention was taken following the inspector's verbal report to ensure that all residents had photographic identification. – Completed

All residents have photographic identification taken within 72 hours of admission as per hospital policy. – Completed

Full medication review is carried out 3-monthly which includes review of usage of psychotropic medications. Next scheduled review 18/09/2018. - Ongoing

There are scheduled audits carried out throughout the year which include Medication Management Audit, Documentation Audit, and Psychotropic Medication Audit. Feedback given to all wards and additional training provided individually on wards where issues may arise. - Ongoing

Ongoing Documentation training and Medication management training is being carried out throughout the year. - Ongoing

Proposed Timescale: 07/09/2018

Theme:

Safe care and support

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

While some staff positively engaged with residents and provided appropriate discreet assistance which respected peoples' dignity, not all residents had such a positive experience. For example, tables were cleared away while residents were still having their meal. In one unit, breakfast was served by a member of the catering staff; while choice was offered to each resident, breakfast was given without the assistance of care staff, who were located on a different floor.

4. Action Required:

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

Clinical Nurse Meeting held on the 8th August to advise CNM's of the requirement that all staff members must respect the care and dignity of the residents at all times.

CNM's advised that respect for the care and dignity of residents is to be included in the agenda of their ward meetings and to reinforce with all staff the importance of positive engagement with residents.

The ward manager must ensure that an adequate number of staff members are available to assist residents at meals and when other refreshments are served.

Proposed Timescale: 07/09/2018

Theme:

Safe care and support

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

A sample of staff files were reviewed. While most of the requirements as listed in the Regulations were in place in the sample of staff files reviewed, vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were not on file.

5. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

Formal discussion took place with the Data Controller CHO5 week of the 30th July in relation to forwarding all Garda Vetting information for placement on staff files. The Data Controller is compiling the necessary information and will handover all Garda Vetting documentation for staff files week commencing the 13/08/18. All staff members within St. Patrick's Hospital Cashel have completed Garda Vetting.

Formal discussion will take place with the Administrator Community Care, on her return from leave, week of the 6th August re the transfer of staff files to St. Patrick's Hospital Cashel. A completion date will be agreed with them but it will be no later than the 30/09/18.

Proposed Timescale: 03/08/2018

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:

There was evidence of rigid institutional routines and practices that negatively impacted the quality of life for residents. This, in turn, negatively impacted nutritional intake and medication management. This resulted in poor outcomes for some residents.

6. Action Required:

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

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

Further training on Person Centred Care has commenced. The training incorporates reflective practice, continuous improvement, nutrition, dignity and respect. All staff members are to receive further training on managing residents presenting with behavioural challenges.

Proposed Timescale: 22/11/2018

Theme:

Safe care and support

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

There was inadequate supervision of staff to ensure the service provided was safe, appropriate, consistent and effectively monitored. This, together with the lack of insight into institutional practices suggested that residents were not adequately protected.

While training records may have indicated that all staff had up-to-date training related to protection and managing behaviours that challenge, evidence showed that institutional practices were not recognised as such.

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:

Immediate action taken: Clinical Nurse Meeting held and CNM's advised that all staff on their wards must at all times ensure that their practices reflect HIQA regulations and hospital policy for provision of safe and dignified care to our residents. Discussion with CNM's re supervision of staff practices on wards.

Further Safeguarding training is to be included in the training schedule. The training is to include the dignity and rights of the residents.

Since the inspection an additional member of staff has enrolled in an external training programme for the delivery of the Safeguarding training.

Proposed Timescale: 22/11/2018

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

While some staff demonstrated good practice and positive engagement with residents with communication needs and residents exhibiting aspects of responsive behaviours which were related to the behavioural and psychological symptoms of dementia (BPSD), the inspector observed that all staff did not engage to this high standard. Consequently, opportunities to prevent residents becoming anxious or annoyed were missed. (Policies relating to these issues were not implemented in practice.)

8. 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:

Hospital policies are in place relating to the needs of patients presenting with behavioural difficulties and psychological symptoms of dementia. These are reviewed and updated to reflect best practice. Staff members have been advised to review same and ensure that they engage positively with residents at all times as outlined in hospital policies and procedures.

Further training on Person centred care has commenced .The training incorporates reflective practice, dignity and respect, communicating with patients who present with behavioural and psychological symptoms of dementia.

Proposed Timescale: 22/12/2018

Theme:

Person-centred care and support

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

Appropriate arrangements were not in place to ensure that the rights of residents were respected in relation to privacy, dignity and their ability to exercise choice. Residents privacy and dignity could not be assured due to lack of communal and private space, multi-occupancy bedrooms, inadequate storage space for personal possessions and less than optimal location of some toilet facilities. This limited residents in the extent they could exercise choice around activities in their personal space, such as watching television or listening to the radio or receiving visitors in private, without adversely impacting other residents. The impact on the privacy and dignity of residents warranted a judgment of major non compliance for this outcome.

In addition, personal information on signage displayed on wardrobes, bed headrests

and walls was not respectful of residents', consequently, privacy and dignity of residents could not be assured.

9. Action Required:

Under Regulation 09(4) you are required to: Make staff aware of the matters referred to in Regulation 9(1) as respects each resident in a designated centre.

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

The HSE Provider is working closely with HSE Estates in relation to the development of a CNU on the grounds of St. Patricks and on a green field site in Clonmel. Design Teams are planned to be in place in the last quarter of 2018, with building completion planned for the 1st quarter of 2022.

Information and signage that is personal to residents has been removed from wardrobes, bed headrests and walls – completed immediately.

Proposed Timescale: New building to be completed in 2022

Removal of signage: Completed 25/07/2018

Proposed Timescale: 25/07/2018

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 inadequate communal facilities or suitable private areas available to residents to receive visitors.

10. 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:

The HSE Provider is working closely with HSE Estates in relation to the development of a CNU on the grounds of St. Patricks and on a green field site in Clonmel. Design Teams are planned to be in place in the last quarter of 2018, with building completion planned for the 1st quarter of 2022.

Proposed Timescale: 30/06/2022

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 inadequate storage space to enable residents maintain control over their personal possessions and belongings.

11. 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:

The HSE Provider is working closely with HSE Estates in relation to the development of a CNU on the grounds of St. Patricks and on a green field site in Clonmel. Design Teams are planned to be in place in the last quarter of 2018, with building completion planned for the 1st quarter of 2022.

Proposed Timescale: 30/06/2022

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

Complaints were recorded and responded to in a timely fashion in one unit, however, while there were complaints logged for 2017 in another unit, there were no complaints logged for 2018.

12. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

Further education and training on Complaints management is to be implemented and staff advised to log all complaints, however small. Staff also advised to ensure that the complaints log is completed and available for inspection at all times.

Proposed Timescale: 22/11/2018

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Not all staff had access to or were familiar with the Health Act and regulations appropriate to their role and responsibility.

13. Action Required:

Under Regulation 16(2)(a) you are required to: Make copies of the Act and any regulations made under it available to staff.

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

A copy of the Health Act (plus amendments) and the Residential Care Standards are available on all wards. They are reviewed and updated on an ongoing basis. Copies of previous HIQA inspections are also available on all wards. Staff members have been reminded that these records are available for review by residents and staff.

Proposed Timescale: 07/09/2018

Theme:

Workforce

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

Not all staff had access to or were familiar with relevant standards appropriate to their role and responsibility.

14. Action Required:

Under Regulation 16(2)(b) you are required to: Make copies available to staff of any relevant standards set and published by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

A copy of the Health Act (plus amendments) and the Residential Care Standards are available on all wards. They are reviewed and updated on an ongoing basis. Copies of previous HIQA inspections are also available on all wards. Staff members have been reminded that these records are available for review by residents and staff.

Proposed Timescale: 07/09/2018

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

As identified in all previous inspection reports, the premises was not fit for purpose. It could not meet the individual or collective needs of residents due to lack of communal and private space, multi-occupancy bedrooms, inadequate personal and equipment storage space, and less than optimal location of some toilet facilities. Therefore, privacy

and dignity of residents could not be assured.

15. 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:

The HSE Provider is working closely with HSE Estates in relation to the development of a CNU on the grounds of St. Patricks and on a green field site in Clonmel. Design Teams are planned to be in place in the last quarter of 2018, with building completion planned for the 1st quarter of 2022.

Once these units are in place the collective and individual needs of the residents will be met.

Proposed Timescale: 06/06/2022