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:	16 January 2020
Centre ID:	OSV-0000661
Fieldwork ID:	MON-0025799

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:	42

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
Thursday 16 January 2020	09:30hrs to 18:30hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

Feedback was very positive about the care received by residents. Residents told the inspector that they felt they were well cared for by staff who knew their individual needs, likes and dislikes. When asked about daily life in the centre one resident replied "always people here to help". Resident families echoed this opinion.

Residents described how they spent their day and said they were encouraged to be independent, to make choices for themselves and to be as mobile and active as possible. The inspector spoke with multiple individual residents at their bedsides. The inspector observed that there is ongoing issues with storage for resident personal clothing. The inspector did observe that the space available has been maximised to place items of personal value such as books and ornaments.

A common theme from conversation with residents and relatives was that staff are very kind. Residents were happy with the length of time it took to have their call bells answered. All persons spoken with knew the management team and informed the inspector that they would not hesitate to make a complaint.

Capacity and capability

The inspector found the centre was delivering a high standard of care to the residents. The person in charge was organised in her approach and engaged with the inspector throughout the day. This inspection was unannounced. The information requested was made available in a timely manner and presented in an easily understood format. The inspector found the management team work cohesively to ensure that the service delivered is safe and of high quality. The management hold a variety of meetings on a weekly and monthly basis to discuss all operational matters and clinical issues. Statistical information gathered was used to inform the management plan. Appropriate follow up is taken when required.This was evidenced by;

- A comprehensive auditing schedule was in place. Where improvements were identified as required, action plans and changes were communicated to staff.
- The person in charge had good oversight of risk within the centre. For each risk identified it was clearly documented what the hazard was, the level of risk, the controls in place and the person responsible. This document was kept live and updated when needed.
- Staff felt supported by the management team. A high importance had been placed on training specific to dementia care. The person in charge had sourced a number of training courses for staff to attend to ensure that evidenced based care was delivered. Training records identified that

additional training was provided in multiple areas. This enhanced the quality and safety of care for residents.
- The management team actively promoted a restraint free environment. The ethos and delivery of care was focused on eliminating the use of restrictive practices.
- The nursing management team had introduced a falls prevention management initiative which had positive outcomes for residents.

Following the last inspection that informed the registration renewal of the centre an extra condition of registration was applied to the registration of the centre. The condition states that by 31 December 2021 the designated centre will be replaced by a newly constructed designated centre compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 in line with Statutory Instrument 293 of 2016 and the National Standards for Residential Care Settings for Older People in Ireland, 2016. The inspector requested an update from the registered provider representative on progress. The inspector was told that the design plans are completed and are ready for submission to the planning authority.

The management team had set up a quality and safety person centered care group that met monthly to discuss all operational and clinical areas of concern. Statistical information was gathered to inform the management plan. The 2019 annual review was completed and was made available for review. In addition, priorities for 2020 were outlined in the quality improvement plan.

The inspector found that a review of recruitment procedures and staff files was required to ensure full compliance with regulation requirements. The registered provider had failed to ensure that all staff had a vetting disclosure on file prior to commencing work within the centre in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016. In the absence of the required documentary proof of current vetting the provider was issued with an urgent compliance plan. The provider responded to the urgent compliance plan on the same day and the actions taken provided the Chief Inspector with the necessary assurance that the centre will ensure that all staff are appropriately vetted prior to commencing their role within the designated centre.

The inspector spoke with staff. The staff confirmed that the management team have a presence in the centre and were readily available for support. Staff turnover in the centre was low. This impacted positively on residents as staff knew their needs. Staff informed the inspector that they would not hesitate to bring any issue concerning a resident to the attention of the person in charge and had full confidence in management to take action if required. The inspector reviewed the complaints log. There was good evidence that appropriate steps are taken in the management of complaints received. The documentation in place evidenced that the management engaged with the complainant to ensure that all reasonable measures were taken to ensure a satisfactory outcome.

Regulation 15: Staffing

Sufficient numbers of staff with appropriate skills were available to meet the assessed individual and collective needs of residents in the centre. A planned and actual staff rota was available.

Staffing numbers are stable. This had a positive impact on the care delivered to residents. For example, residents told inspectors that they were cared for by staff who knew their individual need, likes and dislikes, with consistency in who attended to their needs. In addition, residents reported that their call bells are answered without delay.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training and records reviewed evidenced that all staff had received training in safeguarding and safety, manual handling and fire safety. The inspector found that training in other areas such as falls prevention, restraint management and medication management was also in place. The centre had placed a high level of importance on staff training specific to dementia training and the management of behaviours that challenge. Staff were supported and facilitated to attend training.

Staff were appropriately supervised. Following on from the last inspection all new staff now complete an induction programme. Staff informed inspectors that they were well-supported by the management team.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place that identified the lines of authority and accountability. The person in charge was supported by an assistant director of nursing and two clinical nurse managers. The provider representative holds monthly meeting where all operational and clinical issues are discussed. The 2019 annual review of the quality and safety of the care delivered to residents was available for review. The annual review included the priorities and quality improvement initiatives set out for 2020, as identified by residents through

the resident surveys.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was available. Further review of the detail is required to ensure that the Statement of purpose is accurate and contains all of the information set out in Schedule 1. For example, a more detailed description of how the centre supports residents to access the national screening programme.

Judgment: Substantially compliant

Regulation 30: Volunteers

The roles and responsibilities of volunteers was set out in writing. A Garda Síochána vetting disclosure was in place.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents were notified to the Chief Inspector as set out in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents and relatives told the inspector that they would not hesitate to make a complaint. The complaints procedure was enlarged and prominently displayed in the main entrance. The person in charge maintained a complaints log which detailed the subject of the complaint, investigation and all communication made with the complainant. An appeal process was available. There were two complaints logged for 2020. Records evidenced that appropriate actions were in process to address the concerns.

Judgment: Compliant

Regulation 14: Persons in charge

The centre was managed by a suitably qualified and experienced nurse. She had a strong presence within the centre and was known to the residents and relatives. She held authority, accountability and responsibility for the provision of the service. During the inspection she clearly demonstrated that she had good knowledge of the regulations and standards of the care and welfare of residents in the centre.

Judgment: Compliant

Regulation 21: Records

A number of staff files were viewed and they contained most of the regulatory documentation. However, the registered provider had failed to ensure that all staff had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 available for inspection. In the absence of the required documentary proof of vetting the provider was issued with an urgent compliance plan in this regard.

Judgment: Not compliant

Quality and safety

The inspector found that the residential centre was providing a high standard of care, support and quality of life for residents. The person in charge worked full time and was supported by an assistant director of nursing and two clinical nurse managers. The clinical nurse management team held responsibility and accountability for the delivery of clinical care. There was a comprehensive auditing schedule in place that monitored all aspects of care delivery. The inspector summarised that quality improvement initiatives were having a positive outcome on the daily lived experience of residents. This was evidenced by;

- Comprehensive person centered care plans were in place that guided care
- Development of the Forever autumn programme in place that monitors the number of falls.
- There was a high level of importance placed on education and training delivered to staff.

- The active promotion of a restrictive free environment.

Residents' assessed needs were addressed by person-centred care plans that reflected their individual preferences and care choices. The documentation in place was easily understood. The nurse management team had recently reviewed the care planning system in place to ensure that it was clearly outlined and easily navigated. This meant that staff could efficiently and effectively learn about residents under their care. This in turn ensured that care was delivered in line with the residents' documented needs and preferences. The inspector found good evidence of consultation between the clinical team and relatives. On admission, all residents had been assessed by a registered nurse to identify their individual needs and choices. The assessment process used validated tools to assess each resident's dependency level, risk of malnutrition, falls risk and skin integrity. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. Arrangements were in place to evaluate care plans on a four monthly basis. Changes in overall care needs were easily tracked.

The centre has residents who have responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) due to their medical condition. A positive approach was taken to support these residents' care needs. Each resident had a detailed, person-centred behaviour support care plan in place that clearly identified their support needs and informed prevention management strategies. Compassionate, sensitive and supportive care from staff positively impacted on their well-being and quality of life in the centre.

As highlighted in previous reports, there was concerns on the availability of space for individual residents to store personal items of clothing and personal belongings in the multi occupancy rooms. The inspector acknowledges that additional wardrobes and lockers were purchased. Further review is required. For example: some of the wardrobes were not large enough for residents to hang their coats.

Despite the limitations to the space available the inspector observed that the rights to privacy was respected. For example, appropriate screening was in place during care procedures. Staff sought consent for care procedures. In addition, staff were observed to be kind and caring in their interactions with residents. The inspector observed that staff chatted freely with residents on topics of interest to them. The inspector observed there was a range of stimulating and engaging activities that provided opportunities for socialisation and recreation. All staff had a good understanding in their role and responsibility regarding normal socialisation and engagement with residents. Staff considered activities an important part of their role to ensure residents were comfortable and at ease in the environment.

Regulation 11: Visits

All visitors are requested to sign in on entering and leaving the centre. There were

no restrictions on visits and family members said that staff were welcoming and approachable at all times.

Judgment: Compliant

Regulation 12: Personal possessions

Following the last inspection a programme of refurbishment was completed and new furnishings were purchased. The inspector acknowledges the actions taken to date. However, further review of wardrobe space for storage of items that require hanging is required. The inspector found multiple examples throughout all three units whereby residents did not have sufficient hanging space for more than five/six pieces of clothing.

Residents spoken with were happy with the laundry services provided.

Judgment: Not compliant

Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The risk register was a comprehensive and detailed document that was kept under review by the person in charge. The risk register identified risks and included the additional control measures in place to minimise the risk.

Judgment: Compliant

Regulation 28: Fire precautions

Annual servicing of fire fighting equipment had been completed. Quarterly servicing was completed in 2019. Daily checks on exits were carried out throughout the premises. Fire drills were completed. The fire alarm was checked.

All staff had completed annual fire training. Staff spoken with talked through what action to take in the event of the fire alarm being activated. Each resident had a completed personal emergency evacuation plan in place to guide staff.

Day time fire simulation drills had been completed with learning taken to ensure that residents could be assisted to evacuate in a safe and efficient manner. Simulated fire evacuation drills of the largest compartment for night time conditions had not

been carried out. The person in charge committed to complete same.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Each resident's needs were comprehensively assessed on admission and at regular intervals thereafter. Staff used a variety of accredited assessment tools to complete a comprehensive assessment of each resident's needs, including risk of falling, malnutrition, pressure related skin damage and mobility assessments. These assessments informed care plans to meet each resident's needs. The interventions needed to meet each resident's needs were clearly described in person-centred terms to reflect their individual care preferences.

The inspector found that residents' care plans were reviewed and updated as necessary. Where possible, residents were consulted with regarding their care plan development and subsequent reviews. The families of residents unable to be involved in this process were consulted on behalf of individual residents. Records were maintained of this consultation process.

Judgment: Compliant

Regulation 6: Health care

Residents were provided with timely access to medical and allied health professional services as necessary. In addition, there was good evidence that advice received was followed which had a positive impact on the resident.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The management team was seen to be actively promoting a restraint-free environment. There was a total of seven residents who had bedrails in use on the day of inspection. The inspector reviewed the resident files and found that appropriate assessment of need had been completed. The resident files were compliant with regulation requirements.

The inspector reviewed multiple care files of residents who exhibited responsive behaviours and found that the care plans in place were detailed and person centered. The staff were familiar with the residents and were knowledgeable on the

triggers that may cause any distress. In addition the staff knew how to deescalate any behaviours in a manner that was not restrictive. The detail recorded in the care plans was comprehensive. This meant that the specialist team reviewing a resident could make informed decisions on how best to support the residents specific care needs.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to support the identification, reporting and investigation of alleged or suspected abuse. All staff had received training in the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to participate in the organisation of the centre by resident meetings. The minutes of the December 2019 minutes were reviewed. In addition, a resident survey had been completed. Resident's feedback was taken seriously with evidence of quality improvement from suggestions made. For example; enhancement of the activities within the centre.

The centre has placed a high value on ensuring that the centre becomes imbedded into the community. For example; the Blossom together programme whereby the local pre school children visit on a fortnightly basis.

Advocacy services were also available from the national agency for advocacy and this was advertised in the centre. In addition, there was a notice board situated in close proximity to the main reception that was populated with multiple information leaflets for resident information.

Judgment: 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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 21: Records	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

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

Inspection ID: MON-0025799

Date of inspection: 16/01/2020

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 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: To ensure compliance with Regulation 3 the statement of purpose has been reviewed and updated to reflect all the information set out in Schedule 1. An additional description on how residents have access to the National Screening Programs has been included in the Statement of Purpose.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: To ensure compliance with regulation 21 all staff files have been reviewed and completeness has been measured against the requirements of Regulation 21. The review has been confirmed that all staff files hold all information as set out in Schedule 2. Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 are held in the center for all staff. The following process has been put in place by the Register Provider: Prior to staff taking up appointment in the center, the staff file will be reviewed by the Person in Charge and the Provider Representative to ensure it is fully compliant with Regulation 21.	

Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: To ensure compliance with Regulation 12 a review of suitability of current wardrobes has been undertaken by the Person in Charge and a wardrobe replacement programme has been initiated to replace where applicable those wardrobes that do not have sufficient hanging space for resident's clothes. This will ensure that residents have adequate space and storage for their personal possessions.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A review of Fire precautions to include Fire Simulation Drills has been carried out and a Simulated Night time fire drill has taken place with shared learning following it. A full range of Fire Simulation drills will continue at regular intervals throughout 2020.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	30/06/2020
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.	Not Compliant	Orange	21/01/2020
Regulation 28(1)(e)	The registered provider shall ensure, by means	Substantially Compliant	Yellow	31/01/2020

	of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	20/01/2020