Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	St Patrick's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Summerhill, Carrick on Shannon, Leitrim
Type of inspection:	Announced
Date of inspection:	24 April 2018
Centre ID:	OSV-0000661
Fieldwork ID:	MON-0021339

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The designated centre provides 24- hour care to 46 residents, male and female primarily requiring nursing and/or palliative care. Some have a diagnosis of dementia and others are young chronic sick persons under 65 years of age.
The centre is made up of three units located on the ground floor of a two storey building which was formerly a hospital. Two of the units accommodating 14 residents in each are mainly for long term care and a specialist dementia unit (SDU) accommodates 18 residents. Three beds in the SDU are for residents requiring respite or assessment on a short-term basis and one designated bedroom is for residents receiving end of life care
The aim of the centre is to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their health and well-being.

The following information outlines some additional data on this centre.

Current registration end date:	26/06/2018
Number of residents on the date of inspection:	44

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
24 April 2018	12:00hrs to 19:00hrs	Siobhan Kennedy	Lead
25 April 2018	09:00hrs to 19:00hrs	Siobhan Kennedy	Lead

Views of people who use the service

Residents who communicated with the inspector and those who completed questionnaires provided by the Health Information and Quality Authority (HIQA) were in the main positive with regard to provision of facilities and services and the care received. During the inspection residents told the inspector about their daily experiences and the choices that they could make. They described their routines, activity plans and interactions with the community. Residents expressed satisfaction regarding food and mealtimes. In particular, they were happy with the support and assistance provided by staff. Residents were able to identify a staff member who they would speak with if they were unhappy with something in the centre. The inspector shared with the person in charge some of this suggestions made by residents to further improve the service. These included more opportunities to be involved in the community, insufficient space for personal belongings, more parking facilities near to the entrance of the centre and more involvement in deciding the type of social and recreational activities to be programmed.

Capacity and capability

During the previous inspection, 24 October 2017 the designated centre was not in compliance with the legislation in relation to governance and management, staffing, safeguarding, health and safety and the premises.

Since that inspection the management team led by the provider representative and the person in charge worked on an action plan related to each of the areas highlighted above and with the staff team were able to make changes which contributed to residents experiencing an improved service.

The inspector found that the governance arrangements had improved. The full-time provider representative and person in charge had good knowledge in the provision of residential and dementia care and funding was made available to implement changes to the environment, install security features and recruit and train staff to reduce institutional care practices and initiate more person centred care.

Staff members informed the inspector that the person in charge was a good leader who motivated the staff team and provided opportunities for the staff to rotate their working shifts. The person in charge and the management team facilitated the inspection process and were knowledgeable regarding their roles, management of the centre, the regulations and standards governing residential care and the care

and condition of residents.

The provider representative was available at the commencement of the inspection and for feedback on the inspection. It was evident that the deployment of resources through informed decisions and actions facilitated the delivery of an improved quality of care for residents.

A review of staffing had been carried out and a staff recruitment drive resulted in the recruitment of 6 staff nurses, a clinical nurse manager and 8 health care assistants. An examination of documentation to be held in the designated centre in relation to persons working at the centre was examined and found to be satisfactory. Records showed that newly recruited staff received induction and this was confirmed by some recently recruited staff members. Staff appraisals as part of the probation process had commenced.

The numbers and skill mix of staff at the time of inspection were sufficient to meet the needs of residents. Staff training records showed that staff had access to education and training, appropriate to their role and responsibilities. Since the last inspection two senior staff had attended a five day residential dementia course, 14 staff had attended a two-day national dementia programme and 34 staff received training via the virtual dementia bus which aims at providing staff with an understanding of the lived experience of residents with dementia. The centre has access to a clinical nurse specialist in dementia and provides on-site support and education to staff and families. A staff member is currently attending a one year person centred programme and by sharing this knowledge with the staff team is hoping to support staff to move away from institutional practices and provide person centred care. All staff have up to date mandatory training and other training included managing responsive behaviours, restraint, hand hygiene, CPR and training in a range of clinical areas. In communication with the inspector staff demonstrated that they were knowledgeable and skilled in the areas which they had received trained, for example, fire safety procedures, safeguarding and safe moving and handling of residents. Staff told the inspector that they work as a team and aspects of their work was monitored and supervised in a way that provided them with guidance and support. Staff members who expressed an opinion were positive about working in the centre and emphasised that meeting residents' needs and preferences was central to their work.

There was evidence that systems had been devised to audit and monitor performance and incidents/accidents. The management team had set up monthly quality and risk meetings and introduced new reporting and recording systems. Issues of concern raised on a daily basis are now communicated to relevant persons to be actioned. Arrangements were in place to carry out investigations and review incidents and accidents. An annual review report was forwarded to the inspector. It was prepared in consultation with residents and had a quality improvement plan.

Prior to the inspection the provider submitted the required documentation. The application for the renewal of registration was completed on the 8 December 2017 seeking approval to accommodate 46 residents. An examination of the information showed that the floor plan and the statement of purpose outlining the facilities and

services corresponded to the findings on inspection.

The complaints policy and procedure was widely advertised and residents were familiar with the process. The complaints record showed a complaint had not yet been resolved but the provider representative was actively involved in bringing this matter to a satisfactory resolution. The complaint had been shared with relevant staff members in order to bring about a change in practices.

The Information governance arrangements ensured that record-keeping and file management systems were secure.

Registration Regulation 4: Application for registration or renewal of registration

An application for renewal of registration was completed and contained the necessary information.

Judgment: Compliant

Registration Regulation 6: Changes to information supplied for registration purposes

The information provided was in accordance with the regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The centre was managed by a suitably qualified and experienced nurse who has authority in consultation with the provider representative and is accountable and responsible for the provision of the service.

Judgment: Compliant

Regulation 15: Staffing

From an examination of the staff duty rota, communication with residents and staff it was found that the numbers and skill mix of staff at the time of inspection were sufficient to meet the needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

While staff probationary appraisals had been initiated these had not been carried out for all new staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

An effective governance structure was in place with clear lines of accountability so that staff working in the service were aware of their responsibilities and knew who the reporting mechanisms.

Judgment: Compliant

Regulation 24: Contract for the provision of services

Contracts of care had been agreed on admission highlighting the terms on which residents reside, services to be provided and the fees.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose outlined the facilities and services, provided details about management and staffing and described how residents' well being and safety was being maintained.

Judgment: Compliant

Regulation 34: Complaints procedure

An outstanding complaint requires further work to reach a satisfactory resolution for all involved.

Judgment: Substantially compliant

Quality and safety

There was a good atmosphere and residents and staff interacted well.

In the care plan records examined there was evidence that a multidisciplinary care team consulted with residents regarding the development of their individual care plans which included assessment of needs and treatment plans. Staff liaised with the community services regarding admission and discharge arrangements and appropriate referrals were made to the community health care professionals. Prior to the inspection HIQA received a number of notifications in respect of a resident being accommodated at the centre. A review of the resident's care took place and a qualified senior staff member now leads the care staff team. There was evidence that she had mentored staff to ensure that the resident's treatment plan was being consistently implemented to bring about improved outcomes for that resident and the resident group. The inspector was informed that this resident no longer required the assistance of a one-to-one staff member, however, this was an option which would be approved by management and implemented if necessary. Staff members had undertaken training in managing responsive behaviours. A communication record is maintained in order to update incoming staff regarding residents' care and conditions. The management of medicines was satisfactory.

Residents' nutritional and hydration needs were met and residents confirmed that meals and meal times were an enjoyable experience. Residents received palliative care based on their assessed needs and this aimed at maintaining and enhancing their quality of life and respected their dignity.

Residents meetings were held and at one of these meetings residents chose to rename the "cubicles" preferring the term "suites" (referring to the open bedrooms spaces located off the corridor) and residents were involved in choosing the screening to be in place to provide some privacy from the corridor. Some residents confirmed that they had been consulted in a range of matters for example the daily routines and day-to-day running of the centre while others would have liked to have had more consultation and involvement.

Residents had opportunities to participate in meaningful activities in accordance with their interests, abilities and capacities. The group social and recreational programme was relevant and meaningful to the residents who participated and for those who did not wish to participate staff were seen to engage them on a one-to-one basis with activities of their preference. The inspector saw some residents using the snoozelan room and a group involved in music therapy. Three staff members had participated in training in order to provide residents with greater opportunities and activities including sonas and imagination gym specifically for residents with dementia.

The centre was built in 1841 and has been used as a care facility since 1928 and extended in the 1970's and 1998. In addition to the residential centre the building accommodates the day hospital, outpatient departments and a refurbished second-floor which is used by residents requiring short term care.

During previous inspections to this centre it had been highlighted that the design and layout of the current centre did not meet the needs of the residents and did not comply with schedule 6 of the regulations primarily due to the lack of privacy and dignity for residents in the multi-occupied rooms, insufficient communal facilities and lack of storage.

The person representing the provider informed HIQA that a new centre would be constructed to replace the current designated centre, however no details in respect of plans or timescales were provided. The written response in the action plan of the previous inspection (24 October 2017) confirmed that the design team for the designated centre had been appointed and was working on the stage I report (feasibility study) for consideration by the national director of estates. During this inspection there was no further update. The above deficits remain outstanding at this inspection.

However, it was noted during this inspection that much work had been carried out to improve the current centre, protect residents' privacy and dignity and make it more homely for residents until the new centre is constructed.

Sheemore and McGarry wings accommodate 28 residents (14 in each wing) and Monsignor Young Unit (MYU) accommodates 18 residents with dementia-specific needs. There were 13 single rooms (one of which was designated only for palliative care in the MYU), six twin rooms, 6 rooms with three beds and one room with four beds.

There was evidence that work had been carried out on the individual units or was in progress. The inspector was informed that the refurbishment/redecoration programme in the dementia unit had been postponed in order to facilitate the inspection. This programme included replacing damaged flooring in bathrooms and toilets. The inspector saw that new bedroom furniture had been purchased but there was still some evidence of hospital/locker style furniture which is not suitable or sufficient for residents' personal possessions. New curtains had been hung in bedroom/corridor areas which were visible from outside the rooms. Bi folding privacy screens had been erected to provide some privacy between the bed

rooms/suites and the corridor but this measure is insufficient for the provision of residential care.

In the main, residents' communal facilities were combined day and dining rooms which were also used for activities.

While storage space had been improved this still remains an issue.

Since the last inspection ,the reception area, which has a coffee dock and seating area has been refurbished and provides a very pleasant area for residents to meet. In this area there are visitor's toilets,a memory resource room and administration offices. The main kitchen and chapel are accessed through the staff dining room which is also used for residents' activities.

There was an internal courtyard and access to external grounds. There are a few car parking spaces at the entrance to the centre and more in the grounds of the facility.

Some new equipment had been purchased for example low low beds, ultra low low beds and pressures relieving mattresses. Some of the sitting chairs had been reupholstered.

Policies and supporting procedures were implemented that ensured residents were protected from abuse. Staff members who communicated with the inspector were knowledgeable regarding their duty to report any past or current concerns for the safety of the residents living in the centre. Some residents told the inspector that they felt safe in the centre.

There were arrangements in place to manage risk. The inspector was informed that the existing staff security system/emergency call facility in the dementia unit is being repaired and in the meantime the inspector saw that staff carried a mobile security system to request the assistance of a staff member if required.

A restraint free environment was promoted and any restraint measure was used in line with the national guidelines. This included carrying out a comprehensive risk assessment prior to the implementation of any restrictive measure and records were maintained in accordance with the regulations regarding restraint. The inspector saw that records included a section on chemical restraint.

Responsibility for infection prevention and control was clearly defined. There was good evidence of hand hygiene, the use of protective clothing, the safe disposal of sharps and waste management.

Fire safety arrangements were in place. The inspector was informed that the fire officer visited the centre to ensure compliance with the regulations. Fire doors were checked and those with gaps for example leading into the dementia unit were repaired or replaced. There was evidence from the training records that staff had participated in fire safety training and monthly simulated fire evacuation drills. Records showed if there were any issues/concerns identified during the drills. Staff who communicated with the inspector described their understanding of the fire safety procedures and knew how to disengage the locked gate in the enclosed

garden adjoining the dementia unit in the event of an emergency. The smoking room was decommissioned and the centre is advertised as a non-smoking facility.

Regulation 12: Personal possessions

Residents did not have adequate space to store and maintain their clothes and other personal processions in their bedroom space.

Judgment: Not compliant

Regulation 17: Premises

The premise was not appropriate to the number and needs of the residents and was not in accordance with the schedule of the regulation.

The centre did not comply with schedule 6 of the regulations primarily due to the lack of privacy and dignity for residents in the multi-occupied rooms, insufficient communal facilities and lack of storage.

No plans including costings and time frame have been submitted to HIQA regarding the proposal to construct a new centre to replace the current designated centre.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were offered choices of wholesome and nutritional meals which were safely prepared, cooked and served. Nutritional assessments were carried out in respect of the dietary needs of residents and appropriate foods provided.

Judgment: Compliant

Regulation 26: Risk management

The fixed staff security system/emergency call facility in the dementia unit was not

working and required repairment or replacement.

Judgment: Substantially compliant

Regulation 27: Infection control

Staff implemented procedures for the prevention and control of health care associated infections.

Judgment: Compliant

Regulation 28: Fire precautions

Adequate precautions had been taken against the risk of fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The management of medicines was satisfactory.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Adequate arrangements were in place to assess residents' needs and treatment plans were described in individual care plans which were formerly reviewed.

Judgment: Compliant

Regulation 6: Health care

Appropriate medical and health care was provided.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff had up-to-date knowledge and skills, appropriate to their role, to respond to and manage behaviour that was response. Restrictive measures were reduced from the previous inspection. Restraint was used in accordance with appropriate guidance.

Judgment: Compliant

Regulation 8: Protection

Policies and procedures were implemented to protect residents from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Some residents expressed the view that they had not been sufficiently consulted in the organisation of the designated centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Registration Regulation 6: Changes to information supplied for registration purposes	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Patrick's Community Hospital OSV-0000661

Inspection ID: MON-0021339

Date of inspection: 24/04/2018 and 25/04/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The person in charge has a process in place to ensure all new staff have an individual planned probationary appraisals programme in line with HSE Recruitment Policy. • A process is in place to update the Person in Charge by the direct line manager regarding probationary appraisal outcomes through review of the Probationary documentation. • All staff including new staff are supervised by their line manager during each shift • All newly recruited staff are currently completing their probationary appraisals programme. There is a record in individual personnel files.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Registered Provider has set a date suitable to the complainant to meet to share the complaint review outcome, action plan and closed out actions. The complainant will be given the outcome verbally and in writing and will have the opportunity to seek clarity. The complainant will be provided with written information on the appeals process in line with HSE policy. The Registered Provider met with the complainant to discuss and share complaint review, the subsequent action plan and closed out actions were discussed. The complainant was happy with the complaint review, action plan and outcomes. At the meeting the complaint was closed out with the complainant. The complainant was provided with information on the appeals process in line with HSE policy.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal	

possessions:
The Person in Charge has a programme in place for the replacement of the old hospital / locker style furniture to ensure residents have adequate space to store their clothes and retain control over their personal property, processions and finances. To date 30 residents have replacement home style spacious lockable wardrobes. The remainder wardrobes have been purchased and await delivery.

Delivery of the final 7 wardrobes and lockers are expected the 2nd week of October 2018. Once in place all 43 residents and 3 short term respite and assessment patients will have refurbished or new wardrobes and lockers to replace the old hospital / locker style furniture.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.

The HSE wishes to confirm that the letter dated 24th March 2016 signed by HSE representatives regarding St. Patrick's Hospital, Carrick-on-Shannon (attached) continue to have the same standing today as authorised in the attached memorandum, issued by HSE representatives.

Subsequent to a meeting with HIQA representatives on the 9.8.2018 at the HIQA Offices Dublin it was agreed a letter will be forwarded by the HSE on or by 30.8.18 to confirm completion date of the design phase, construction and date of occupancy. .

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:

The fixed staff security system has been replaced and is fully operational as of the 31/15/2018.

The fixed staff security system has been replaced and is fully operational as of the 31/5/2018.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The Registered Provider continues to assure that the centre has a number of processes in place to ensure that residents are consulted about and participate in the organisation of the designated center. These include:

- Residents "Just Friends" meetings
- Monthly Residents and Family News Letter
- Annual Residents Survey
- One to One meetings with residents with PIC and/ or PPIM
- Clinical Nurse Managers are currently designing a feedback form to complete with

residents capturing individual views and preferences particularly for those residents who choose not to attend the “Just Friends” meetings or voice their wishes and views in a group setting.

The CNM’s in conjunction with the DON have designed a feedback form which captures resident’s individual views and preferences particularly for those residents who choose not to attend the “Just Friends” meetings or voice their wishes and views in a group setting. These are currently in use in the Designated Center.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	31/07/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	5/06/2018
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises	Not Compliant	Orange	31/12/2021

	which conform to the matters set out in Schedule 6.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Yellow	31/05/2018
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	26/06/2018
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	30/06/2018