

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Patrick's Hospital
Centre ID:	OSV-0000589
Centre address:	Cahir Road, Cashel, Tipperary.
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Bridget Farrell
Lead inspector:	Louisa Power
Support inspector(s):	Liam Strahan;
Type of inspection	Announced
Number of residents on the date of inspection:	124
Number of vacancies on the date of inspection:	21

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
19 May 2015 09:10	19 May 2015 19:30
20 May 2015 07:30	20 May 2015 18:30
21 May 2015 08:30	21 May 2015 13:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

The inspection was an announced renewal of registration inspection, took place over three days and was the seventh inspection of the centre by the Authority. As part of the inspection process, inspectors met with the provider nominee, assistant director of nursing, residents, relatives, visitors and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures, risk management documentation and staff records. The documentation submitted by the providers as part of the application process was submitted in a timely and precise manner and was also reviewed prior to the inspection including questionnaires completed by residents and relatives; the feedback was positive and is referenced in the body of the report.

St. Patrick's Hospital, Cashel comprises a total of six units over two sites. Five of the units (rehabilitation centre, St Benedict's, St Clare's, St Michael's, St Anthony's and St Anne's/Bernadette's units) are located on the main campus in the outskirts of Cashel town. St Anthony's Unit is located on a separate site in Clonmel, approximately 14 miles from Cashel. Residential, respite and rehabilitation accommodation is provided on the main campus in Cashel; respite and residential accommodation is provided in Clonmel.

The premises continued to provide significant challenges to the provision of person-centred care that respected the privacy, dignity and independence of residents. Inspectors observed that staff endeavoured, despite the issues posed by the premises, to ensure that residents' medical and nursing needs were met to a good standard. Residents looked well and cared for, engaged readily with inspectors and provided positive feedback on the staff, care and services provided. Inspectors found evidence of good practice in a range of areas. Staff interacted with residents in a respectful, warm and friendly manner and demonstrated a thorough knowledge of residents' needs, likes, dislikes and preferences.

Prior to the inspection, a meeting was held attended by the provider nominee, person in charge and relevant parties employed by provider. A plan to address the considerable premises issues was discussed. However, the Authority was not satisfied that some of the plans outlined would meet the needs of residents who require long term care.

A number of additional improvements were identified to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The required improvements are set out in detail in the action plan at the end of this report and include:

- statement of purpose
- contract
- residents' guide
- review of documentation relating to residents' finances, medication management and complaints
- emergency plan
- smoking arrangements
- care planning processes
- procedures for consultation with residents
- activity provision
- review of staffing levels.

An action plan was submitted by the provider in response to this report. The Authority did not agree this action plan with the provider in relation to the significant premises issues despite affording the provider two attempts to submit a satisfactory response.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for residents. The statement of purpose detailed all items listed in Schedule 1 of the Regulations. However, the statement of purpose required review as it mentioned Regulations which have been revoked. An updated statement of purpose was submitted to the Authority following the inspection.

Inspectors noted that the statement of purpose was made available for residents, visitors and staff to read. The statement of purpose had been reviewed in October 2014.

Inspectors observed that the ethos of care as described in the centre's statement of purpose was actively promoted by staff.

Judgment:

Substantially Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was evidence of a clearly defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. Inspectors observed a good and supportive working relationship between the person in charge and the provider nominee. Inspectors were satisfied that the management system in place ensured that service provided was safe, appropriate, consistent and effectively monitored.

The unit manager in St Anthony's Unit confirmed that the provider nominee attended the centre for monthly management meetings and the person in charge was available via telephone or in person on a daily basis. Minutes of the monthly management meetings were made available to inspectors. The provider nominee, unit manager, person in charge and medical officer were among the attendees. Items discussed included human resources, recruitment, maintenance and training.

Staff with whom inspectors spoke were clear about the management structure and the reporting mechanisms both within the unit and the centre.

There was a system in place to review and monitor the quality and safety of care and the quality of life for residents. Audits were made available to inspectors from 2014 and 2015. The audits formed the basis for the annual review of the quality and safety of care delivered to residents. Audits were completed in pertinent areas such as care planning, food safety, hygiene, medication management and sharps disposal. The audits identified areas for improvement and proposed actions. An annual satisfaction survey was completed by residents and relatives. Improvements were brought about as a result of learning from audits and surveys such as an enhanced advocacy programme and improved documentation. Results were made available to residents and their representatives.

Judgment:

Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A residents' guide was available which included details of the services and facilities provided, procedure respecting complaints and the arrangements for visits. The residents guide, however, was not in an accessible format and much of the information

included was not pertinent.

Inspectors reviewed a sample of residents' contracts of care and noted that contracts were signed and dated by the resident or their representative at the time of admission. The contract set out the overall basic fee for the provision of care and services. However, the contracts did not clearly set out the services to be provided. Consequently it was unclear as to what services were included in the basic fee and what services incurred an additional charge. There was also a statement that any additional charges would be in accordance with the schedule of fees; however there was no schedule of fees attached to the contracts examined.

Judgment:

Substantially Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The designated centre was managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of service.

The person in charge was absent during the inspection and the Authority had been informed of the planned absence in advance. The person in charge has worked in the designated centre as a nurse since 1991 and as director of nursing since 2007. She has demonstrated her ability as a suitable person in charge throughout all previous inspections and inspectors saw evidence that demonstrated her ongoing suitability through review of documentation and discussion with staff, residents and relatives.

The person in charge was employed full time and was a nurse with more than three years experience in the area of nursing of the older person within the previous six years. The roster reflected that the person in charge also works twilight shifts and weekends.

The person in charge demonstrated her commitment to her own professional development and education. The training matrix confirmed that all mandatory training was up to date. The person in charge had completed a post graduate diploma in holistic psychotherapy and counselling. The person in charge has attained a post-graduate diploma in gerontology nursing and completed a certificate in management.

The person in charge reported to be visible, accessible and effective by staff, residents and relatives. Staff with whom inspectors spoke reported that the person in charge was

approachable and supportive.

The person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis.

Judgment:

Compliant

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The records listed in Schedules 2, 3 and 4 of the Regulations were maintained in the centre. All of the key policies as listed in Schedule 5 of the Regulations were in place. Staff with whom inspectors spoke demonstrated adequate knowledge of these policies and inspectors saw that policies were made available to staff on each unit. The policies listed in Schedule 5 were all seen to be within their review dates. Inspectors saw that many of the policies were implemented by staff. However, as outlined in outcome 9, the reason for not administering medicines was not always recorded in line with the centre's medication management policy.

Records were stored securely and were kept for the required period of time. Residents' records were kept in a secure place. Inspectors found that there was a system in place for maintaining files and records which was organised and accessible.

Inspectors reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

There was a residents' directory which was up to date, and contained all matters referred to in article 19. Entries to the nursing records were maintained in line with relevant professional guidelines. Daily records were completed.

Residents' records as outlined in Schedule 3 were available in the centre. Records listed in Schedule 4 to be kept in a designated centre were all made available to inspectors.

Records relating to inspections by other authorities were maintained in the centre including documentation relating to food safety and fire safety.

The centre was adequately secured against accident or injury and insurance cover complied with the all the requirements of the Regulations.

Judgment:

Substantially Compliant

***Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There had been no periods where the person in charge was absent from the centre for 28 days or more since the last inspection and there had been no change to the person in charge. The provider was aware of the obligation to inform the Chief Inspector if there is any proposed absence of the person in charge and the arrangements to cover for the absence.

The person in charge was absent during the inspection and the Authority had been informed appropriately. Inspectors were satisfied that there were suitable arrangements made for the management of the centre the absence of the person in charge. The assistant director of nursing was identified as the person to act as the person in charge in her absence. The assistant director of nursing demonstrated good, sound clinical knowledge and that she had a good understanding of her responsibilities when deputising for the person in charge throughout the inspection.

Judgment:

Compliant

***Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that systems were in place to protect residents from being harmed or suffering abuse. There were processes in place to provide residents with support that promoted a positive approach to behaviour that challenges. A restraint-free environment was promoted. However, some improvements were required in relation to the implementation of positive behaviour support plans and documentation to guide the use of chemical restraint.

The provider, assistant director of nursing and all the staff spoken with confirmed that there had been no incidents of alleged, suspected or reported abuse in the centre since the previous inspection.

There were organisational policies in place in relation to the protection of vulnerable adults and response to allegations of abuse, which had all been reviewed since the last inspection. The policies were comprehensive and contained sufficient detail to effectively guide staff. However, the policies required review to incorporate the 'Safeguarding Vulnerable Adults from Abuse' national policy and procedures.

Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Staff with whom inspectors spoke were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Residents with whom inspectors spoke confirmed that they felt safe in the centre and that they knew who to talk to if they needed to report any concerns of abuse.

Inspectors reviewed the processes around safeguarding of residents finances. There were systems in place both for centrally held funds and funds held in units for residents. However, the systems required reviewed to ensure that a robust and clear system was in place. This would ensure that complete and accurate records of funds were maintained.

A centre-specific policy in relation to the management of behaviour that is challenging was made available to the inspectors and had been reviewed in August 2014. The policy was comprehensive and evidence based. Records confirmed that training was provided to relevant staff in the response and management of behaviour that is challenging.

Care plans outlined clear strategies to guide staff in the proactive and reactive management of behaviour that challenges. Strategies demonstrated a positive approach to behaviour that challenges including the use of distraction techniques. Detailed psychiatric assessment had been completed. Multi-disciplinary input was sought when appropriate. Inspectors observed that staff implemented some of the strategies outlined such as distraction and diversional therapy. However, inspectors noted that other strategies were not always implemented such as the development of life stories and identification of previous hobbies and interests.

A policy in relation to restraint was made available to inspectors and had been reviewed in August 2014. The policy was comprehensive, evidence based and promoted a restraint-free environment. Inspectors observed a significant reduction in the use of bedrails. Where bedrails and lapbelts were in use, their use followed an appropriate assessment and consideration of all alternative measures. Inspectors noted that signed consent from residents was secured where possible and the use of bedrails was discussed with residents' representatives as appropriate. Multi-disciplinary input was sought when planning the use of restrictive procedures. The policy suitably detailed the ongoing monitoring and observation of a resident while a bedrail was in place and this was evidenced in practice. A risk-balance tool was completed for residents prior to the use of a bedrail.

Inspectors observed that chemical restraint was administered infrequently. However, inspectors noted that care plans had been developed or completed following the prescribing of 'as required' medication to ensure that the medication is administered in accordance with "Towards a Restraint Free Environment in Nursing Homes", a policy document published by the Department of Health.

Judgment:

Non Compliant - Moderate

***Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.***

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Overall there was evidence that the provider was committed to protecting and promoting the health and safety of residents, staff and visitors.

The health and safety policy and statement were made available to inspectors and had been last reviewed in 2014. These documents were augmented by a risk register which included a range of centre-specific risks, an assessment of each risk and the controls identified as necessary to reduce each risk. The risks identified specifically in the Regulations were included in the risk register. There was evidence that the risk assessments were regularly reviewed and updated.

A comprehensive emergency plan was in place, dated December 2014, which covered events such as adverse weather conditions, water shortages and electrical power outage. The emergency plan was not adequate as it would not guide staff in the event of the premises being uninhabitable. Additional policies were in place for responding to missing persons, accidental injuries, self harm and response to aggression or violence.

Inspectors reviewed a sample of incident forms and saw that accidents and incidents were identified and there were arrangements in place for investigating and learning from accidents. Clinical risk management meetings took place on a quarterly basis and were attended by the local clinical risk manager, person in charge and other relevant staff. Incidents that have occurred in the previous quarter are discussed at these meetings and minutes reviewed by inspectors indicated a proactive approach to learning from incidents and accidents.

Suitable fire equipment was observed to be provided throughout the centre. There was an adequate means of escape. Fire exits were unobstructed and clinical nurse managers reported that the exits are subject to a visual check daily, while records were maintained on a weekly basis. Inspectors reviewed these weekly records. Fire records were comprehensive, accurate and easily retrievable. There was a fire evacuation plan which included evacuation orders for each unit as well as picture-plans indicating routes of evacuation. The clear procedure for safe evacuation of residents and staff in event of fire was also displayed prominently in a number of areas throughout the centre.

The training matrix confirmed that fire training was up to date for all staff. Staff demonstrated good knowledge on the procedure to follow in event of a fire, describing both horizontal and full evacuation. Staff confirmed that even though drills occur on a regular basis, at least every six months, these drills do not constitute a full simulated evacuation of a resident.

A personal emergency evacuation plan (PEEP) was seen to have been developed for long stay residents but had not been developed for short stay residents. Where PEEPs were in place most took into account the number of staff required to evacuate the resident, the ideal means and route of evacuation and the location of the resident. In one instance, a PEEP was found to not have been updated in line with the resident's changing needs.

The fire alarm was serviced on a quarterly basis, most recently in March 2015. Fire safety equipment was serviced on an annual basis, most recently in October 2014. Emergency lighting had been serviced regularly, most recently in January 2015.

In many instances, the design and layout of the premises presented health and safety challenges for residents and this is outlined further in outcome 12. Access to high risk areas, such as the sluice, was seen to be unrestricted, due to unlocked doors.

Each unit had a designated smoking area. However, in two of the units these areas were in the open corridors rather than a separate smoking area and non-smoking residents informed inspectors that this arrangement was unsatisfactory. Only one of the smoking rooms had mechanical ventilation. While inspectors observed fire extinguishers and blankets in the smoking areas but there were no fire retardant aprons available to smokers. Residents who smoked were each individually assessed. Inspectors observed that residents who smoked were supervised by staff and staff stored cigarettes and lighters for residents to minimise the risk of fire. Some smoking areas did not contain a call bell or other means to raise the alarm. An action plan was submitted by the provider in response to this report. The Authority did not agree this action plan with the provider

in relation to the smoking areas on open corridors despite affording the provider two attempts to submit a satisfactory response.

As outlined in outcome 18, the training matrix confirmed that 97% of staff were trained in the moving and handling of residents. Staff demonstrated a good understanding of the use of the hoist and contemporary moving equipment. Safe moving and handling practices were observed. Residents had a personalised manual handling plan which was reviewed every four months or more frequently if a resident's condition changes. There was evidence of regular physiotherapist input into these assessments and care plans. Hand rails and grab rails were installed throughout the centre.

Inspectors observed that improvements were required to ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority, are implemented. Inspectors saw and staff confirmed that there were adequate supplies of personal protective equipment (PPE) available. Inspectors observed that there were hand hygiene facilities available to staff and visitors. However, in one instance, inspectors observed that hand hygiene equipment was not present in a high risk area. This was brought to the attention of the unit manager who remedied this immediately. Designated hand washing facilities were provided in the sluice rooms. Supplies of alginate bags were provided for contaminated linen. Training in infection prevention and control had been facilitated for staff in 2014/15.

There was a contract in place for the disposal of clinical waste and records were maintained of removal and transport.

Judgment:

Non Compliant - Major

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The centre-specific policy on medication management and administration was made available to inspectors which had been reviewed in March 2015. The policy was comprehensive and covered the ordering, receipt, storage, prescribing, administration, refusal and crushing of medicines. The policy was supplemented by additional policies relating to nurse prescribing, oxygen therapy and insulin storage. Records available which confirmed that staff had read and understood the policy. Staff with whom inspectors spoke demonstrated adequate knowledge of this document.

Medications were supplied by the pharmacy department in the local acute hospital for long stay residents. Medications were observed to be stored securely.

Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation. Medications requiring refrigeration were stored appropriately.

Medication management training was facilitated regularly and nursing staff demonstrated knowledge and understanding of professional guidance in medication management. Inspectors observed resources relating to medication management were available to staff on all units.

Staff reported and inspectors saw that it was not practice for staff to transcribe medication and no residents were self-administering medication at the time of inspection.

A sample of medication prescription sheets and administration records were examined. The medication prescription sheets examined were current. However, medication prescription sheets examined did not always contain a signature for each medication order. Therefore, these prescription orders are not complete authorisations to administer medications as per the Medicinal Products (Prescription and Control of Supply) Regulations (Amendment) 2007.

Medication administration sheets examined identified the medications on the prescription sheet, contained the signature of the nurse administering the medication and allowed space to record comments on withholding or refusing medications. The times of administration matched the prescription sheet. However, as outlined in outcome 5, the medication administration records were not always complete.

An inspector reviewed a sample of prescriptions where residents had difficulty swallowing tablets. Where medications were administered in a modified form such as crushing, this was not individually prescribed by the medical practitioner on the prescription chart.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors noted that a comprehensive record of all incidents was maintained. Notifications to the Authority were made in line with the requirements of the Regulations.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

There was evidence that timely access to health care services was facilitated for all residents. A medical officer was appointed for the centre and inspectors saw timely referrals were made. A consultant geriatrician completed a weekly round on the rehabilitation unit. An "out of hours" GP service was also available if required. In line with their needs, residents had ongoing access to allied healthcare professionals including dental, psychiatry of old age, occupational therapy, speech and language, chiropody, physiotherapy and dietetics. The records confirmed that the care delivered encouraged the prevention and early detection of ill health through regular blood profiling, quarterly medication review and annual administration of the influenza vaccine. Residents were enabled to make healthy living choices such as smoking cessation and healthy eating.

An inspector reviewed a selection of care plans. There was evidence of a pre-assessment undertaken prior to admission for residents. After admission, there was a documented assessment of all activities of daily living, including communication, breathing, eating and drinking, elimination, personal care, mobility, spirituality and dying. There was evidence of a range of evidence based assessment tools being used and ongoing monitoring of falls risk and nutritional need. A care plan was developed for each resident which detailed their needs and choices. Each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances and was reviewed no less frequently than at four-monthly intervals, in consultation with residents or their representatives.

However, a number of issues were identified in relation to the development, review and implementation of care plans:

- care plans were not always implemented
- a number of care plans reviewed contained generic information and were not sufficiently personalised
- care plans were not always developed to meet the assessed needs of residents
- the nature and extent of care plan review was inconsistent.

Wound management was in line with national best practice. Wound management charts were used to describe the cleansing routine, emollients, dressings used and frequency of dressings. The dimensions of the wound were documented and used to evaluate the wound on an ongoing basis.

There was a strategy in place to prevent falls whilst also promoting residents' independence. An evidence-based assessment tool was used to assess residents' risk of falls every four months. Care plans were developed which outlined interventions to reduce falls such as ultra low beds and sensor mats. Inspectors noted that the interventions outlined had been implemented. There was an accessible and timely physiotherapy service available to residents.

The inspector noted that comprehensive information was provided on transfer to and from hospital. A resident's right to refuse treatment, e.g. medicines or transfer to hospital, was respected and documented.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The premises did not meet the collective and individual needs of residents. The design and layout posed significant challenges in the provision of person-centred care that promoted the privacy, dignity and independence of residents.

St Patrick's Hospital was originally built as a workhouse in the 1800's, was architecturally typical of buildings of this era and built with this purpose in mind. The buildings were

large imposing stone structures, constructed in regular formation; some were stand alone while some were interlinked on what was originally a self-sufficient campus. Despite the age and origins of the buildings, inspectors found that the premises and external grounds were visibly clean, well maintained, adequately heated, lighted and ventilated and generally in good decorative order. A lift was provided in a unit that accommodated residents on two floors.

The design and layout of the units is not suited to meeting the individual or collective needs of residents in terms of their privacy, dignity, independence and space provided. Four single bedrooms were provided, three of which were ensuite. There were three twin bedrooms, none of which were ensuite. Only two of the single bedrooms provided a minimum of 9.3m² of usable floor space. The twin bedrooms provided a minimum of 7.4m² per resident as required under the National Quality Standards for Residential Care Settings for Older People in Ireland. The rest of the bedrooms provided accommodation for three to seven residents. The size and ward-type layout of these bedrooms did not provide adequate space for residents at their bedside for provision of care, private activities, personal storage and the use of assistive equipment.

On St Clare's unit, inspectors saw that two multi-occupancy rooms continued to act as corridors/thoroughfares thereby impacting on and limiting the privacy that could be afforded to both residents and staff while delivering personal care. Only two of the four bedrooms on this unit are not routes into other bedrooms, communal areas, toilets, bathrooms etc. Inspectors saw that staff sought to deliver discreet personal care while other dependent residents and their visitors were also present in the room.

The design and layout of this unit is further impacted on by the requirement to negotiate three ramps internally; records reviewed indicated and staff spoken with confirmed that risks had been identified in relation to the use of the ramps due to the inadequate space to safely move residents and to safely use equipment such as hoists. The ramps impacted significantly on residents' ability to move freely around the unit, particularly at night. This was also identified by residents who completed questionnaires.

Sanitary and toilet facilities in many units were insufficient or inadequate to meet the needs of the residents having regard to their dependencies. Many bathrooms, shower facilities and toilets were not easily accessible or located conveniently to bedrooms and communal areas.

Storage for equipment was limited throughout and inspectors saw equipment stored in sanitary facilities, smoking areas and corridors.

Call bells were not installed in a number of rooms used by residents, including sanitary facilities and a smoking area.

Communal space was provided for residents on each unit. However, inspectors saw that this space was inadequate. On one unit, a dining space was not available to residents at times as it was also used as an area for staff to take breaks. Two of the units only had one communal area used for both recreation and dining. One of these units was St Clare's unit which also had limited personal space for residents.

There was ample and attractive outdoor space on the grounds for residents that contained a number of safe pathways and seating opportunities.

An action plan was submitted by the provider in response to this report. The Authority did not agree this action plan with the provider in relation to the significant premises issues despite affording the provider two attempts to submit a satisfactory response.

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The complaints of residents, their representatives or advocates were listened to and acted upon. There was an effective appeals process. However, improvements were required in relation to documentation, auditing and learning from complaints to ensure consistent management of complaints.

There was a centre-specific and comprehensive complaints policy, last reviewed in June 2013. The complaints policy identified the nominated a complaints officer and also included an independent appeals process. A summary of the complaints procedure was displayed prominently throughout and was included in the statement of purpose. Residents were given a copy of the complaints procedure on admission, within the resident's guide. An audit was undertaken to monitor complaints, however inspectors noted that it was insufficient to trend complaints in a meaningful way.

The complaints log recording complaints and actions undertaken to resolve the complaints was reviewed. However, inspectors found that the recording of complaints was not consistent in relation to:

- the name of the person receiving the complaint
- the name of the complainant
- the satisfaction of a complainant with the outcome.

The majority of responses to complaints were seen to be through, comprehensive and prompt. However, inspectors saw that the response to some minor complaints was not appropriate. For example, a resident was informed of the arrangements for heating the centre instead of being offered an extra blanket or layer or clothing.

While there was an audit of complaints, the audit only considered complaints that were

escalated. It did not review complaints resolved at ward levels and so was unable to trend, and set learning outcomes, for all complaints

Residents and relatives with whom the inspectors spoke were able to identify who they would make a complaint to, stated that any complaints they may have had were dealt with promptly and were satisfied with the complaints procedure.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The centre-specific policy on end of life care was made available to inspectors and was reviewed in March 2015. This policy was augmented by a number of other centre-specific policies which covered areas such as the use of a syringe driver and an automated defibrillator device (AED). Inspectors noted that these policies were comprehensive and evidence based.

Inspectors reviewed a selection of care plans of deceased residents and noted that residents had received appropriate care and their physical, emotional, social, physiological and spiritual needs had been met. Inspectors observed that there was timely recognition when a resident was approaching end of life and adequate care plans and supports were put in place to meet residents' needs. An inspector spoke with a volunteer whose spouse had received end of life care in the centre. The volunteer told the inspector that their spouse had received a high standard of care and that she was volunteering to 'give something back'.

As previously outlined, the premises posed a number of challenges to the delivery of care, particularly at end of life. The lack of private space, especially where bedrooms act as corridors/throughfares, impedes the delivery of care that respects the privacy, dignity and autonomy of residents.

Religious and cultural practices were facilitated. Members of the local clergy visited residents on a regular basis. Staff confirmed that ministers from a range of religious denominations were facilitated to visit. Access to specialist palliative care services was available on a 24 hour basis from South Tipperary hospice home care team.

Arrangements were in place for capturing residents' end of life preferences but

improvements were required. Discussions regarding end of life care with residents and representatives were documented and captured residents' wishes on spirituality, religious practices at end of life and funeral arrangements. However, these discussions did not identify a preferred place of death. Designated single bedrooms were now available on two units and were offered when residents approach end of life. These bedrooms were ensuite and provided adequate accommodation for family and friends. The centre-specific policy stated and staff confirmed that, if possible, the option to go home for end of life care was facilitated.

Family and friends were suitably informed and facilitated to be with the resident at end of life. Family members who chose to remain overnight were made comfortable. Tea/coffee, snacks and meals were provided and available at all times.

Inspectors confirmed that any decisions not to attempt resuscitation were seen to be based on clear clinical rationale and discussions and decisions were clearly recorded and reviewed as appropriate

Inspectors noted that practices after death respected the remains of the deceased person and family members were consulted for removal of remains and funeral arrangements. Staff with whom inspectors spoke confirmed that staff members and residents were all informed and support was given when appropriate. Deceased residents were remembered at residents' meetings and at the annual celebration of life, light and hope.

The end of life policy stated that personal possessions were returned in a sensitive manner and staff with whom inspectors spoke demonstrated an empathetic understanding of the needs of resident and family at end of life.

Judgment:

Substantially Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

There were centre-specific policies in place in relation to meeting the nutritional and hydration needs of residents. These policies had been reviewed in the previous three years, were comprehensive and evidence based.

Meals for residents were prepared in an external kitchen and delivered to each unit on a heated trolley. The food served was sufficient in quantity, nutritious and wholesome. Residents with whom inspectors spoke and who completed questionnaires confirmed that the meals were of a high standard.

There was a clear, documented system between nursing and kitchen staff regarding residents' meal choices and preferences. There was evidence that choice was available to residents for breakfast, lunch and evening tea with respect to menu options and dining location. The menu for the day was displayed in the various locations throughout and inspectors observed staff informing residents of meal choices. As outlined in outcome 12, dining space was not always available to residents.

Breakfast was served to residents between the hours of 08:30 hrs to 09:30 hrs. Residents had a choice for breakfast; hot/cold cereals, breads, toast and beverages. Dinner/lunch was served at 12:30 hrs and inspectors observed the meal to be an unhurried and social occasion. The evening meal was served at 16:45 hrs with a further supper at 19:30 hrs. Staff demonstrated awareness of residents' preferences and inspectors observed a choice of snacks being made available. A fruit bowl was observed on many units and was stocked with a variety of fruit. Night staff had access to the kitchenette to make hot drinks and a light snack for residents. Inspectors noted ample supplies of food on the units including milk, cheese, eggs, yoghurt, bread, cereals, cold meat salads and ice-cream.

Inspectors saw that residents were provided with a range of hot and cold drinks; fresh water was available at all times from water dispensers or jugs in communal areas.

Residents were encouraged to remain independent and assistance was offered in a discreet and respectful manner. Gentle encouragement was given to residents who were reluctant to eat.

It was observed that every effort was made to present modified diets in an attractive manner. Staff with whom inspectors spoke demonstrated adequate knowledge of residents' needs in relation to diet and fluids of modified consistency and this was evidenced in practice.

Inspectors noted that, where a resident received enteral nutrition, there was evidence of regular input by the dietician. Care plans reviewed demonstrated the management of the tube site, enteral tube and the associated complications were in line with best practice.

Residents' weights were monitored on a monthly basis and the Malnutrition Universal Screening Tool (MUST) was also utilised in practice. Appropriate action was taken following assessment including the implementation of food charts and referral to the dietician.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Even though staff endeavoured to protect residents's rights and dignity, the premises posed significant challenges. There was evidence of consultation with residents but improvements were required to ensure that the process was effective.

A residents' forum was facilitated both in the main premises and in St. Anthony's Unit. Minutes from most recent meetings were made available to inspectors. Feedback sought during this meeting informed practice and suggestions, e.g. activities and new menu options, were seen to be implemented. Inspectors spoke with a resident who attended the forum in the main premises and he reported that the forum was not as effective as it once was. Inspectors saw that, given the size of the centre, the proportion of residents who sat on the forum was limited.

The assistant director of nursing reported that the annual resident/representative satisfaction survey was in progress. Areas examined included contact with visitors, care team, privacy, complaints, choices, interaction with staff, physical environment, cleanliness, activities and meals. Results of 2013/14 survey were reviewed and inspectors saw that there was a high level of satisfaction with the care and support provided. Feedback had led to changes, e.g. in advocacy arrangements.

Advocacy arrangements had been reviewed and there was a newly appointed advocate for each unit. The assistant director of nursing outlined that the advocates would attend the units on a regular basis to meet and interact with residents.

The assistant director of nursing outlined how she and the person in charge ensured that the centre was run in a way that maximises residents' capacity to exercise personal autonomy and choice. Residents were given choice in relation to rising and retiring times, meals and appearance. Residents reported that they enjoying going out to play cards, to visit family or for meals with family and friends. However, the design and layout of the premises reduced residents' ability to exercise personal choice, especially in relation to personal care and space.

Inspectors observed that staff endeavoured to ensure that routines and practices maximised residents' independence. Residents were encouraged to independently attend

Mass in the oratory where appropriate. Residents' independence was promoted during mealtimes and activities. However, the premises and facilities impacted negatively on residents' independence. Residents were unable to independently access some of the centre, including sanitary facilities, due to the presence of ramps.

Staff and residents reported that there were no restrictions on visitors and inspectors observed a high level of visitor activity throughout the inspection. There were limited opportunities on many of the units for residents to receive their visitors in private.

Inspectors observed televisions and radios in the communal areas. Residents also had access to televisions in their bedrooms and newspapers were delivered every day. Residents' personal communications were respected and residents had access to a private telephone. The centre was part of the local community. Many residents enjoyed reading the local newspaper and newsletters from local parishes were observed to be made available in communal areas.

Residents are facilitated to exercise their civil, political and religious rights. Residents were conversant in current affairs and reported being afforded the opportunity to vote in the recent referendum. Mass was celebrated in the centre on a daily basis in the oratory. The person in charge confirmed that ministers from a range of religious denominations were facilitated to visit.

Staff with whom inspectors spoke confirmed that they made every effort to provide care in a dignified way that respected residents' privacy. Staff reported that screening curtains were used to protect and respect residents' privacy as much as possible. However, as previously outlined, the multi-occupancy bedrooms and the location of some bedrooms as corridors/thoroughfares impacted on and limiting the privacy that could be afforded to both residents and staff while delivering personal care.

Staff with whom inspectors spoke were aware of the different communication needs of the residents. Individual communication requirements were highlighted in care plans and reflected in practice.

Inspectors observed that activities were provided on each unit including bingo, live music, arts and crafts. The activities schedule was prominently displayed on each unit. Artwork by residents was displayed throughout St. Anthony's Unit and residents on this unit enjoyed a varied range of activities. However, on other units, activities took place in the afternoons only, were limited in choice and residents were not informed of activities in other units that they may wish to attend. Residents indicated, through questionnaires and discussion with inspections, that they would like more activities, such as movie nights, question time, baking and music.

Judgment:

Non Compliant - Major

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a centre-specific policy on residents' personal property and possessions which had been reviewed in 2015.

Residents' clothing was labelled to ensure that residents' own clothing was returned to them after laundering. Residents reported that their laundry was almost always returned to them. If laundry was not returned, residents reported that staff had ensured that the missing item was found and returned as soon as possible.

Residents with whom the inspector spoke confirmed that they could retain control over their personal possessions and clothing. However, inadequate personal storage was provided for residents' personal possessions and the residents' guide outlines that there were restrictions in space for personal clothing.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

There was a planned roster in place. Based on observations, a review of the roster and

incident forms, resident/representative feedback, a review of staffing was required, especially from 17:30 to 20:00, to ensure that staff numbers and skill-mix were appropriate to meeting the assessed needs of the complement of residents accommodated on each unit.

There was a registered nurse on duty at all times on each unit and a record is maintained of current registration details of nursing staff. Staff were observed to competently deliver care and support to residents that reflects contemporary evidence based practice.

A sample of staff files was reviewed and contained all of the required elements. Inspectors saw that there was a selection of healthcare reading materials and reference books stored in the each nurses' station. Inspectors noted that copies of both the Regulations and the Authority's Standards were available. Training had been provided and staff were able to articulate adequate knowledge and understanding of the Regulations and the Authority's Standards.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies; the programme reflected the needs of residents. All staff employed had attended mandatory fire and elder abuse training. Further education and training completed by staff included dementia, positive behaviour support, medicines management, infection control. However, gaps were identified in the training matrix in relation to manual handling training.

Inspectors noted that regular staff and nurse manager meetings took place. Topics discussed include training, complaints/compliments, staff induction, maintenance, equipment, health and safety, human resources and recruitment. Staff were supervised appropriate to their role and a formal system of annual appraisal had been implemented. However, inspectors saw that appraisals were inconsistent. Some records did not identify improvements to practice or accountability.

Staff confirmed that the person in charge was approachable, supportive and had retained a strong clinical role. Based on a review of the roster, the person in charge worked a number of twilight and weekend shifts to ensure supervision of all staff.

A centre-specific policy on recruitment, selection and vetting of staff was made available to inspectors. It was noted that effective recruitment procedures were in place including the verification of references.

Inspectors saw evidence that confirmation was obtained for agency staff that registration, mandatory training, vetting and references had been obtained.

Volunteers had undergone the required vetting procedures and were supervised appropriate to their role and level of involvement in the centre.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Louisa Power
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St Patrick's Hospital
Centre ID:	OSV-0000589
Date of inspection:	19/05/2015
Date of response:	28/07/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The residents' guide was not in an accessible format.

Action Required:

Under Regulation 20(1) you are required to: Prepare and make available to residents a guide in respect of the designated centre.

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

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

The resident's guide has been reviewed and updated in conjunction with the Advocates.

Proposed Timescale: 30/07/2015

Theme:

Governance, Leadership and Management

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

The schedule of additional charges was not attached to the contracts examined.

Action Required:

Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

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

The Contract of Care has been amended to itemise the services that the patient must pay for directly themselves.

Proposed Timescale: 09/07/2015

Theme:

Governance, Leadership and Management

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

The contract did not clearly outline all the services to be provided.

Action Required:

Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

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

The Contract of Care has been amended to include details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise.

Proposed Timescale: 09/07/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The centre's medication management policy was not always implemented.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

Further Medication Management training scheduled and given with specific reference to the correct procedures to be followed in relation to medications not administered.

Proposed Timescale: 09/07/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Strategies outlined in positive behaviour support plans were not always implemented.

Care plans were not always developed to guide staff in the use of chemical restraint in line with national policy.

Action Required:

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

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

Training in care planning to include care planning for behaviours that are challenging scheduled and given.

Training in medication management with special emphasis on PRN psychotropic medicines scheduled and given.

Proposed Timescale: 30/07/2015

Theme:

Safe care and support

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

The policies in relation to the protection of vulnerable adults and response to allegations of abuse required review to incorporate the 'Safeguarding Vulnerable Adults from Abuse' national policy and procedures.

Financial systems required reviewed to ensure that a robust and clear system was in

place to ensure that complete and accurate records of funds were maintained and that staff could easily reconcile residents' finances.

Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

St. Patrick's policy in relation to the Protection of Vulnerable Adults will be reviewed in line with the "Safeguarding of Vulnerable Persons of Risk of Abuse National policies and procedures". Training on the policy will be rolled out as training is disseminated nationally (to commence with designated teams in August)

Policy re the Protection of Vulnerable Adults: October 2015

Proposed Timescale: 09/07/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The emergency plan was not adequate as it would not guide staff in the event of a premises being uninhabitable.

Action Required:

Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

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

Emergency plan has been amended to include total evacuation of the building.

Proposed Timescale: 09/07/2015

Theme:

Safe care and support

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

Access to high risk areas, such as the sluice, was seen to be unrestricted, due to unlocked doors.

Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

All areas have been reviewed to ensure that appropriate security systems are fitted to all high risk areas in line with risk management policy.

Proposed Timescale: 30/07/2015

Theme:

Safe care and support

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

Personal evacuation plans had not been developed for short stay residents.

Personal evacuation plans had not been updated in line with a resident's changing needs.

Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

Personal evacuation plans are now in place for short term residents.

Personal evacuation plans have now been updated in line with the residents' changing needs.

Proposed Timescale: 09/07/2015

Theme:

Safe care and support

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

Smoking areas were provided in open corridors.

Smoking aprons were not available in all smoking areas.

A means to raise the alarm was not provided in all smoking areas.

Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Furnishings that were not fire-resistant have been removed. Fire fighting equipment is now located adjacent to all smoking rooms.

All residents who smoke in open corridors will continue to be risk assessed to ensure that all risks associated with smoking are reduced to a minimum.

The Authority did not agree this action plan with the provider in relation to smoking on open corridors despite affording the provider two attempts to submit a satisfactory response.

Proposed Timescale: 09/07/2015

Outcome 09: Medication Management

Theme:

Safe care and support

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

Medication prescription sheets examined did not always contain a signature for each medication order.

Where medications were administered in a modified form such as crushing, this was not individually prescribed by the medical practitioner on the prescription chart.

Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

Medication management training scheduled and given. Discussion with medical officers has taken place to advice of the hospital policy in relation to documentation of prescribed medication.

Proposed Timescale: 09/07/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Care plans were not always implemented.

A number of care plans reviewed contained generic information and were not sufficiently personalised.

Care plans were not always developed to meet the assessed needs of residents.

Action Required:

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

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

Care plan training scheduled and provided with particular emphasis on the completion of care plans within 48hrs of admission and with more individualised care plans.

Proposed Timescale: 30/07/2015

Theme:

Effective care and support

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

The nature and extent of care plan review was inconsistent.

Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Care plan training scheduled and provided with emphasis on consultation and sign-off with residents' family.

Proposed Timescale: 09/07/2015

Outcome 12: Safe and Suitable Premises**Theme:**

Effective care and support

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

The design and layout of the premises did not meet the individual and collective needs of residents.

Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

Previously a Project Team was established with an objective of modifying and developing facilities, in a phased basis at St. Patrick's Hospital Cashel to ensure compliance with Environmental Standards.

Phase 1: The closure of St. Clare's Ward and the transfer of long stay residence to a new facility on the grounds of Our Lady's is near completion i.e. builders will move off site of the new facility week ending the 17th July. Equipping of the unit is in progress and will be completed within a short time frame.

Phase 2: This phase involved the transfer of Rehab and long stay patients/residents to the first and second floor of Our Lady's. However, as the HSE have been advised that the 2nd floor would not achieve registration for long stay residents, this phase is now under review and consideration.

An application is being made for capital funding to redevelop this site. This will be considered by the HSE in September 2015. The intention is to seek approval for the development of a new Community Nursing Unit on the grounds of St Patrick's Hospital, Cashel.

In the short term staff within St. Patrick's will continue to meet the needs of the residents within the constraints of current facilities.

Proposed Timescale: The Authority did not agree this action plan with the provider in relation to the significant premises issues despite affording the provider two attempts to submit a satisfactory response.

Theme:

Effective care and support

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

- Emergency call bell facilities were not provided in some sanitary facilities and smoking areas.
- Inadequate private and communal accommodation was provided for residents
- The vast majority of bedrooms did not contain the minimum floor space as outlined in the National Quality Standards for Residential Care Settings for Older People in Ireland.
- Personal storage was limited
- Many communal areas were multi-purpose
- Limited storage was available for equipment
- Sanitary and toilet facilities in many units were insufficient or inadequate to meet the needs of the residents having regard to their dependencies

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Previously a Project Team was established with an objective of modifying and developing facilities, in a phased basis at St. Patrick's Hospital Cashel to ensure compliance with Environmental Standards.

Phase 1: The closure of St. Clare's Ward and the transfer of long stay residence to a new facility on the grounds of Our Lady's is near completion i.e. builders will move off site of the new facility week ending the 17th July. Equipping of the unit is in progress and will be completed within a short time frame.

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In the short term staff within St. Patrick's will continue to meet the needs of the residents within the constraints of current facilities.

Proposed Timescale: The Authority did not agree this action plan with the provider in relation to the significant premises issues despite affording the provider two attempts to submit a satisfactory response.

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The recording of complaints was not consistent in relation to:

- the name of the person receiving the complaint
- the name of the complainant
- the satisfaction of a complainant with the outcome.

Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

Complaints template amended to include details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Proposed Timescale: 09/07/2015

Theme:

Person-centred care and support

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

The response to some minor complaints was not appropriate

Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

Complaints training scheduled and given.

Proposed Timescale: 09/07/2015

Theme:

Person-centred care and support

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

The complaints audit did not review complaints resolved at ward levels and so was unable to trend, and set learning outcomes, for all complaints

Action Required:

Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

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

Complaints audit template to be revised to include informal local complaints review and analysis.

Proposed Timescale: 30/07/2015

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

End of life discussions did not identify a preferred place of death.

Action Required:

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

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

End of Life Care training programme to be amended to include preference for place of death

Proposed Timescale: 23/07/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Many activities took place in the afternoons only, were limited in choice and residents were not informed of activities in other units that they may wish to attend.

Action Required:

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

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

Menu of activities now in place to include morning activity sessions. Lists have been posted on each ward giving details of the activities taking place throughout the hospital.

Proposed Timescale: 09/07/2015

Theme:

Person-centred care and support

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

The design and layout of the premises reduced residents' ability to exercise personal choice and independence, especially in relation to personal care and space.

Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

Previously a Project Team was established with an objective of modifying and developing facilities, in a phased basis at St. Patrick's Hospital Cashel to ensure compliance with Environmental Standards.

Phase 1: The closure of St. Clare's Ward and the transfer of long stay residence to a new facility on the grounds of Our Lady's is near completion i.e. builders will move off site of the new facility week ending the 17th July. Equipping of the unit is in progress and will be completed within a short time frame.

Phase 2: This phase involved the transfer of Rehab and long stay patients/residents to the first and second floor of Our Lady's. However, as the HSE have been advised that the 2nd floor would not achieve registration for long stay residents, this phase is now under review and consideration.

An application is being made for capital funding to redevelop this site. This will be considered by the HSE in September 2015. The intention is to seek approval for the development of a new Community Nursing Unit on the grounds of St Patrick's Hospital, Cashel.

In the short term staff within St. Patrick's will continue to meet the needs of the residents within the constraints of current facilities, ensuring that residents can exercise

choice in as much as is possible.

Proposed Timescale: Ongoing

Theme:

Person-centred care and support

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

The multioccupancy bedrooms and the location of some bedrooms as corridors/thoroughfares impacted on and limiting the privacy that could be afforded to both residents and staff while delivering personal care

Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

Previously a Project Team was established with an objective of modifying and developing facilities, in a phased basis at St. Patrick's Hospital Cashel to ensure compliance with Environmental Standards.

Phase 1: The closure of St. Clare's Ward and the transfer of long stay residence to a new facility on the grounds of Our Lady's is near completion i.e. builders will move off site of the new facility week ending the 17th July. Equipping of the unit is in progress and will be completed within a short time frame.

Phase 2: This phase involved the transfer of Rehab and long stay patients/residents to the first and second floor of Our Lady's. However, as the HSE have been advised that the 2nd floor would not achieve registration for long stay residents, this phase is now under review and consideration.

An application is being made for capital funding to redevelop this site. This will be considered by the HSE in September 2015. The intention is to seek approval for the development of a new Community Nursing Unit on the grounds of St Patrick's Hospital, Cashel.

In the short term staff within St. Patrick's will continue to meet the needs of the residents within the constraints of current facilities.

Proposed Timescale: Ongoing

Theme:

Person-centred care and support

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

Consultation with residents is not effective in some areas.

Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

Residential meetings have been reorganised to make them more functional with rotation through each unit.

Proposed Timescale: 09/07/2015

Theme:

Person-centred care and support

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

There were limited opportunities on many of the units for residents to receive their visitors in private.

Action Required:

Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

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

Previously a Project Team was established with an objective of modifying and developing facilities, in a phased basis at St. Patrick's Hospital Cashel to ensure compliance with Environmental Standards.

Phase 1: The closure of St. Clare's Ward and the transfer of long stay residence to a new facility on the grounds of Our Lady's is near completion i.e. builders will move off site of the new facility week ending the 17th July. Equipping of the unit is in progress and will be completed within a short time frame.

Phase 2: This phase involved the transfer of Rehab and long stay patients/residents to the first and second floor of Our Lady's. However, as the HSE have been advised that the 2nd floor would not achieve registration for long stay residents, this phase is now under review and consideration.

An application is being made for capital funding to redevelop this site. This will be considered by the HSE in September 2015. The intention is to seek approval for the development of a new Community Nursing Unit on the grounds of St Patrick's Hospital, Cashel.

In the short term staff within St. Patrick's will continue to meet the needs of the residents within the constraints of current facilities. Where a resident expresses a request to meet their visitors in privacy, this will be accommodated.

Proposed Timescale: Ongoing

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

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

Inadequate personal storage was provided.

Action Required:

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

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

Previously a Project Team was established with an objective of modifying and developing facilities, in a phased basis at St. Patrick's Hospital Cashel to ensure compliance with Environmental Standards.

Phase 1: The closure of St. Clare's Ward and the transfer of long stay residence to a new facility on the grounds of Our Lady's is near completion i.e. builders will move off site of the new facility week ending the 17th July. Equipping of the unit is in progress and will be completed within a short time frame.

Phase 2: This phase involved the transfer of Rehab and long stay patients/residents to the first and second floor of Our Lady's. However, as the HSE have been advised that the 2nd floor would not achieve registration for long stay residents, this phase is now under review and consideration.

An application is being made for capital funding to redevelop this site. This will be considered by the HSE in September 2015. The intention is to seek approval for the development of a new Community Nursing Unit on the grounds of St Patrick's Hospital, Cashel.

In the short term staff within St. Patrick's will continue to meet the needs of the residents within the constraints of current facilities.

Proposed Timescale: Ongoing

Outcome 18: Suitable Staffing

Theme:

Workforce

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

A review of staffing was required, especially from 17:30 to 20:00, to ensure that staff numbers and skill-mix were appropriate to meeting the assessed needs of the complement of residents accommodated on each unit.

Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

A business case completed in respect of additional staffing on the 17:30 to 21:30 shift has been approved and forwarded to the NRS for processing.

Proposed Timescale: In progress

Theme:

Workforce

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

The system of appraisal was inconsistent and may not improve the practice or accountability.

Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

The template of appraisal has been revised to include follow-up on actions and outcomes.

Proposed Timescale: 09/07/2015