Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

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:	Unannounced
Date of inspection:	14 June 2023
Centre ID:	OSV-0000661
Fieldwork ID:	MON-0037473

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.

Number of residents on the date of inspection:	37

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as 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
Wednesday 14 June 2023	09:30hrs to 09:30hrs	Catherine Rose Connolly Gargan	Lead
Wednesday 14 June 2023	09:30hrs to 18:30hrs	Ann Wallace	Support

What residents told us and what inspectors observed

Overall feedback from residents regarding the service they received and their quality of life in St Patrick's Community Hospital was positive. Residents told the inspectors they were happy and content in their environment and that staff were kind and always attentive to their needs. The inspectors observed that residents' accommodation was arranged into three units on the ground floor level. The first floor in the premises was being utilised by the acute hospital services as a step-down unit and both services shared a common entrance and foyer area. The residents' accommodation was divided into three separate units; the Monsignor Young Dementia Unit, the Dr McGarry Unit, and the Sheemore Unit. Each unit was linked into the main circulating corridors

Inspectors observed that residents in the dementia unit were facilitated to enjoy fulfilling and meaningful lives. Staff had a very good knowledge of residents' individual life stories, their needs and preferences regarding their care and daily routines and staff interactions with residents were observed to be gentle, kind and respectful. However, this was in contrast to inspectors' observations of residents' lived experience in the Sheemore and Dr McGarry units.

The inspectors observed that residents in Sheemore unit spent their day by their bedside. This unit had been recently refurbished and there were three newly refurbished communal rooms available in this unit however on the day of the inspection only one small communal room was used by a small number of residents.There was no activities programme available to inform residents of activities being provided and the inspectors did not observe any activities happening for residents on this unit. Inspectors observed that the majority of residents in this unit also ate their meals by their bedside. The dining room was small and did not provide adequate seating for the number of residents accommodated on this unit.

Residents on Sheemore unit had access to safe outside space in a partially covered courtyard which was adjacent to the unit. The courtyard was nicely laid out with raised flower and shrub beds, seating and safe pathways however, no residents were observed using this outdoor area on the day of the inspection.

The Dr McGarry unit was still being refurbished and the works were approaching completion. While most residents spent their time in the sitting room of the Dr McGarry unit the layout of residents' seating in this room was institutional in nature and did not promote social interactions between residents. Inspectors observed that number of higher dependency residents were served their meals on portable bed tables even in the dining room. Staff who spoke with the inspectors were not able to give an explanation of why the residents were not able to sit at a dining table to take their meals. This again gave an institutional feel to the lived environment for the residents. During the afternoon, inspectors observed residents in this unit enjoying a card game, painting, singing and praying the rosary. Residents with one-to-one needs were supported to do jigsaws and were also listening to music. A

second communal room had been made available to residents on the unit since the last inspection but the decoration of this room was not completed and it was not observed to be used by any residents on the day of the inspection.

The provider had developed a small courtyard area for residents on the Dr McGarry unit since the last inspection. While outdoor seating was provided the area lacked colour and interest and was mainly used by some residents as a smoking area on the day of the inspection. A second small internal courtyard in the centre of the unit was available but not accessible to residents. The inspectors observed that this area was overgrown and not well maintained. In contrast the residents on the Monsignor Young dementia unit enjoyed access as they wished to two pleasant outside gardens which were nicely laid out with colourful seating,residents were seen enjoying these outdoor spaces throughout the day of the inspection.

The inspectors were told by residents that they went on regular outings to the local town and other areas of interest in the centre's wheelchair accessible bus. Children from the local playgroup also called into the centre with their teacher and joined the residents for arts and crafts. Some residents told the inspectors that they especially enjoyed the visits by the children, they reminded them of their grandchildren and their own children when they were young.

There was also a large church on site which was accessible to residents through the staff dining room. Although the inspectors were told that residents liked to go to the church and that residents could avail of refreshments in the staff dining room, no residents were observed visiting the church or having refreshments in the staff dining room on the day of this inspection.

Residents were complimentary about the quality of the food they were provided with and their comments included 'better than any hotel', 'there is always a choice and if you don't fancy any of that, you can have something else', the cook here is 100%' and ' I never ate so well'. While the majority of residents said they were happy living in the centre, one resident told the inspectors that they would prefer to be living in the community but, suitable accommodation was not available for them. This was brought to the attention of the centre's management at the inspection feedback meeting.

The inspector observed that painting and decoration had been used to support residents in identifying key areas. Colour coding and vinyl prints were used to identify toilet doors and bedroom doors to support residents with orientation and way finding. Memorabilia familiar to residents such as dressers, crockery, tea-sets, ornaments, flower pots and other items were used in the communal areas to create a homely and comfortable environment for residents.

The Monsignor Young Unit offered residents a circuit for those who were walking with purpose and had several points of interests along the way for residents to engage in. Many of the residents had a background in farming and the environment was designed to capture their interests. For example, there were pictures of cattle and sheep displayed along with a full size replica of sheep, a cow and a calf outside grazing in the residents' outdoor garden. Raised flower beds with hand trowels were

available for any of the residents with an interest in gardening in the courtyard.

Many residents had personalised their bed areas with photographs and other personal items.

Staff who spoke with the inspectors were knowledgeable about the residents and were respectful in their interactions with residents. However on some units staff resident interactions were largely focused on care tasks and interventions and were not person centred. Residents on these units spent long periods of time without any social interaction either with other residents or with staff. Residents told the inspectors that staff were busy and that they did not want to bother them.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

The day-to-day care and services provided for residents was well managed and ensured that residents received nursing and care to meet their assessed needs. However this inspection found that the provider had failed to progress the scheduled programme of fire safety improvements and refurbishment works to improve the lived environment for the residents. In addition the oversight of fire safety in the centre did not ensure that non-compliance was identified and addressed in a timely manner.

The centre has a restrictive condition in place which required the provider to complete the planned refurbishment and fire safety improvement works by 01 January 2022. This inspection found that although a lot of improvement work had been done in the centre the provider remained not compliant with Regulations 28 and 17 and the designated centre was in breach of its current conditions of registration.

The registered provider is the Health Service Executive (HSE) and a service manager attended the inspection to represent the provider. As part of a national provider network St Patrick Community Hospital benefits from access to and support from the HSE national resources such as Community Health Organisation management teams (CHO) human resources, staff training and development, clinical practice development, finance and information technology.

There had been a change of person in charge in June 2023 and the new person in charge facilitated the inspection supported by the assistant director of nursing (ADON). The registered provider representative attended the inspection in the afternoon. The new management team worked well together and were knowledgeable about the residents and their care needs and progress in the centre. In addition the management team were up to date with staff issues and had a plan

in place to recruit to the current staff vacancies in the centre.

There were established governance and management processes in place with oversight of key areas in clinical care and support services for the residents. Resident's feedback was sought through resident meetings and questionnaires and this feedback was used to informed quality improvement plans including the annual review. However inspectors found that the oversight of the lived environment and the lived experience of residents in the centre was not robust and did not identify a number of the findings of this inspection. For example inspectors found that daily routines and staff practices on two of the units did not promote resident's choice and flexibility in their daily routines. This was particularly evident in relation to the activities that were available for residents and the resident's meal time experience. These findings are discussed further in the quality and safety section of this report.

Overall there were sufficient staff available to provide care and services for residents and to attend to their needs in a timely manner. Call bells were answered promptly and residents confirmed that staff were attentive and that they did not have to wait for staff to come to them. There were some vacancies in nursing and care staff which were being filled at the time of the inspection. In the interim these were covered by regular agency staff who supported the in house staff team. This helped to ensure continuity of care for residents from staff with whom they were familiar. However changes in the staff and volunteer team providing activities needed to be addressed to ensure that residents had access to meaningful activities and entertainments in line with their needs and preferences.

There were robust selection and recruitment processes in place to ensure appropriate staff were selected to join the staff team. The inspectors reviewed a sample of staff records and found that overall they met the requirements of the regulations, however two files reviewed did not have satisfactory explanations of employment gaps. All staff had appropriate Garda vetting in place before they commenced working in the designated centre.

Staff had good access to mandatory training and the training matrix reflected high levels of staff compliance with their mandatory training requirements. As a result staff who spoke with the inspectors were knowledgeable about their roles and responsibilities in relation to key areas such as fire safety and safeguarding residents. However agency staff did not demonstrate adequate knowledge of fire safety procedures which needed to be addressed by the provider so that all staff working in the centre were aware of what to do in the event of a fire emergency.

Records were held securely and were made available for the inspectors for the purpose of this inspection.

There was a risk register in place and the provider had clear processes for managing risks and reporting and learning from incidents that occurred in the centre or in other designated centres managed by the national provider. However the oversight of environmental risks and fire safety within the staff team working in the centre required improvements. These findings are discussed under Regulation 23.

Regulation 14: Persons in charge

There was a new person in charge who met the requirements of the regulations. They are an experienced registered nurse with previous management experience of being a person in charge in another designated centre.

The person in charge demonstrated good knowledge and understanding of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and of their regulatory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff with the appropriate knowledge and skills to meet the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The current training programmes did not ensure that agency staff working in the centre had access to fire safety training to ensure they were able to respond to a fire emergency.

A number of staff had not received training in person-centred care and did not demonstrate a person-centred approach to their practices.

Staff supervision in two of the units was not effective which was leading to poor outcomes for residents. For example;

- Housekeeping schedules were not completed for a number of days.
- Staff practices did not ensure that residents were offered choice in their care and daily routines.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The Directory of residents was up to date and was available for the inspectors to review. The Directory contained all of the information as required under Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Two staff files did not include a satisfactory rationale for several gaps in the staff members' employment history as required under Schedule 2 of the regulations.

Judgment: Substantially compliant

Regulation 22: Insurance

There was a contract of insurance in place which had been recently renewed. The insurance cover met the requirements of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to ensure that there were adequate resources available to complete the fire safety improvement works and refurbishment plan for the centre in a timely manner and in line with the conditions of their registration.

The oversight of fire safety was not robust. For example;

- Records showed that the weekly fire checks had not been completed for two weeks in February and one week in April 2023.
- The weekly fire equipment checks did not identify a number of the non-compliances identified on this inspection. These are set out under Regulation 28. Fire precautions.

The management of environmental risks was not robust. For example;

- Cleaning products were being stored on open shelving in Sheemore unit and were accessible to residents who might enter that area.
- Two external fire escapes were impeded by chairs that had been placed by

staff.

Judgment: Not compliant

Regulation 31: Notification of incidents

Arrangements for recording accidents and incidents were in place and were notified to the Health Information and Quality Authority as required by the regulations.

Judgment: Compliant

Quality and safety

Overall, residents were provided with good standards of nursing and health care in line with their assessed needs and residents rights were mostly respected. Care and supports were informed by residents' needs and usual daily routines. However more focus and resources were now required to make the improvements that were required to bring the centre into compliance with the regulations and to ensure that the resident's on all units could enjoy a safe and pleasant lived environment. Furthermore improvements were required to ensure that residents were supported to spend their days as they wished and had access to meaningful activities in line with their interests and capacities.

A number of improvements had been made by the provider since the last inspection to ensure residents were protected from risk of infection. For example there were sufficient supplies of personal protective equipment (PPE) and staff completed appropriate hand hygiene procedures. Adequate numbers of clinical hand hygiene sinks to support effective staff practices were in place. However further improvements were required as reported under Regulation 27.

Notwithstanding the significant works carried out to ensure residents were protected from risk of fire, further actions were found to be necessary on this inspection. The inspectors' findings are discussed under Regulation 28: Fire precautions.

Residents were provided with good standards of nursing care and timely health care to meet their clinical needs. Residents' records and their feedback confirmed that they had timely access to their general practitioners (GPs), specialist medical and nursing services including psychiatry of older age and allied health professionals as necessary. This optimised their continued good health and well being. Residents' care plans were detailed and reflective of their individual preferences and wishes regarding their care and supports. Care plans were regularly updated and residents or, where appropriate, their families were consulted with regarding any changes

made.

Residents were encouraged and supported to personalise their bedrooms and the layout of residents' bedrooms met their individual needs. The provider was progressing a refurbishment programme which was delayed. Works were completed on Sheemore unit and at an advanced stage in the Dr McGarry unit. Works in the dementia unit were planned but had not commenced at the time of this inspection. Works completed in the Sheemore and Dr McGarry units included separation of residents' bedroom accommodation from corridors with the erection of a wall between the corridor and a number of residents bed-spaces. These improvements helped to promote residents' privacy. In addition the improved compartmentation in the unit improved the safety of residents in the event of a fire in the centre. Further actions were also necessary regarding maintenance in the centre to ensure residents' living environment was kept in a good state of repair and that effective cleaning could be achieved in all parts of the centre.

Residents' rights were mostly respected in the centre. However, not all residents had access to appropriate meaningful activities on the day of the inspection. Actions were also necessary to ensure residents accommodated on Dr McGarry unit could safely access an outdoor area as they wished.

Residents were supported to safely meet with their visitors. Residents had access to religious services and were supported to practice their religious faiths in the centre.

Residents' meetings were regularly convened and issues raised needing improvement were addressed. Residents had access to local and national newspapers and radios.

The provider had comprehensive procedures in place to protect residents from abuse. These included rigorous staff selection and vetting processes and mandatory training for all staff to ensure they were aware of their roles and responsibilities to keep residents safe. However the garden adjacent to the Sheemore unit was open to the public and adequate measures were not in place to monitor unauthorised persons who may enter the designated centre via the courtyard.

There was a positive approach to care of residents predisposed to experiencing episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). A minimal restraint environment was promoted and the procedures in place were in line with the national restraint policy guidelines.

Regulation 11: Visits

Residents' families and friends were facilitated to visit and practical precautions were in place to manage any associated risks. Residents access to their visitors was not restricted and suitable facilities were available to ensure residents could meet their

visitors in private outside of their bedrooms if they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Some residents' wardrobes in twin bedrooms and in a bedroom with three beds in the dementia unit were located along walls outside their bed spaces. Each resident in the bedroom had a section of the wardrobe to store their clothes in. This meant that residents in these bedrooms could not maintain control of their clothing and personal possessions as other residents could access their personal wardrobe space.

Some residents' bedside lockers were not by their bedsides in the Sheemore unit and this meant, their personal possessions placed in and on the lockers were not within their reach when they were in bed or resting in their chairs by their bedside.

Judgment: Substantially compliant

Regulation 17: Premises

The design and layout of some areas of the centre did not meet the number and needs of the residents accommodated on those units. This was evidenced by;

- The dining room on Sheemore unit did not provide enough dining space to facilitate all residents to eat their meals in the dining room if they wished to do so. The dining table available only permitted four residents to sit around it at one time. This had been identified in the provider's own nutritional audit in January 2023 but had not been addressed.

The designated centre did not conform to all of the matters set out in Schedule 6 of the regulations. For example;

- The outside space available for residents on the Dr McGarry unit was not well set out and did not provide a safe and secure outside area for the residents. The two garden areas consisted of one concrete area at the end of the unit furnished with a wooden bench and a wooden table. It was a very hot day on the day of this inspection and there was no shading available for residents using this area. Furthermore, there was no planting to engage residents or to provide colour and interest. The second area was an internal courtyard which could be accessed form the link corridor and the main lounge but was not available for resident' use. The area was overgrown and untidy. There was no seating or tables set out for residents to use this courtyard even though this was marked as a garden on the floor plans against which the designated centre was registered. These are repeat findings form the previous two

inspections.

- There was not sufficient storage available and a number of the store rooms and storage areas that were in use were not well managed. For example, items were not appropriately segregated and a number of store rooms were untidy and cluttered with boxes and items stored on the floor which prevented the floor being dusted and cleaned. Inspectors also observed that trolleys for used linen collection were being stored in communal bathrooms which created a risk of transmission of infection.
- Grab rails were not in place on both sides of one en suite toilet and in a communal shower. These findings did not promote residents' independence and safety.
- The floor covering in a toilet used by visitors close to the centre's reception area and in a sitting room in the dementia unit was damaged and was unsightly and did not support effective floor cleaning procedures.
- Paint was damaged/missing on a number of bedroom doors, doorframes and on wall surfaces in some residents' bedrooms and on walls along a number of the corridors. This meant that these surfaces could not be effectively cleaned. This is a repeated finding from the last inspection.
- A nurse call bed was not fitted in a single bedroom in Sheemore unit.

Judgment: Not compliant

Regulation 27: Infection control

The inspectors found that the following required action by the provider to ensure residents were protected from risk of infection and that the centre was in compliance with Regulation 27.

- The interior surface of a wardrobe in a newly refurbished single bedroom in Sheemore unit which the provider has applied to the Chief Inspector for registration was unclean and the condition of some of the interior surfaces in this wardrobe did not support effective cleaning.
- Surfaces and the floor covering in the centre's hairdressing room located close to the Sheemore unit were unclean. Inspectors' observed that this room contained items of equipment which they were told were awaiting disposal. The room was cluttered and there was storage of boxes directly on the floor which hindered effective floor cleaning. The area around the water outlet in the sink was stained and the fabric on the arm rest of the chair was torn and the foam was exposed. These findings posed a risk of cross infection to residents.
- An area of the floor at the side of a stairs in Sheemore unit used for storage of residents' wheelchairs was not adequately cleaned. Inspectors also observed mould-like staining on the wall surfaces in an area behind this stairs. These findings posed a risk to residents of cross infection.
- A number of boxes were stored directly on the floor in the centre's laundry room and toilet rolls were stored on the floor in a cleaner's room. These

findings did not support effective floor cleaning and posed a risk of cross infection to residents.
- Although an enclosed waste storage compound was available, large waste storage bins were inappropriately stored in a number of areas around the exterior of the centre premises.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had failed to complete all of the fire safety improvement works identified in their own Fire safety Risk Assessment completed in 2021 in line with time-line set out in Condition 4 of the designated centre's current registration. Furthermore, the fire safety improvement works in the short stay unit which was located on the floor above the designated centre had not commenced to address a number of high risks identified in the centre's 2021 Fire safety Risk Assessment. Because of the co-location of the short stay unit on the first floor and the designated centre on the ground floor of the premises, this increased the fire risks to residents in the designated centre.

The Provider had not made adequate arrangements for maintaining and testing all fire equipment. This was evidenced by;

- Four fire extinguishers in the laundry had not been serviced in line with the manufacturer's recommendations.
- A number of cross corridor fire doors were damaged and some of them did not have intumescent strips to prevent the spread of fire and smoke.
- The cross corridor fire door at the entrance to the occupational health corridor was not connected to the fire alarm system and would not close in the event of the fire alarm being activated. This door was open on one side on the morning of the inspection and would have needed a member of staff to close it if the fire alarm sounded. This was not addressed in the centre's fire safety policy and procedures
- The weekly fire safety checks carried out in the centre on key equipment, such as the fire alarm and the fire extinguishers had not identified a number of the findings on this inspection. Furthermore, records showed that these weekly checks were not completed for two weeks in February 2023 and one week in April 2023. Furthermore, the four fire extinguishers in the laundry were not included if fire equipment to be checked on the weekly fire safety checks.

The provider failed to make adequate arrangements for reviewing fire precautions. For example;

- The link corridor on Dr McGarry unit was a fire escape route however a waste bin and a trolley were located along the wall on one side which narrowed the

escape route. Access along this escape route was reduced further during lunch time when the hot trolleys and serving trolley for the lunch time meal were plugged into sockets along the wall on the other side creating a pinch point which would hinder egress in the event of a fire evacuation being necessary.
- Two external fire exit routes were blocked by chairs. These were removed on the day of the inspection.
- There was no fire blanket or suitable receptacle for safe disposal of used cigarettes in the resident's smoking areas on Sheemore and Dr McGarry units. As a result inspectors found discarded cigarette butts left on the benches and seats in these areas.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents' needs were comprehensively assessed within 48hours of their admission and regularly thereafter. Staff used a variety of accredited assessment tools to identify each resident's risk of falling, malnutrition, pressure related skin damage and their safety with mobilising among others. Residents' care plans detailed the care and support interventions that staff must complete to meet their care and support needs. This information was person-centred and reflected each resident's usual routines and individual care and support preferences and wishes.

Residents care plans were regularly updated and regular reviews were completed in consultation with residents and their families on their behalf as appropriate.

There were no residents with wounds on the day of this inspection and if needed, policies and procedures were in place to inform evidence based wound care. A woundcare link nurse was available on each unit to support staff with managing residents' wounds.

Judgment: Compliant

Regulation 6: Health care

Residents nursing and healthcare were met. Residents had timely access to a general practitioner (GP) and were appropriately referred to allied health professionals, specialist medical and nursing services including psychiatry of older age, community palliative care and tissue viability specialists and their recommendations were implemented. An on-call medical service was accessible to residents out-of-hours as needed. Residents were supported to safely attend out-

patient and other appointments to meet their ongoing healthcare needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A small number of residents experienced intermittent responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were observed to maintain a positive and supportive approach to residents' responsive behaviours and their responses were dignified and person-centred. Behaviour support care plans were in place for residents predisposed to responsive behaviours to inform the most effective de-escalation techniques and ways to respond to the behaviours.

No restrictive full-length bedrails were in use in the centre and a restraint free environment was promoted. Arrangements were in place to ensure an assessment was completed which included a multidisciplinary approach in consultation with the resident or their representative, the resident's general practitioner (GP) and the physiotherapist. Procedures were in place to ensure residents' safety when restrictive equipment was in use and to ensure that use was not prolonged. Alternatives to full length bedrails were in use and there was evidence of good use of these alternatives such as grab rails and low profile beds.

Judgment: Compliant

Regulation 8: Protection

Sufficient measures were not in place to protect residents from unauthorised access by members of the public into residents' accommodation in the designated centre. For example

- The reception area provided open access to the general public because it was shared between the designated centre and the short stay units on the first floor of the building. Although a receptionist was employed each weekday until 17:00hrs, access to the centre was not supervised after 17.00hrs until the doors were locked at night. This meant that the public had unrestricted access into the designated centre when the reception area was not manned.
- The general public had open access to the residents' outdoor courtyard on Sheemore unit. This risk had not been identified and managed by the management team.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were not supported to exercise choice in their daily routines in two of the three units in the centre. This was evidenced by:

- Residents could not choose to access the dining room in Sheemore unit as the dining room could only accommodate less than 50% of the residents living in this unit. This meant that the majority of the residents had their meals by their bedside.
- One resident who expressed a wish to return to living in the community did not have a plan in place to support them to access a community placement that had been organised for them by an independent advocacy service. This meant that their choice to live in the community was not being progressed.

The provider had a social activity schedule in place that included group and one-to-one social activities in each of the three units. However, residents in two of the units were not provided with opportunities to participate in meaningful social activities during the morning of the inspection. Furthermore, the social activities facilitated in the afternoon were not as displayed on the social activity notice board. Inspectors observed that some residents with higher levels of cognitive impairment did not appear to have equal access to social activities to meet their interests and capacities to participate. This observation was validated by records reviewed by the inspectors which showed that some of these residents had not attended social activities for a number of days.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not 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	Substantially compliant
Regulation 9: Residents' rights	Not compliant

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

Inspection ID: MON-0037473

Date of inspection: 14/06/2023

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:
To ensure compliance with Regulation 16: Training and staff development the following has been put in place:

1. The Person in Charge has reviewed and updated the designated centres Fire induction training. This induction process ensures that all agency staff working within the centre are aware of how to respond in the event of a fire.
All current agency staff working within the centre have had an additional training session on the fire process and evacuation processes within the centre

2. The Person in Charge and the Practice Development co coordinator have completed sessions with staff on person centred care practices. The Provider, the Person in Charge and the Practice Development co coordinator are meeting with the regional Nursing Midwifery Practice Development team in early September as to develop a bespoke training programme which will include all staff working within the centre. This programme will focus on person centred care practices and thus will further enhance the quality of life of residents residing within the centre

3. As to ensure compliance with housekeeping schedules the Person in charge has implemented a quality assurance process in which the CNM's on the unit or the domestic supervisor review and countersign daily completed housekeeping schedules. This ensure schedules are adhered to within the designated centre.

4. The audit schedule within the designated centre has been updated to include an audit of the daily housekeeping schedules. This audit will be completed by the Person in Charge or the Assistant Director of Nursing on a monthly basis. Following the audit a quality improvement plan will be developed with robust time frames as required

5. An external clinical and environmental audit was completed by the Infection control

nurse specialist to ensure that there is oversight of infection control practices. This external clinical environmental audit process will remain ongoing on a quarterly basis. This will provide additional oversite and governance by the specialist team in Infection Prevention and Control

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
To ensure compliance with regulation 21: Records the following process has been put in place:

1. A review of all staff files has taken place within the centre. Any gaps noted in the employee's employment history have been actioned and records have been updated as to provide rational for gaps in employees history.

2. All new staff members recruited within the designated centre have a full employee history on file

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance with regulation 23: Governance and management. The following process has been put in place :

1. The Director of Nursing and the Assistant Director of Nursing will ensure that the weekly fire checks are completed on a weekly basis in line with the HSE Fire Register. This will ensure good oversite and governance in relation to Fire compliance

2. Fire checks are carried out twice daily by unit staff as to ensure that all fire exits are not impeded in any way. All staff are made aware at the safety pause three times daily on the importance of having fire exits free from obstruction. The Person in Charge and the Assistant Director of Nursing will continue to do safety walk abouts of the designated centre ensuring fire exits are not impeded at any time

3. Fire Safety and Fire Safety compliance will continue to be a standing agenda for the provider and the Person in Charges governance meetings. All issues in relation to Fire Precautions will be reviewed and discussed. Any issues in relation to fire safety will be

actioned locally or escalated to the fire risk department for auctioning within a time bound time frame

4. A review of the storage of cleaning products has taken place within the designated centre. All cleaning products are now stored in a secured locked press within the designated areas

5. All fire risks as identified on the fire risk assessment have now been completed within the designated centre. Superficial repairs to a number of fire doors with the centre is required. An external company as requested by the HSE will repair the works to these doors. Works will be completed by the 27/10/2023

6. Fire upgrade works will be completed in the non-designated centre adjacent to the designated centre by the 31/05/2024. These works will be completed in three phases. These works will ensure that all areas within St Patrick's Community Hospital is Fire compliant.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
To ensure compliance with Regulation 12: Personal possessions. The following process has been put in place:

1. A review of resident's bedroom areas in the dementia unit has taken place. This review resulted in wardrobes being allocated to residents within their individual bed space. This now allows for residents to have access to maintain control of their clothing and personal possessions

2. A review of resident's bedroom areas in the Sheemore unit has taken place in conjunction with residents as to ensure that residents have access to their bedside lockers while in bed or resting. This review resulted in changes to the bedroom layout of some residents bed spaces as agreed with the resident. These residents can now access their personnel possessions while in bed or resting. For two residents alternative bedside lockers have been sourced and ordered. These lockers will allow for residents to have access to their belongings while resting or while in bed. These lockers are to be delivered by the 29/09/2023

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: 1. A review of dining space in the Sheemore Unit has taken place and a meal time audit completed. This identified that the maximum number of residents that can be accommodated is six at any one setting. Following this review alternative approaches to meal times are currently being trialed within the centre. These include: • A combined approach to meal times with the adjacent Dr Mc Garry Unit. This combined meal time experience will allow residents to socially engage with other residents from a different unit within the designated centre during meal times. • Two meal time settings will be trailed for residents accommodated in the Sheemore Unit. This will allow residents to attend the dining room as they wish for meals. • The current activity room in the Sheemore Unit will be trialed as the dining room as this is a larger room then the current dining room. This will allow more residents to dine in a comfortable setting. If this is the preferred option by residents the current dining room will be re purposed as the activity room 2. A full review of the outside space on the Dr Mc Garry unit has taken place. This review identified the need for an external shade provisions for residents on hot days. Parasols have been purchased and are in place for resident usage. 3. A review of the internal courtyard has taken place and a redesign of this area has been completed and works have commenced. It is planned that works will be completed by the 30/09/2023. This area will have outdoor seating and tables for residents 4. Decluttering and deep cleaning of all storage areas has been completed. All items stored in store rooms are now stored on shelves and no items are stored on the floor. An additional storage area has been sourced to ensure appropriate segregation of items and safe storage. The practice of storing linen collection trolleys in communal bathrooms has ceased which will reduce the risk of infection transmission. 5. Grab rails have now been fitted in the en suite toilet and in the communal shower area 6. The Person in Charge and the Provider have requested maintenance to replace the flooring in the visitor's toilets and in the sitting room in the dementia unit as to support effective floor cleaning. This will be completed by the 29/09/2023. A review of décor in the centre has been completed and painting has commenced and is due to be completed by the 29/09/2023 7. A nurse call bell system has been fitted in the single bedroom in the Sheemore unit.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control:	

To ensure compliance with Regulation 27: Infection control the following processes have been put in place:

1. The Person in Charge has purchased a new wardrobe for the single room in the Sheemore Unit

2. A review of the hairdressing room has taken place. This process involved a decluttering of the room and all items not in use have been disposed of. All items which require storage and now stored on shelves within the room. A review of the furniture has taken place and all furniture is now Infection Control compliant.

3. A review of the area under the stairs in the Sheemore Unit has taken place. This area has been included on the units cleaning schedule as to ensure good Infection control processes. The wall under the stairs has been cleaned and is included in the centres painting programme which has commenced within the centre. This is to be completed by the 29/09/2023. Items which were previously stored under the stairs have now been located to an alternative storage point

4. A review of the laundry and the cleaner's room has taken place. This review resulted in the decluttering of both rooms. Items stored on the floor are now stored on shelving which allows for effective floor cleaning. Both rooms have been added to the units Infection Control Audit schedule which takes place monthly within the designated centre. All audit finding will be addressed by the Person in Charge and a quality improved plan developed with corrective actions completed within a required time frame

5. A review of the designated centres waste storage has taken place. A waste compound section has now been identified at the back of the building and will store all waste bins. The designated centre is currently reviewing the collection of waste materials within the centre and the disposal of waste to the waste compound

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To ensure compliance with Regulation 28 Fire Precautions the following process have been out in place:

1. The Provider and the Person in Charge contacted the external agency whom completes the servicing on the day of inspection requesting an urgent service of the fire extinguishers in the laundry area. These extinguishers were omitted in error from the regular services completed by the external company on behalf of the HSE. All fire extinguishers have now been serviced in line with the manufactures recommendations. This has been completed as of the 21/06/2023

2. All fire risks as identified on the fire risk assessment have now been completed within

the designated centre. Superficial repairs to a number of fire doors within the centre has been identified. An external company as requested by the HSE will repair the works to these doors. Works will be completed by the 27/10/2023

3. The provider in consultation with the regional fire officer has requested an external company to connect the fire door at the entrance to the occupational health corridor to the fire alarm. This is to be completed by the 31/08/2023. In the interim, this door is to remain closed at all time. This is communicated to staff at the weekly governance meetings and signage has been place on same as a measure to remind staff to keep the door closed

4. A review of the weekly fire checks has been completed within the centre. A responsible identified person has been nominated to complete the fire checks in line with the HSE Fire Risk Assessment. This process will be monitored by the Person in Charge which will ensure effective governance and oversite

5. A review of the link corridor on the Dr McGarry unit was completed. This review resulted in the waste bin and trolley being relocated to another location. During meal times the food trolley has been relocated to another area within the unit. This ensures that the fire safety route is not restricted

6. Fire Safety and Fire Safety compliance will continue to be a standing agenda for the provider and the Person in Charges governance meeting. All issues in relation to Fire Precautions will be reviewed and discussed. Any issues in relation to fire safety will be actioned locally or escalated to the fire risk department for auctioning within a time bound time frame

7. The Person in Charge has a process in place where staff on each unit reviews fire exits three times daily. All staff are notified at the safety pause of the importance of ensuring that all fire exits are kept clear at all times. The Person in Charge and the Assistant Director of Nursing will continue to do safety walk around which will ensure that no fire exits are blocked

8. A Fire blanket and freestanding receptacles for safe disposal of used cigarettes in the smoking areas on the Sheemore and Dr McGarry units are ordered. This will be in place by the 31/08/2023

9. Fire upgrade works will be completed in the non-designated centre adjacent to the designated centre by the 31/05/2024. These works will be completed in three phases. These works will ensure that all areas within St Patrick’s Community Hospital is Fire compliant.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The Provider and the Person in Charge has completed a review of the reception area. As identified on the day of inspection a receptionist is employed daily until 17.00 hrs. For times when the reception area does not have any personnel a secure visiting process is being implemented. The Provider and the Person in Charge has met with a company whom provides intercom systems. This process will allow for visitors etc to notify the unit of their request to visit. This process will reduce the risk of unrestricted access to the centre by members of the public. This system is to be installed on the 18th and 19th of October 2023

2. A review of the outdoor courtyard in the Sheemore unit has taken place. A monitored secured locked system has been put in place which allows staff to be notified when members of the public are accessing the garden. This ensures that residents are safeguarded at all times.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
o ensure compliance with Regulation 9 Residents Rights the following process have been put in place:

1. A review of dining space in the Sheemore Unit has taken place and a meal time audit completed. This identified that the maximum number of residents that can be accommodated is six at any one setting. Following this review alternative approaches to meal times are currently being trialed. These include:
• A combined approach to meal times with the adjacent Dr Mc Garry Unit. This combined meal time experience will allow resident to socially engage with other residents from a different unit within the designated centre during meal times.
• Two meal times settings will be trailed for residents accommodated in the Sheemore Unit. This will allow residents to attend the dining room as they wish for meals.
• The current activity room in the Sheemore Unit will be trialed as the dining room as this is a larger room then the current dining room. This will allow more residents to dine in a comfortable setting. If this is the preferred option by residents the current dining room will be repurposed as the activity room
2. A multidisciplinary meeting with one resident who expressed a wish to return to living in the community has taken place. The resident is currently waiting to view suitable placement in the community for the resident to live. Community support services will have to be approved and in place prior to the resident leaving the designated centre and residing in the community. The Person in Charge continues to work closely with the independent advocate and the national team involved in this initiate. This residents continues to be supported by staff to engage in social activities in the residents local

town as the resident wishes
3. A review of the social activity schedule has taken place within the centre in conjunction with the residents. This review has ensured that activities are meaningful for residents. The Person in Charge has also reviewed and implemented additional activities for those residents whom have a higher level of cognitive impairment. This now ensures that these residents have equal access to social activities.
4. A revised schedule of group activities which includes the Dr McGarry and Sheemore residents has been developed as well as one to one social activities

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(a)	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 a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	29/09/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	07/08/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	07/08/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre	Not Compliant	Orange	30/09/2023

	are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	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.	Not Compliant	Orange	30/09/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	02/08/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/05/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	02/08/2023

	place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	29/09/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/05/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/10/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire	Not Compliant	Orange	31/10/2023

	precautions.			
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	02/08/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	20/10/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/09/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	10/09/2023