

Health Information and Quality Authority  
Social Services Inspectorate

Inspection report  
Designated centres for older people



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Type of centre:	<input type="checkbox"/> Private <input type="checkbox"/> Voluntary <input checked="" type="checkbox"/> Public
Registered provider:	Pat Dolan
Person in charge:	Mr Anthony Wadd
Date of inspection:	29 September 2009 and 30 September 2009
Time inspection took place:	<b>Day 1 Start:</b> 11:30 hrs <b>Completion:</b> 18:30 hrs <b>Day 2 Start:</b> 07:30 hrs <b>Completion:</b> 17:30 hrs
Lead inspector:	P.J Wynne
Support inspector(s):	Siobhan Kennedy Catherine Connolly Gargan
Type of inspection:	<input type="checkbox"/> Registration <input checked="" type="checkbox"/> Scheduled <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced

## About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

**Evidence of good practice** – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

**Some improvements required** – this means that practice was generally satisfactory but there were areas that need attention.

**Significant improvements required** – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website [www.hiqa.ie](http://www.hiqa.ie).

## Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

## About the centre

### Description of services and premises

St Patrick's Community Hospital was built in 1841 and has been used as a care facility since 1928. The hospital provides a range of services to the local community including a day centre, an X-ray department, physiotherapy and occupational therapy.

The centre has a bed capacity for 112 residents. 74 are allocated to extended residential care, 18 are dementia specific. There are five beds allocated for convalescent care, five for respite, five for rehabilitation, three for palliative care and two for assessment.

Accommodation is organised over two floors with three units on the ground floor. "The Sheemore" is a 30 bedded female unit, the "Dr Mc Garry", a 28 bedded male unit and the "Monsignor Young" an 18 bedded dementia specific unit, providing care to both male and female residents'. "The Rivermeade unit" on the upper floor provides care to 36 male and female residents. There are thirteen single rooms. The remainder of the residents in each unit are accommodated in shared bedrooms configured in two, four, five, six or nine beds. These are referred to by residents, relatives and staff as "wards".

There is a reception located at the entrance foyer with a small coffee shop and seating area is available for residents' use.

There is a nurses' station and pharmacy room located on each unit. Three units have a combined dining/sitting room area.

There is a quiet room located on the ground floor.

The external grounds are available to residents', ramps provide access to the garden for wheelchair users. There is ample car parking space for visitors.

### Location

The centre is located in a residential area on the periphery of the town, a short drive off the N4 Dublin / Sligo primary route. All town amenities are located nearby, accessed by a pedestrian footpath.

<b>Date centre was first established:</b>	1928
<b>Number of residents on the date of inspection</b>	110

Dependency level of current residents	Max	High	Medium	Low
Number of residents	59	47	4	0

### Management structure

Anthony Wadd, the Person in Charge, reports to Bridget Smith, Service Manager for Older People, and Cara O'Neill, General Manager, who both report to Pat Dolan, the Local Health Manager and designated provider, on behalf of the Health Service Executive.

There are two Assistant Directors of Nursing reporting to the Person in Charge. This management team is supported by four Clinical Nurse Managers who are responsible for the delivery of care.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	21	16	13	10	6	3

## Summary of findings from this inspection

This was an announced inspection carried out over two days. It was the first inspection of this centre by the Health Information and Quality Authority.

Inspectors spoke with, and listened, to the person in charge, residents, relatives and staff. They also viewed policy documents, staff rotas, care plans and medical notes.

The inspection team found the staff to be confident, well informed and skilled in all aspects of their roles. Staff described an open relationship with the person in charge and other senior managers and could readily bring matters to their attention.

The inspectors were satisfied that the nursing, medical and other healthcare needs of residents were being met and the nursing care was of a high standard. Nursing staff were familiar with residents' care needs. However, social and personal care needs were not documented and the formal care planning process did not encompass a multi-disciplinary approach.

While there was a social activity working group in place, and a constructive program of activities was scheduled on a regular basis, it was not meeting the needs of highly dependent residents.

The provider strived to maintain strong connections with the local community. The centre has a comfort fund for residents based on local community fundraising events.

There were numerous challenges posed by the structure and layout of the physical environment and the multi-occupancy accommodation to ensure residents' privacy and dignity were maintained.

Inspectors had concerns regarding the safety and evacuation procedure of residents from the first floor, in the event of a fire occurring at night, as there are only two staff members on night duty.

The action plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. These include the requirements for the improvement of the building structure, in particular the size and layout of rooms, the maintenance of equipment and the further development and review of policies, procedures and guidelines.

The Health Information and Quality Authority received a notification of abuse prior to the scheduled inspection. The actions taken by the provider were reviewed by the inspectors. Protective measures had been put in place by the person in charge following the reporting of the allegation. The Health Service Executive, service manager and industrial relations officer were fully informed of these measures and a formal investigation of the matter was underway. The provider was asked to submit a report to the Health Information and Quality Authority on the outcome of the investigation, including any protective measures to be implemented, following an

evidenced based risk assessment of the matter. This information was received by and acceptable to the Authority.

## **Residents' and relatives' comments**

Nine resident and eight relative questionnaires were completed prior to inspection. The inspectors met the majority of residents. However, due to physical frailty and dementia, a number were unable to share their experiences of living in the centre.

### **Residents**

All residents were unanimous in their praise for staff and said they felt well cared for and safe.

Comments from residents included:

"Staff look after me well", "I sleep well and couldn't ask for more" and "I feel very safe here". One resident told the inspectors she would "like to get out more to the garden to see the birds".

Residents confirmed that they knew who to make a complaint to and they were able to identify the person in charge.

### **Relatives**

Many of the relatives, interviewed on the day of inspection, spoke highly of the staff and their relationship with the residents.

Comments from relatives included:

"We can visit at any time", "staff are very helpful" and "I'm very satisfied with the way my relatives clothes are looked after". One relative said that "while the care is second to none" he felt his father could be better stimulated during the day.

## Overall findings

### 1. Governance: how well the centre is organised

**Outcome:** The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

**Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.**

#### Evidence of good practice

The person in charge and the senior management team demonstrated excellent knowledge of the regulations. There were copies of the legislation and the *National Quality Standards for Residential Care Settings for Older People in Ireland* on each residential unit. Staff were introduced to the standards through a seminar facilitated by members of the management team.

Staff who spoke with inspectors were well informed and knowledgeably discussed the legislation and the Standards.

A comprehensive statement of purpose was made available to the inspection team prior to inspection. Information brochures documenting the philosophy of care for each of the four residential units were also available.

Staff had a clear understanding of the management structures and they could describe their reporting relationships and lines of accountability within the centre.

Residents' records, care plans and personal information were stored in a safe and secure place.

Adequate systems and procedures were in place to protect residents from abuse. A clear policy on reporting and investigative mechanisms was in place to respond to incidences of reported abuse. Staff had been Garda vetted and elder abuse training has been undertaken.

#### Some improvements required

The community radiology department was located in the hospital. Public access to the department was through the front door of the centre. At the time of inspection, the impact of this on the residents' privacy and safety had not been assessed.

The historical origin of the centre and grounds placed it on a heritage trail. A local heritage group funded the seating area and coffee shop. The inspectors were told that the public, although with a guide at all times, can sit in this area and avail of refreshments from the shop which is located beside the main entrance doorway. The local Heritage Committee Board membership included two members of the centre's management team. However, there were no residents appointed to this Board and residents were not consulted concerning the impact of these visits.

Accidents and incidents were recorded. However, "near misses" were not documented, and inspectors observed that the documentation used to record accidents and incidences were out of date. Analysis and risk assessments were not completed in each case of an accident.

Money belonging to residents was forwarded to the regional finance department for safekeeping. When the resident requested money, it was returned by the Health Service Executive in cheque format. Residents stated that they did have money in safekeeping. However, they did not have cash to buy refreshments or toiletries from the shop if they wished as their payments were issued by cheque.

### **Significant improvements required**

The range of policies, procedures and guidelines available did not meet current regulations in that they were incomplete, and / or in draft form and had not been communicated to all staff.

The inspectors concerns were regarding the safety and evacuation of residents from the first floor in the event of a fire occurring at night. At the time of the inspection, there were only two staff members on night duty and this was an inadequate number to undertake the safe evacuation of these residents.

Residents did not have a written contract with the registered provider, outlining the details of their care and provision of services.

## 2. Quality of the service

**Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.**

**A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.**

### Evidence of good practice

St Patrick's Community Hospital was one of 18 selected to participate in the national practise development programme for the past two years. The aim of the programme was to implement a module of person-centred care. A multidisciplinary practise development group, including residents, families, nurses, care assistants, catering staff and allied health professionals was formed to develop this approach. It focused on four main themes, to include communication, meal and meal times, end of life care and physical environment. The group was in the process of developing policies in each of these areas.

Arising from local community fund-raising, at the time of inspection, a comfort fund for residents was in place. The residents are involved in decisions on how the fund was used. The inspectors observed details of some proposed comfort projects, including a sensory garden, artwork to brighten a corridor and the development of a games room.

The chapel has been refurbished, and a video link established, to allow liturgical events to be transmitted directly to the television in the sitting rooms of each unit, to facilitate residents who are unable to attend.

The centre has a black Labrador dog named Phoebe, who lives with a member of the volunteer committee. This person brings the dog to visit a number of times each week. Inspectors saw the bond the residents had with the dog and the interest the visits generated amongst residents.

The inspectors were informed by the person in charge that strong connections with the local community are encouraged. A prayer group attends on a regular basis. On the first Sunday of each month, local musicians visit and play for the residents of each unit. Transition year students visit and undertake projects alongside the residents which includes the completion of life histories. A representative of the Citizen Information Bureau attends if requested and is able to meet the residents in private.

There is a wheelchair accessible minibus available for use by residents. The inspectors were informed that the minibus is used to transport residents on various

outings and to Sligo General Hospital for outpatient appointments. Its roadworthiness was certified and it was fully insured.

The provider facilitated residents who wish to participate in the political process. Prior to the inspection, a polling booth was set up to enable residents to vote in the Lisbon Treaty Referendum.

### **Some improvements required**

At the time of inspection, there was no formal advocacy service available to residents should they wish to obtain help, to make a complaint or require assistance to express their views. The inspectors were told the lack of an advocate was an issue which had been raised by the residents' group. A submission had been made by the person in charge to the governing body identifying the need for advocacy assistance.

### **Significant improvements required**

While there is a social activity working group in place, and, at the time of the inspection, a constructive program of activities was scheduled on a regular basis, it was not meeting the needs of highly dependent residents. The program does not take account of residents who are unable to leave or actively participate within a group setting. There were no daily activities for residents whose dependency had been assessed as maximum.

As the centre has been selected for the National Practise Development Programme, a significant amount of data has been collected and a number of working groups have been established to determine residents' needs. The work of the program to date does not demonstrate that the needs of residents are being met through the initiative. A clear example was the strict, fixed meal times. Residents had not been asked their opinion on the time and choice of meals. An inspector was informed by a member of the management team "the staff roster needs to change, to meet the needs of the residents; the residents were fitting into the staff regime".

At the time of inspection, the care practices and the manner in which information is communicated concerning the residents' needs, did not ensure that privacy and dignity was maintained towards the resident at all times. There were notices displayed over the residents' bed pertaining to the personal needs of residents, which included notices such as; "diabetic", "nil by mouth", "soft diet" and "family take clothes home to launder". The moving and handling risk assessment for residents' was displayed alongside his / her bed. The inspectors took into account that these were inherited practices.

A notice in a shared bedroom requested visitors not to sit on residents' beds and to use the chairs provided instead. However, there were only two chairs available. Two relatives visiting a sick resident had to sit on high stools, located beside the resident's bed during their visit. There was no provision made for the residents to spend private time with his / her family.

### 3. Healthcare needs

**Outcome: Residents' healthcare needs are met.**

**Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an on-going basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.**

#### Evidence of good practice

At the time of the inspection, an orthopaedic consultant, geriatrician and psychiatry of old age consultant attended on a monthly basis and, if required, urgently attended by phone referral.

St Patrick's Community Hospital has a social worker, physiotherapy, occupational therapy and a radiology services department on site which residents could easily access if required.

There are close links with Sligo General Hospital, providing the residents with access to pharmaceutical, peripatetic, advanced medical and nursing services if required. Many of the residents had been admitted via Sligo General Hospital.

The nursing notes described general welfare in detail and were up to date and comprehensive moving and handling risk assessments had been undertaken for all residents.

Residents' medication records were stored securely and systems were in place for updating and reviewing of medication charts. The medication charts for each resident were reviewed and updated in accordance with new prescriptions being issued or expiring. All residents' medication records were retained on an encrypted database. A pharmaceutical technician attended the centre twice weekly to stock take and check all medication dates. While there was a lot of medication held in the centre, at the time of inspection, there was no out of date stock, all medication was within date. There was a good system in place for checking stock levels and disposal of unused or out of date medication.

A clinical pharmacist attended for four hours each week and reviewed the medication charts, to check for drug interactions, the dosage and timing. The pharmacist made recommendations to the person in charge and to general practitioners regarding routine tests and to monitor certain medicines.

The clinical pharmacist had delivered six training modules on the administration of medication to nursing staff, and had developed a medication administration chart for each resident. The aim of the training is to assist nursing staff in administering drugs. The chart included special instructions and advice on alternative forms and

solubility, which assisted nursing staff to administer medications that best meet the individual needs of the residents.

The controlled drugs register was reviewed by inspectors and it was observed that this was checked twice daily, at shift change over and was signed by two nurses from alternate shifts.

### **Some improvements required**

The residents were cared for by a team of five general practitioners, who attended the on a daily basis. Residents did not have a choice of their own general practitioner.

### **Significant improvements required**

The care plans reviewed by the inspector focused mainly on physical care needs of residents'. They did not include the personal and social care needs of residents.

During the inspection, one relative reported that in her view, relatives should be more involved in assisting the nursing staff to make / take decisions regarding care issues. The relative considered this to be especially necessary when a resident was not fully able to understand the consequences of not taking medication / medical intervention.

The care planning process was fragmented and inconsistent throughout the four units in St Patrick's Community Hospital. Care plans were not reviewed or updated routinely. There was no consistent evidence of resident or family involvement.

However, a number of staff are part of a working standards group formed to review the care plans. Inspectors were told by a nurse manager that a new template had been developed, which will benefit the residents by addressing their personal and social care needs in a more holistic manner. The person in charge was working with the Nurse Education Unit in piloting this new care plan and one resident's care plan is currently assisting in the piloting process of same.

While a physiotherapist or occupational therapist report was noted in care plans, there was no routine, consistent evidence of multidisciplinary involvement in care planning, to ensure residents' individual needs were being met.

There were care plans and day to day records for all residents. However, there was a variety of formats in use and this posed a risk of errors being made in how information was recorded in care plans. For example, in some care plans the Cheltenham score was being used to determine dependency level, while in others a different unit, the Barthel Index, was being utilised. Similarly there was evidence in care plans of both the Norton and Waterlow pressure score being used.

In one care plan a photograph of a pressure sore had been taken and a weekly tracing of the sore recorded, the wound assessment chart had not been completed as part of the resident's care plan. Additionally, good practice such as tracing

pressure sores had not been implemented for all residents with pressure sores. At the time of inspection there was not a high number of residents with pressure sores (there was only two). However, there was not a consistent validated tool used throughout the centre to manage pressure sore care.

There was no uniformity in the assessment of residents' care needs. Risk assessment in care records was not being completed for all residents. The inspector was told that in one unit, a fall risk assessment was not being completed and this was evident when care plans were reviewed.

The restraint policy was in draft format. Inspector's observed one resident who sat in her wheelchair throughout the day had the lap belt fastened. Instances where restraint such as lap belts and bedrails were used was not documented in care plans, and risk assessments were not reviewed on a regular basis. There was no assessment outlining the reasons why restraint was in use and no evidence of any other professional input.

While there was evidence of good practice, a centre-specific policy on medication management to govern all aspects of medication from ordering, prescribing, storing and administering was not complete. The inspector was informed that some medications were being crushed, yet there was no policy on the crushing of medication in the centre. The policy on the administration of suppositories, eye drops and ointment were in draft format.

## 4. Premises and equipment: appropriateness and adequacy

**Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.**

**A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.**

### Evidence of good practice

Recently, refurbishment work had been undertaken. Some of the areas addressed included:

- wash hand basins and taps had been replaced
- a new central kitchen and associated catering areas had been installed
- satellite television on each ward was provided
- double glazed window units and new sills were fitted
- kitchenettes in two of the "wards" had been upgraded
- new leather settees and dining tables had been purchased.

The replacement of the roof of the building, which is subject to a preservation order, was underway.

Fire safety had been given high priority due to a recent fire. A new fire alarm and hydrant system had been installed. Fire equipment was serviced and residents' beds were fitted with horizontal evacuation sheets.

There was a traceable system of laundering, with the implementation of an innovative tagging system for residents' clothing. Each garment had been tagged with the name of the resident, identifiable by the insertion of a small button like device.

This comprehensive system ensured that personal laundry was collected in colour coded laundry bags, laundered and returned to the particular residential area, in individually named containers. Bed linen was laundered outside the centre.

Management and staff have taken significant steps to ensure infection prevention and control measures are in place. Hand gels were provided throughout the centre and visitors and staff were observed using them appropriately.

There was evidence of the use of colour coded cleaning utensils for the different areas of the centre.

## Some improvements required

### Toilets and washing facilities

There were risks of infection, and to the safety of residents, due to the following:

- toilet seats were not available on some toilets
- the flooring in some toilets did not cover the floor space, was stained and/or wet
- clean towels were stored openly in toilets and washing and bathing facilities.

Residents' personal toiletries and shower gels were stored in communal bathing facilities posing a risk of cross infection to residents.

### Sluice rooms

The maintenance of the sluice room and the facilities in the room were inadequate. Inspectors found:

- the cisterns in some of the sluice rooms were not flushing and backsplashes were not in place
- wall and ceiling tiles were missing.

The space in the sluice room was used for storage of equipment posing a risk of cross infection.

### Communal space

A number of concerns regarding communal space were identified by inspectors. These included:

- there were holes in the walls and ceilings where work had been undertaken and the finished surface had not been made good
- the paint on walls was chipped off or had flaked
- floor covering in some rooms was not sealed at the joining.

There was no evidence of an ongoing program of decoration.

### Equipment and adaptations

Cleaning equipment which was not in use had been left in the hallways and not stored safely.

A number of beds in the dementia care unit were in poor condition and not suitable for use.

### Outside space

Weeds were growing in some of the paved areas and moss and algae on some paths posed a risk of slips and falls.

## Significant improvements required

The structure of the building was not conducive to a residential care setting as there were challenges posed by the physical environment. These challenges made it difficult to ensure that residents' privacy and dignity was met on a daily basis and during end of life care.

Difficulties were presented due to the multi occupancy of the bedroom space, which in some instances accommodated up to eight residents in "wards". There was limited space between individual residents' beds which impacted on their privacy and dignity.

The storage space for residents' personal clothing was inadequate overall. A variety of options existed for residents to store their clothes. Some residents' day clothing were found in a single wardrobe in their bedrooms. Other clothing was hanging in limited locker type units located beside each bed in the shared bedrooms, with the surplus hung in storage areas, adjacent to, or off the wards. In one shared bedroom there was no suitable facility and garments were hanging from equipment, furnishings and nails in the walls.

There were few locked areas for residents to store their valuables.

No call system was available for residents and staff to summon assistance.

### **Sanitary facilities**

The number of toilets, wash hand basins and assisted bath/showers provided was not sufficient to meet the individual needs of the number of residents being accommodated, or the minimum number required as outlined in the Standards. There were no showering facilities available in the male changing rooms. The hot water at a number of outlets was very hot, posing a risk of scalds.

### **Equipment and adaptations**

The standing area of a hoist and a shower trolley cushion were dirty. A shower trolley cushion was worn and cracked leading to possible infection risk.

Many of the wheelchairs examined did not have foot plates impacting on the safety of residents.

Maintenance was carried out by an employee with some work being contracted out. A system was in place to identify shortcomings in each residential area. This had proved effective for some small and specific issues identified. However, given the size, age and condition of the premises, it was evident that the above measures were insufficient.

A number of the bedside lights examined did not have bulbs and a problem with the lighting in one of the "wards" was identified. This was highlighted by the inspectors and rectified by evening time.

Large areas of dampness were evident, but this was particularly noticeable in places where the building had been extended. In some areas the plaster had fallen off the walls and in other areas was blistered and rising away from the wall. The paint on the walls was blistered, chipped, scored, flaked or stained. This was more obvious in some areas than others.

The kitchenettes in the "Doctor Mc Garry" and the "Monsignor Young" wards were in a poor state of repair. Water was leaking from the sink unit and the hot water boiler which resulted in the work surface and the back of the cupboards deteriorating from the constant leakage. Cupboard door hinges were loose and cupboard shelves under the sink were worn.

Privacy locks were not available on all toilets and washing facilities which compromised resident's privacy.

In a number of areas there were electrical wall sockets which were not safe. Some wires had been taped off but were uncovered. A notice was displayed at one wall socket "do not use".

## **5. Communication: information provided to residents, relatives and staff**

**Outcome: Information is relevant, clear and up to date for residents.**

**Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.**

### **Evidence of good practice**

Relatives confirmed that they were told of any changes in the condition of a resident.

Residents, relatives and staff meetings had taken place. An active residents' group, in place since 2002 was chaired independently by a volunteer from the community, as a measure to maintain community links and to promote impartiality.

Minutes of the residents' group meeting were viewed by inspectors and issues raised had resulted in improvements which included, a ramp providing full accessibility to the dining and chapel area and the establishment of a pastoral care group, all of which had impacted positively on daily life for the residents.

A newsletter was published to inform residents of the various events occurring. This included news items, information on new staff or residents arriving or leaving, forthcoming activities and photographs from past outings.

A staff hand-over meeting took place to inform the incoming staff group of the care and condition of residents. Staff were familiar with the individual needs and wishes of residents and able to demonstrate their knowledge to inspectors.

Notice boards conveyed up to date information of activities.

### **Some improvements required**

There were no written operational policies and procedures on communication, to ensure that each resident was facilitated and encouraged to communicate.

While there was a complaints procedure, it did not include the name and contact details of the Chief Inspector of Social Services. It did not indicate whether a second person had been nominated to ensure all complaints were appropriately responded to, and that records are maintained according to legislation.

There was no Residents' Guide available to provide information to each resident or prospective resident.

## 6. Staff: the recruitment, supervision and competence of staff

**Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs**

**Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.**

### Evidence of good practice

The inspection team found the staff to be confident, well informed and skilled in all aspects of their roles.

The staff, who spoke with inspectors in each of the four units, confirmed that they were happy at their work, "are listened to and feel valued". One care assistant told inspectors, that she "loved her job". One staff nurse interviewed by inspectors, talked about her work as "not just knowing the resident very well but also knowing the extended family well too". Another member of staff working with residents in the dementia unit described the importance of "investing time" as a fundamental aspect of her caring role.

Low rates of staff turnover were evident ensuring continuity and consistency in care.

The person in charge used a 'Train the Trainer' model for staff training. Training was provided on the use of Percutaneous Endoscopic Gastrostomy (PEG) tubes, the management of syringe drivers, moving and handling and infection control and prevention. The training records confirmed to inspectors that on-going professional education was in place and was reflective of the residents' identified needs.

Two members of staff from the dementia care unit were attending a five-week dementia care programme. Three members of staff were undergoing training on continence management and five other staff were undertaking a Further Education and Training Awards Council (FETAC) Level Five programme.

Each staff nurse worked with a care assistant on day duty and had responsibility for the care planning of up to six residents. Residents were aware of the roles of each member of staff. Each staffing grade was identifiable by the colour of their uniform and identity badges which communicated their full name and grade. Inspectors heard the residents addressing the staff by their first names.

All newly employed members of staff completed a formal one year probation period, with two appraisal meetings with their line manager conducted during the year.

### **Some improvements required**

Line management responsibility for care assistants was with the domestic supervisor. The domestic supervisor was not directly involved in residents' care. The reporting lines of authority for care assistants were not to a nurse in charge. The inspectors were told that this arrangement was in place, to facilitate distribution of workload among the senior grades of staff.

### **Significant improvements required**

The inspection team had concerns for the safety and supervision of residents relating to staffing levels and skill mix in the "Rivermeade" unit, from 18.30 hrs to 08.00 hrs. There were only two members of staff on night duty in the unit to meet the needs of the residents, all of whom had been assessed as maximum and high dependency. Due to the immobility of residents, inspectors had concerns in relation to the ability of staff to evacuate the unit in the event of fire.

Staff nurses deputised for the nurse manager at unit level only. There was no person in charge of the centre from 18.30hrs to 08.00hrs to make decisions in unforeseen circumstances.

#### ***Report Compiled By***

P.J Wynne,  
Inspector of Social Services,  
Social Services Inspectorate,  
Health Information and Quality Authority.

30 October 2009

### Provider's response to inspection report

<b>Centre:</b>	St. Patrick's Community Hospital
<b>Centre ID:</b>	0661
<b>Date of inspection:</b>	29 30 September 2009
<b>Date of response:</b>	14 December 2009

### Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

#### 1. The provider is failing to comply with a regulatory requirement in the following respect:

The number of staff on duty at night time was insufficient and there was no senior manager in overall charge during the night shift

#### Action required:

Provide a person with overall responsibility for the centre during the night shift  
A suitable number of staff must be rostered on duty at night time taking into account fire safety and working practices which ensure a high standard of patient care and safety.

#### Reference:

Health Act 2007  
Regulation 16: Staffing  
Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>The Person in Charge has met the General Manager (November 2009) to discuss and propose contingency arrangements to address the issues with:</p> <ul style="list-style-type: none"> <li>▪ staff numbers on night duty specifically in unit described in the report</li> <li>▪ to discuss and formulate the provision of night manager</li> <li>▪ discuss the contingency arrangements to enable this to happen</li> </ul>	<p>February 2010</p>

<p><b>2. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>No call system was available in the centre for residents and staff to summon assistance.</p>	
<p><b>Action required:</b></p> <p>Provide a system to allow residents and staff summons assistance.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007  Regulation 11: Communication  Standard 25: Physical Environment</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Individual arrangements are in place for Resident's using Single Use Call Bell System to summon assistance for those assessed</p> <p>A process of consultation with Technical Services/General Management to provide a retro fit system adaptable for the needs of the Residents to take place and the financial provision to enable this to be provided.</p>	<p>Addressed</p> <p>September 2010</p>

<p><b>3. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>The size and layout of rooms occupied or used by residents were not suitable for their needs.</p>	
<p><b>Action required:</b></p> <p>Provide adequate bedroom and communal space.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007  Regulation 19: Premises  Standard 25: Physical Environment</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>A consultation process will need to be undertaken with all relevant bodies:</p> <ul style="list-style-type: none"> <li>▪ estates</li> <li>▪ technical Services</li> <li>▪ general/Local Health Management</li> </ul> <p>In conjunction with estates department to put together drawings that can:</p> <ul style="list-style-type: none"> <li>▪ map out bed spaces</li> <li>▪ provide accommodation for "privacy" and "dignity"</li> </ul> <p>If 112 Residents are too remain in the accommodation.</p> <p>Please note that a plan for the provision of new residential accommodation for older people was included in the South Leitrim Area Development Plan in 2001. Two new units were identified for older people in Ballinamore and Carrick on Shannon. Land was purchased and secured in both areas for the new units. Planning permission has been granted for the purpose built residential facility in Ballinamore (December 2009) and we await approval to advance to stage 3.</p> <p>A submission was made to national HSE for a new designated purpose built centre for Carrick on Shannon under the National Design and Build Scheme, however to date, approval has not been granted as not deemed a high enough priority.</p> <p>Both facilities aim to address the overall care needs of Older People in South Leitrim.</p>	<p>Consultation Process</p> <p>January 2010</p> <p>To</p> <p>April 2010</p>

**4. The provider is failing to comply with a regulatory requirement in the following respect:**

There were an insufficient number of toilets, wash hand basins and assisted bath / shower areas and the hot water at a number of outlets was very hot, posing a risk of scalds.

**Action required:**

Provide sufficient toilets, wash hand-basins, baths, showers and assisted baths and showers with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection.

**Reference:**

Health Act 2007  
Regulation 19: Premises  
Standard 25: Physical Environment

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

**Timescale:**

Provider's response:

This can be dealt with in the overall Plan for No.3 and the plans outlined there in.

January 2010  
to  
April 2010

**5. The provider is failing to comply with a regulatory requirement in the following respect:**

The residents did not have a contract of care with the provider.

**Action required:**

Provide each resident or his or her representative with a contract of care.

**Reference:**

Health Act 2007  
Regulation 28: Contract for Provision of Services  
Standard 7: Contract / Statement of Terms and Conditions

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

**Timescale:**

Provider's response:

Person in Charge is awaiting H.S.E. National guidance in relation to contract of care for residential units.

Awaiting National  
H.S.E. Directive

**6. The provider is failing to comply with a regulatory requirement in the following respect:**

Care plans did not take account of residents' personal and social needs and were not being reviewed at frequent intervals.

**Action required:**

Develop care plans for residents that fully describe the personal, social and physical care needs.

Involve the resident or their representative in the care planning process and ensure care plans are reviewed at no less than three monthly intervals.

**Reference:**

Health Act 2007  
Regulation 8: Assessment and Care Plan  
Standard 11: The Resident's Care Plan

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

**Timescale:**

Provider's response:

The person in charge is presently awaiting results of Pilot that took place with facilitation from the Centre of Nursing & Midwifery

December 2009

New documentation to be implemented which will take full account of the Multidisciplinary role involved with Residents Care including the Personal, Social Care and involving residents and their representatives.

February 2010

**7. The provider is failing to comply with a regulatory requirement in the following respect:**

Equipment was not maintained in a safe manner.

**Action required:**

Review all equipment and take the necessary action to make it safe for residents' use.

**Reference:**

Health Act 2007  
Regulation 19: Premises  
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>With regard to the significant improvements noted in Domain 4 Specifically:</p> <ul style="list-style-type: none"> <li>▪ shower trolley cushion cracked (Sheemore)</li> <li>▪ wheelchairs (Foot Plates missing)</li> <li>▪ two Kitchenettes (Poor state of Repair):-</li> <li>▪ Dr McGarry Ward</li> <li>▪ Monsignor Young Unit</li> </ul> <p>The review of all other equipment for Resident Care have maintenance contracts in place and are addressed:</p> <ul style="list-style-type: none"> <li>▪ Hoists</li> <li>▪ Bed</li> <li>▪ Mattresses</li> </ul> <p>The equipment Cleaning and maintenance has been addressed at Unit level and individualized sign off sheets are in place to monitor this with specific accountability</p>	<p>Replaced December 2009 Addressed Will be addressed in January 2010 Will be addressed in February 2010</p> <p>Addressed in January 2010 for contract pricing</p> <p>Audit undertaken December 2009  January 2010</p>

<p><b>8. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>Residents did not have a choice around meal times.</p>	
<p><b>Action require</b></p> <p>Change the times of meals to ensure that residents have a reasonable choice around mealtimes.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:

<p>Provider's response:</p> <p>The Practice Development Group had identified mealtimes as a factor for review and change.</p> <p>Audit has been undertaken with Staff</p> <p>Audit has been commenced in Sub Group to ascertain:</p> <ul style="list-style-type: none"> <li>▪ resident's needs</li> <li>▪ significant other</li> </ul> <p>Consultation process with residents will take into account all areas discussed on 29' 30 September 2009 and will take cognisance of the issues pertaining.</p>	<p>March 2010</p> <p>November 2009</p>
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<p><b>9. The provider has failed to comply with a regulatory requirement in the following respect:</b></p> <p>The program of activities was not meeting the individual needs of residents.</p>	
<p><b>Action required:</b></p> <p>Provide a meaningful activities program that takes account of residents' needs including those who are unable to leave the centre or actively participate within a group setting.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007  Regulation 6: General Welfare and Protection  Standard 18: Routines and Expectations</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>All Key stakeholders including residents representatives will be meeting to address this issue.</p> <p>Access of the resident group noted in the report that being the bed dependent residents to the ongoing activities programmes taking into account their participation in and their response to these based on</p> <ul style="list-style-type: none"> <li>▪ best Practice</li> <li>▪ individual Need</li> </ul> <p>Will be our priority as outlined.</p>	<p>May 2010</p>

<p><b>10. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>There were structural defects to the wall from dampness and water damage.</p>	
<p><b>Action required:</b></p> <p>Take action to prevent dampness and water damage to the interior of the centre. Repair the internal walls of the centre which have been water damaged.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>Preparatory work done in the attic (December 2010) for the roof of the Main building to be replaced as described at the visit on 29 and 30 September 2009.</p> <p>The presentation of plans to address the walls following replacement of the roof will take place following drying out period of 12 months. These can then be decorated and repaired</p> <p>Any works done prior to this will be cosmetic and not cost effective so symptomatic address will be key.</p>	<p>May 2010</p> <p>May 2011</p>

<p><b>11. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>There was no room for residents to meet visitors in private.</p>	
<p><b>Action required:</b></p> <p>Provide suitable arrangements to accommodate residents' visitors.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>

<p>Provider's response:</p> <p>There are designated rooms on each unit that Resident's can meet in private.</p> <p>The fabric of these rooms is under review.</p> <p>The provision of overnight accommodation is being provided with consultation with the Resident's Group/End of Life Group. Funding Secured to utilise space identified once the consultation group have identified the need</p>	<p>Addressed</p> <p>2010</p> <p>April 2010</p>
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**12. The provider is failing to comply with a regulatory requirement in the following respect:**

Notices concerning residents' personal care needs were displayed openly over their beds.

**Action required:**

Put in place a system to ensure information concerning the resident is communicated in a manner to ensure the privacy and dignity of the resident is maintained.

**Reference:**

Health Act 2007  
Regulation 10: Residents' Rights, Dignity and Consultation  
Standard 4: Privacy and Dignity

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

**Timescale:**

Provider's response

A review has been undertaken and a systematic process of the information highlighted has been done

December 2009

Alternative Safe Systems of identifying information for individualized Resident's is being piloted at present taking into account:

- Health and Safety Authority Guidance
- documentation review and maintenance of residents information
- privacy and dignity

March 2009

<p><b>13. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>Residents did not have sufficient and suitable storage facilities for their personal belongings.</p>	
<p><b>Action required:</b></p> <p>Provide suitable storage facilities for the use by residents'.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>This has to be addressed in conjunction with Action (3) not in isolation.</p> <p>To Provide:</p> <ul style="list-style-type: none"> <li>▪ Wardrobe Space (not Lockers)</li> <li>▪ Personal locking space</li> </ul>	<p>January 2010 to June 2010</p>
<p><b>14. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>Throughout the centre paint on the walls was chipped, flaking and stained.</p>	
<p><b>Action required:</b></p> <p>Take appropriate action to clean the centre and equipment and implement an ongoing redecoration program of the centre.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>The person in Charge has met with maintenance manager to discuss Action (14)</p>	<p>January 2010 For initial plans</p>

<p>A Programme of decoration will be drawn up in order to:-</p> <ul style="list-style-type: none"> <li>▪ prioritise areas to be addressed</li> <li>▪ secure Funding to plan these</li> <li>▪ execute these plans expeditiously</li> </ul>	<p>Throughout 2010 Pending funding</p>
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<p><b>15. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>A number of over bed lamps were not working and the lighting in one ward was not working fully.</p>	
<p><b>Action required:</b></p> <p>Provide appropriate lighting at all times.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>Maintenance (O.T. Technician) is undertaking this Action in an ongoing basis as highlighted both in resident's areas and communal areas.</p> <p>The lighting in unit not working fully (Sheemore Ward)</p>	<p>Addressed</p> <p>Addressed</p>

**16. The provider is failing to comply with a regulatory requirement in the following respect:**

Weeds were growing in some of the paved areas and moss and algae on some paths posed a risk of slips and falls.

**Action required:**

Clean the pathways and remove weeds.

**Reference:**

Health Act 2007  
Regulation 19: Premises  
Standard 25: Physical Environment

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

**Timescale:**

Provider's response:

Maintenance (O.T. Technician) addressing these in an ongoing manner.

Addressed

**17. The provider is failing to comply with a regulatory requirement in the following respect:**

The cisterns in some of the sluice rooms were not flushing and backsplashes were not in place.

**Action required:**

Maintain appropriate sluicing facilities.

**Reference:**

Health Act 2007  
Regulation 19: Premises  
Standard 25: Physical Environment

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

**Timescale:**

Provider's response:

All cisterns now flushing and backsplash in place.

January 2010

<p><b>18. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>A large amount of equipment was stored in hallways, bathrooms and sluice rooms.</p>	
<p><b>Action required:</b></p> <p>Provide suitable and sufficient storage facilities which are centrally located.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007  Regulation 19: Premises  Standard 25: Physical Environment</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>This has to be addressed under Action (3) to provide this accommodation.</p>	<p>January 2010 to April 2010</p>

<p><b>19. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>The policy on medication management did not clearly address all aspects of medication management.</p>	
<p><b>Action required:</b></p> <p>Develop a medication management policy that details the crushing of medication and the administration of suppositories, eye drops and ointment.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007  Regulation 33: Ordering, Prescribing, Storing and Administration of Medicine  Standard 14: Medication Management</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>The Person in Charge will co ordinate the development of these areas identified and add them to the existing Medication Management Policy</p>	<p>February 2010</p>

**20. The provider is failing to comply with a regulatory requirement in the following respect:**

The centre did not have a comprehensive policy for risk management.

**Action required:**

Develop a comprehensive policy for care planning for risk factors such as the use of restraint.

Implement a fall risk assessment for residents.

**Reference:**

Health Act 2007  
 Regulation 31: Risk Management Procedures  
 Standard 21: Responding to behaviour that is challenging

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

**Timescale:**

Provider's response

The person in charge will ensure that the development of the comprehensive care policy for risk factors identified:

- restraint
- fall Risk

Jan – March 2010  
 Jan – March 2010

**21. The provider is failing to comply with a regulatory requirement in the following respect:**

The provider did not have all of the written and operational policies listed in Schedule 5 (Policies and Procedures to be Maintained in Designated Centres) of the Regulations.

**Action required:**

The policies and procedures outlined in schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 are required to be available and in up to date format.

**Reference:**

Health Act 2007  
 Regulation 27: Operating Policies and Procedures  
 Standard 29: Management Systems  
 Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response</p> <p>The person in charge has following the visit of 29 / 30 September undertaken a review of the Schedule (5) Regulation Policy and Procedures and with the co-operation and joint work of all members of the Multidisciplinary Team in St Patrick's and with the joint work of the Older Person Care Regional Quality Group are in process of developing these policies and procedures ensuring they are centre specific</p> <p>This work will be ongoing developing reviewing throughout 2010</p>	<p>During 2010</p>

<p><b>22. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <p>A Residents' Guide was not available to residents.</p>	
<p><b>Action required:</b></p> <p>Develop and provide a Residents' Guide to all residents.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007  Regulation 21: Provision of Information to Residents  Standard 1: Information</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>The Residents Guide will be devised as per 21 (1) A – F and will be circulated to all resident's following consultation with stakeholders including our resident's group for approval and suggestions.</p>	<p>May 2010</p>

## Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 25.7 Physical Environment	Ensure that current infection control guidelines are followed.

## Any comments the provider may wish to make:

### Provider's response:

As the person in charge I want to acknowledge and welcome the introduction of the inspection process. It was encouraging to read the paragraph of the summary noting that there was a satisfaction with the nursing medical and other healthcare needs of residents were met and the nursing care was of a high standard.

We will strive to work to a continuous quality person centred approach to enhance the resident's lives.

It has been necessary to address comments and reflections made in relation to the participation of St Patrick's Community Hospital in the national practice development programme. This is for your information and perusal as we do not feel understanding of the aim of the programme, processes used and outcomes achieved are reflected in the comments in your report.

We wish to provide you with the following supporting information to clarify this in relation to the national programme.

This centre was one of 18 residential sites which participated in the national practice development programme for the past two years. The ultimate aim of this programme is to improve the experience for older people through the implementation of a model of person centred practice and an evaluation of the processes used and outcomes achieved. Over the two year period a structured evaluation process was used and involved the collection of data by the MDT through methods such as formal observations of care, resident narratives, and environmental observations. Throughout this timeframe, processes have been established; new ways of working

and new learning has been achieved by the healthcare team which provides a foundation for this work to continue. The inclusion of residents and their family/carers is integral to this process. This is a long term and does not end after the two year period. The philosophy of the programme is based on exploring the culture and context of the care environment and putting in place evidence based methods which allow healthcare teams and residents to change, challenge and influence care in a positive way.

As part the objectives of the programme a structured evaluation process took place over the two year period and there is evidence though quantitative and qualitative methods to support positive change has occurred in the culture and context of the care environment. Working committees have been established and the membership of these groups has been extended to involve residents and community stakeholders. The following details some of the initiatives and developments which have occurred and are currently ongoing.

- resident groups have been established on the specific units and link directly to the main resident panel in the hospital
- the exploration of person centred language
- the strengthening of working relationships with pastoral care group, community groups
- the establishment of St Patrick's Magazine for residents, families and staff.
- enhanced communication throughout the hospital between all members of staff
- increased awareness of individual roles within the healthcare team
- putting in place processes to empower and enable the healthcare team to explore the culture and context of care
- staff development and empowerment
- completion of our church renovation and the installation of a video link throughout the hospital
- the development of a Sensory Garden is in its planning stage.
- the establishment of an activity room for residents
- the redecoration of the hallways in work ongoing
- two standing Committees have been established to explore current practises around End of Life Care, the practice development work and pastoral care group link directly. Membership of this group includes: Community G.P., Religious Leaders from the Community, Community Undertaker and a Resident Volunteer and the specific healthcare team in the hospital
- the introduction of specific personal property bags and sympathy cards to families is now current practice.
- clear links have been made with the Hospice Friendly Hospital programme.
- quiet Family Rooms are in the process of being established in the specific units
- changes have been made in relation to mortuary access to ensure privacy and dignity is enhanced
- the development of the healthcare team professional needs in relation to end of life care is ongoing through education, support and in collaboration with the HFH, Hospice and Centres of Education

- a multidisciplinary group has been established as a working committee to explore, change and enhance nutrition and mealtimes.

Thank you for the opportunity to discuss this in more detail. The involvement in this programme over the last two years has provided the impetus to continue to strive toward a person centred philosophy of care for our residents.

**Provider's name:** Pat Dolan

**Date:** 14 December 2009