

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St. Patrick's Community Hospital
<b>Centre ID:</b>	OSV-0000661
<b>Centre address:</b>	Summerhill, Carrick on Shannon, Leitrim.
<b>Telephone number:</b>	071 96 20011
<b>Email address:</b>	anthony.wadd@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Frank Morrison
<b>Lead inspector:</b>	Thelma O'Neill
<b>Support inspector(s):</b>	Louisa Power;
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	84
<b>Number of vacancies on the date of inspection:</b>	1

## 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 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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 09 October 2014 10:00 To: 09 October 2014 16:30

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

Outcome 05: Documentation to be kept at a designated centre
Outcome 07: Safeguarding and Safety
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection; focusing on residents' End of Life Care and Food and Nutrition. In addition, medication management practices were inspected in all of the units in the centre as a follow up to the notification to the Health Information and Quality Authority (Authority).

St. Patrick's is a Community Hospital which provides short and long-term care for residents with a range of needs; including convalescence, respite care, assessment, rehabilitation, palliative care, extended or continuing care and dementia care. Services include residential, day care, physiotherapy and occupational therapy. At the time of this inspection, a total of 84 residents were accommodated.

During the course of the inspection, inspectors met residents, visitors and staff. Inspectors also viewed documentation, including medical notes and end of life nursing care plans. Policies and procedures were reviewed and inspectors analysed residents/family surveys which were submitted to the Authority prior to the inspection. Residents/families responses indicated that they were happy in the centre; however, they suggested that more staff were required to meet the residents' care needs.

There was evidence that allied health professional support, was available when assessing and implementing resident's care. For example; inspectors viewed evidence of referrals to specialists, such as general practitioners (GPs), Dieticians and

Speech and language therapists (SALT) when reviewing patient care. However, inspectors found that some residents' weights and nutritional status were not consistently monitored and recorded in the resident's care plans. In addition, practices around food and nutrition were found to be institutional, and task -based rather than person -centred. For example; inspectors found that residents requiring assistance with eating and drinking were not afforded adequate support at meal times. Some residents were also found to have experienced weight loss which was significant in some cases.

Inspectors found that staff working in the centre had a good working knowledge of evidence- based practices relevant to both outcomes. However, major shortfalls were identified in the allocation of staffing and its effect on the delivery of nutritional and end of life care provided to residents. In addition, there was no evidence that risk management protocols and procedures in place were used to identify, manage and monitor risks associated with nutrition and end-of-life care. Significant quality improvements were required in areas such as food and nutrition, end of life care, medication management, and the premises.

There was also significant non-compliances found in relation to medication management practices, and some were found to be unsafe, these were in relation to ordering, storing and administering of medications in the centre. These are discussed further under outcomes 5, 7, 9, in the body of the report.

Inspectors found the centre was non- compliant with the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and National Quality Standards for Residential Care Settings for Older People in Ireland; across all of the seven of the outcomes inspected.

The feedback meeting was attended by Damien Woods, Inspector Manager, the person in charge, and the assistant director of nursing as well as the two inspectors. The management team was informed of some good practices as well as the major non- compliances identified. These major non-compliances were in relation to staff shortages, medication management, documentation management, safeguarding and safety, health care, and food and nutrition.

**Section 41(1)(c) of the Health Act 2007. 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.**

***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:**

Resident's nutritional care plans showed evidence of reviews by the dietician and the speech and language therapists. However, some residents nursing care plans had not recorded the resident's nutritional or swallowing difficulties. In addition, some resident's nutritional risk assessments goals were not included in their care plans, and risks identified were not risk rated in the files inspected. For example; residents diagnosed with conditions such as dysphagia (difficulty in swallowing) had not been risk rated. Inspectors also found there was some food and nutritional information kept in the resident's bedside lockers. However, there was no evidence that this information was the most current or that it was regularly reviewed.

The centre used end of life care plan for residents that were very near end of life, and they specified the individualised care needs for these residents. However, inspectors found one instance where two separate care plans were operational at the same time for one resident that was near end of life. Inspectors found that this could lead to confusion and risk of errors or omissions in patient care.

The inspectors noted that the policy in relation to crushed medication management had not been implemented in practice. The policy stated that the prescriber must specify that a medication is to be crushed on each prescription. Inspectors observed that there was an instruction on the front of the prescription chart for medications to be crushed, but each prescription did not contain an authorisation from the prescriber to crush medications. This is detailed further under outcome 9.

Inspectors also observed that the medication administration sheets were left blank at a number of times where medication was due to be administered. In addition, medication administration records did not always contain the dose or route administered. Therefore,

there was not a complete record of each medicine administered signed and dated by the nurse administering the medicines.

**Judgment:**  
Non Compliant - Major

***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:**

The use of chemical restraint was reviewed. Staff with whom the inspector spoke demonstrated knowledge of chemical restraint. There was evidence of input from the psychiatric team in relation to the prescribing of chemical restraint and the centre-specific policy relating to challenging behaviour included a commitment to a restraint free environment. However, the inspectors noted that documentation in relation to chemical restraint was not in accordance with "Towards a Restraint Free Environment in Nursing Homes".

The inspectors did not see documented evidence that chemical restraint was considered only, if the potential benefit of restraint was to the resident; and the risks involved if restraint was not used outweighed the possible negative effects on the resident subjected to chemical restraint. In addition; resident's views in relation to chemical restraint were not documented. The inspector noted that records for residents subjected to chemical restraint did not include a consideration of all alternative interventions.

A full assessment of the resident prior to each episode of chemical restraint, monitoring of residents during any episode of chemical restraint, adverse events resulting from chemical restraint and a detailed record of each episode of chemical restraint were not documented.

**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 policy on medication management was made available to the inspectors. The policy had been reviewed in February 2013. Records were made available to the inspector which confirmed that staff had read and understood the policy. However, the inspectors noted that the policy had not been fully implemented.

Medications for residents were supplied by the local acute hospital. Records made available to the inspectors confirmed that pharmacy staff attended the centre regularly to order stock and complete medication reviews. Staff with whom the inspectors spoke outlined that a delivery of medication was made on a weekly basis but medications could be ordered on any day and would be delivered promptly. In the event of medication being required out of hours, medication could be obtained from an alternative pharmacy.

Medications requiring refrigeration were stored appropriately. The temperature of the medication refrigerator was monitored and recorded daily. Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation. There was a locked room in each unit for the storage of medications. However, the inspectors observed that medication trolleys were stored in communal areas accessible to residents and visitors; the medication trolleys were not secured to a wall.

Medication management training was facilitated and nursing staff with whom the inspector spoke demonstrated knowledge and understanding of professional guidance in medication management.

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

The inspectors saw that medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. The inspectors noted that the medication administration records contained a large number of errors including omission and incomplete recording of the dose or route administered.

Staff with whom the inspector spoke 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.

The inspectors were not satisfied that there was adequate accountability and governance in relation to the medications held at the centre and that the appropriate controls were in place to manage the risk of medication misappropriation. The quantities of medications ordered were observed to be disproportionate in relation to the frequency of orders. There were excessive levels of stock maintained on each unit.

**Judgment:**

Non Compliant - Major

***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:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that residents had a nutritional assessment completed on admission. This included the resident's weight and body mass index (BMI's), in addition a 'Malnutrition Universal Screening Tool' was also used in the centre for assessing resident's at risk of significant weight loss or malnutrition. Inspectors found that resident's initial assessments were based on good evidence based practice.

Although all resident's weight and BMI's had been assessed on admission, there were some resident's BMI scores that had not been reassessed, despite residents losing weight; and there was no reference of the resident's nutritional assessment scores being reviewed and documented in their nutritional care plans. Therefore, it was difficult for staff to identify which residents had lost weight recently or was at risk of significant weight loss.

All residents' files inspected had a food and nutrition care plan. However, there was no evidence that resident's care plans directed their care, for example; inspectors found limited reference to care plan goals in the resident's daily nursing notes. Therefore, patient care was not delivered to each resident in accordance with his/her needs. For example, some residents with swallowing difficulties required extra time to eat their meals; however, inspectors found that there was not appropriate staffing allocated to meet resident's nutritional needs. In addition to the shortage of staffing effecting nutritional support, inspectors also found evidence; of a shortage of staff for basic hygiene care. For example; in one unit over a two-week period, there were four days each week, where no residents received a bath/ shower.



Inspectors also found that there was not a standardised care planning system in operation in the centre and care plans and recording of resident care significantly different from unit to unit. Inspectors found that a lack of standardised documentation or monitoring of resident's nutrition created a risk to residents, especially when residents were transferred to other units, or when staff members were transferred as relief staff into new units, as they would not be familiar with that unit's documentation.

The design and layout of the centre did not promote privacy or dignity for the residents. All of the activities of daily living were all concentrated around resident's beds on a daily basis. For example; eating meals, personal care, relaxing at their bedside and sleeping. Therefore, inspectors found that there was not an appropriate therapeutic environment provided to all residents to ensure a good quality service.

**Judgment:**  
Non Compliant - Major

#### ***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):**  
No actions were required from the previous inspection.

#### **Findings:**

The centre had an end-of-life policy in place. Staff had a good understanding of end-of-life care and best practices. Relatives of residents who had died in the previous year returned completed surveys. All family members stated that care was provided in a kind and sensitive manner; however, some family members commented that they would have liked more staff available to care for their loved one near end of life. Relatives spoken with on the day of inspection were very complimentary of the staff working in the centre, however three of the relatives stated that more staff were urgently required to care for their loved ones.

Inspectors found that relatives were facilitated to stay with their loved ones when they were near end of life. In some units there was a visitor's room that included reclining chairs, a television and some reading material, including facilities to make tea and coffee; however, these facilities were not available in one of the units. Inspectors observed many difficulties for relatives, in the physical environment as many of the four or five bed multi-occupancy rooms did not provide privacy and dignity for residents or their families near end of life.

The end-of-life policy stated the assistance in meeting residents' multi-denominational spiritual needs would be met, and the policy outlined the procedures for caring for

residents from other religious denominations to guide staff. The procedure for verification and notification of death were outlined in the centre's policy and staff spoken to could articulate practice in this area. Residents viewed Mass daily via video link from the onsite chapel, however, in Monsignor Young unit the television screen was fuzzy and difficult for residents to view. The priest also visited residents when near end-of-life and residents were offered and received the sacrament of the sick and dying.

The centre used a specific end of life care plan for residents that were very near end of life. The care plans documented the resident's needs and wishes, and nursing care required including nursing and medical evaluations which were in date and regularly reviewed. Resident's had clearly outlined their preferences for end-of-life care, and this was documented in the resident's care plan.

However, information was absent from some of the residents end of life plans, such as, residents/family members preferences and wishes in matters relating to their/family members funeral. For example; where they would like their funeral service to take place, or the music they would like at the service, or where they would like their final resting place to be. Some nurses also expressed difficulties or a lack of specialised skills to hold sensitive discussions with residents and relatives to elicit their wishes prior to the person's death.

The inspector noted that some meetings were held between residents', and their family members and their general practitioner's, (GPs) to discuss end of life care planning. For example; in one case, the patient had requested that they did not want any emergency life- saving treatment and the General practitioner had diagnosed that the patient was in the terminal phase of an illness, and life saving treatment was not of beneficial for the patient, and a DNR (Do not Resuscitate) order was documented on the resident's medical file by the GP. The resident's end of life plans also included issues, such as, pain relief measures, so that resident's pain was monitored daily, and residents were kept comfortable and pain-free near end of life.

The physical environment in the centre required major refurbishment and bedrooms were mostly multi-occupancy rooms. There was no physical structure dividing the walkway throughout some of the units. In some units, residents that shared multi occupancy bedrooms were offered a single room (if available) when near end of life; however, this option was not available to one resident on the day of inspection.

Inspectors found that there was limited space around beds and a lack of privacy and dignity for the residents due to the open plan design. Inspectors observed that the privacy provided to one resident near end of life and their family was limited, for example; There was only a light curtain around the resident's bed. When walking through the wards, visitors and staff had the full view and access to all residents, lying in their beds or sitting in their chairs.

There were two residents near end of life on the day of inspection, inspectors viewed their end of life care plans and found that they reflected the resident's death and dying preferences/wishes. Residents were medically assessed when near end of life, and their care plans included details such as the resident's name, and next of kin details, resident/family wishes near end of life, environmental options, religious and communication goals. Resident's end of life medical and nursing reviews, were

documented in their end of life care plan notes. However; inspectors found in one of the residents files, that some nurse's were using two sets of care plans for one resident; as some nurses were not aware that the resident's daily care notes had been transferred to the resident's end of life care plan. This recording error could lead to confusion and risk of medication errors or omissions in patient care. Although there were processes and procedures in place for end of life care, the inspectors found that due to shortages of staff on duty these were not being enacted appropriately. This is discussed in more detail under staffing in outcome 18.

There was an on- site mortuary available, or families could request to use their local funeral home for non-family members to visit and pay their last respects. The nurse manager stated she sent a personalised sympathy card to the relatives from staff in the centre, and showed the inspector some thank you cards they had received from family members that had previously passed away. The belongings of the deceased were returned to the family or significant other persons at an appropriate time after the funeral.

The inspectors found this centre was non -compliant in end of life care due to the lack of privacy and dignity for residents near end of life. Inspectors also observed a resident near end of life having to wait for nursing care and their care plans not been used appropriately.

**Judgment:**  
Non Compliant - Moderate

### ***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):**  
No actions were required from the previous inspection.

**Findings:**  
Inspectors found that there was good access to the local GPs.) practice, the centre has access to five GPs working in the practice, and they rotated on call duties each month and the out of hours GP service was provided by Nowdoc. Residents were regularly reviewed by their General Practitioner's and community dieticians.

Inspectors viewed the nursing and medical files of eleven residents across a number of units, and specifically viewed their food and nutritional assessments. This included the residents nutritional needs, based on a dieticians assessments and Malnutrition Universal Screening Tool assessments. Records also showed that some residents had been reviewed by a dietician and their treatment plans were recorded in the residents' files

under MDT reviews. However, inspectors found that the resident's medical diagnosis, dietitian or Speech and Language (SALT) recommendations were not always recorded in the resident's food and nutritional care plans. In addition; residents diagnosed with conditions such as dysphagia had not been risk assessed, or risk rated, therefore it was difficult for staff, especially locum staff to identify which residents were at the highest risks of nutritional deficiencies in the units. Inspectors also found that the processes in place to ensure residents do not experience poor nutrition and hydration were not effective as nutritional assessments were not being recorded in the residents care plans. Also MDT recommendations were not consistently implemented in a manner that safeguarded residents with nutritional difficulties.

Inspectors also found that in some of the resident's files, there was no appropriate record maintained of the amount of fluid and nutrition that some residents were receiving. This was of particular concern for residents that were bed bound. In addition, Inspectors found that some residents requiring assistance with eating and drinking were not afforded adequate staff support.

Some residents were found to have experienced weight loss which was significant in some cases. For example; one resident was found to have lost 12kg in weight over the previous two months. Inspectors found that this resident's weight had not been checked for the two months, prior to his admission to his new ward. Following admission to his new ward the resident's care plan had been reassessed and he had been medically reviewed by the GP, and the dietitian, following these assessments the resident was prescribed high protein food supplements for his weight loss. Additional staff support was also given to this resident at meal times. Since these interventions have been put in place, the resident has continuously gained weight.

The hospital kitchen staff provided meals to the eighty five residents residing in the centre, and also for up to thirty residents receiving day care. In addition, meals on wheels were provided to residents living in the community, and the staff meals were also provided in the canteen. There were two weekly menu cycles; these menus were reported to be flexible, and interchangeable depending on fresh food stocks been supplied. There was a different main course, and supper on offer each day. The unit staff and kitchen staff communicated daily regarding the daily menus and resident's nutritional requirements. Meals were cooked fresh daily with the exception to pureed meals that were purchased from an external food company for residents that required special dinners. Inspectors were concerned regarding the choice for meals available for residents eating the pureed meals. Meals were sent to each of the four units twice a day, in Ban –Marie's (hot food trolley).

Inspectors reviewed the menus and found that some of the supper menu options, such as chicken nuggets and chips are not deemed nutritional, or particularly suitable for older residents that had swallowing and chewing difficulties. Inspectors found that chips were on the menu four evenings in the current menu cycle. In addition; two evenings each week there was no hot supper offered to the residents; on those evenings there was only a salad or sandwiches on the menu. Inspectors found that these options were not suitable for residents requiring soft diets or pureed meals.

The evening teas were given out at 4.00pm each evening and inspectors noted that residents next received a meal at breakfast time at 8.00am the next morning. The chef assured inspectors that residents could have food whenever they wanted to eat. However, inspectors observed the food stocks in the kitchenette in one of the units and there was limited food available for residents that may request an evening or midnight snack.

Most residents spoke with were positive in their comments about the food that they received. They said that the quality and quantity of food was very good. However one resident informed inspector that he didn't like mince, however, no alternative was offered to him, despite him making his dislikes known to staff.

Inspectors did not view evidence of any nutritional audit being carried out or a meeting with residents to discuss menus, or any food or nutritional issues with the managers, or the chef.

The hospital had a nutrition and hydration policy in place, which included protected meal times. Inspectors found that there was restricted visiting times four times a day in this centre. These were at the three meal times, morning, lunch and tea, and in the evening after 9.30pm. Inspectors found that these restrictions were enforced as there was a stand informing visitors of the visiting hours at the doors to each ward areas. Exceptions were made for relatives of residents near end of life.

There were very poor dining room facilities available in the some of the units for the residents to eat their meals. The dining rooms viewed were found to be unattractive and institutional in character. The inspectors observed that the majority of residents were assisted to eat either in bed or beside their bed. Drinks were provided at meal times and they were distributed by staff, however inspectors did not observe staff offering drinks at any other time outside meal times. All residents did not have access to fresh drinking water, as there were no jugs of water or juice on resident's bedside tables or lockers that inspectors observed.

The inspectors were informed that it was the care staffs role to assist the residents with their meals; as the nurses focused on medications, doctor's rounds, wound care and nursing residents near end of life. However, inspectors found that there was not sufficient staff members on duty in one of the units to assist resident with their meals. For example; in one unit, there were only two health care assistants on duty to assist 13 maximum / high dependencies residents with their meals. Seven of these residents were in bed, and required the assistance of two staff to sit up right for their meals. In another unit seven of the 20 residents remained in bed all day during the inspection, and also required staff assistance at meal times.

The evening meals were scheduled at 4pm, and many of the staff shifts finished at 4.30pm every day. This meant that supper times clashed with the staff handover and shift changes in each unit. Inspectors found that staffing rosters created nutritional risks to residents, as staff support was required for residents to receive their meals, and as a result this change over of staff at this time, residents may not receive appropriate staff support to eat their supper in a manner that they require.

**Judgment:**

Non Compliant - Major

**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:**

On the day of inspection, in one of the wards there were thirteen female residents, one of whom was nearing end of life and another resident was seriously ill. There was one nurse and two care assistants on duty to care for these high dependency residents. There was no extra staff support made available to this unit despite the resident's conditions deteriorating. Inspectors observed that in two units in this hospital, there were significant numbers of residents in bed all day. In one unit that accommodated thirteen female residents, seven individuals regularly stayed in bed all day. Nurses confirmed that this was the practice most days for most of these residents.

Inspectors also visited the male side of one unit where 11 max/high dependency men reside. There was only one nurse and one health care assistant rostered to care for these residents. Inspectors went into this unit at 1.30pm there was seven beds unmade, no staff presence on the ward and no staff members supervising the 11 residents. Although the inspector did find that there were two staff on duty, and they were attending to a person near end of life in one of the side rooms. Inspectors found that the supervision of the other residents was inadequate, as there were a number of these residents in bed and others residents were sitting out on chairs at the side of their bed, with no staff members supervising them.

Inspectors found evidence that the staffing skill mix at certain times of the day was inadequate, to meet the needs of residents. For example; there was evidence of staff shortages after the shift changes at 4.30pm. On one occasion when one unit was short a staff member in the evening, three different care attendants were sent up to help in the unit, each for an hour at a time from the other three wards in the centre. This created inconsistency in staffing in all four wards in the hospital and inspectors found that resident's care was task focused instead of individualised and person centred.

Training had been provided for eighteen nursing staff in 2010/2011 on the training on nutritional assessments for resident using the malnutrition universal support tool (MUST). In addition training was completed by 35 nurses and 25 care staff in caring for residents' with dysphasia to ensure that residents were provided optimal care. There was also an ongoing training programme on topics related to food and nutrition scheduled for staff in the New Year. However; staff required training/ refresher training in end of life care, nutritional care, and documenting and reviewing residents' care plans, risk assessments and risk rating clinical care for residents

**Judgment:**  
Non Compliant - Major

### **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:***

Thelma O'Neill  
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 report<sup>1</sup>

Centre name:	St. Patrick's Community Hospital
Centre ID:	OSV-0000661
Date of inspection:	09/10/2014
Date of response:	29/10/2014

#### 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 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:**

1. Dieticians or Speech and Language (SALT) assessments, diagnosis and recommendations were not consistently recorded in the resident's food and nutritional care plans.
2. Residents nutritional or swallowing difficulties had not been risk rated; therefore, it was difficult for staff to identify which residents had high nutritional needs and risks.

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



**Action Required:**

Under Regulation 21(1) you are required to: 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.

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

Recommendations following Dietician or Speech and Language Therapy assessments will be consistently recorded in the residents care plans.

Each resident's nutritional status, food and fluid choice is included in the enclosed format to ensure they receive safely the food that has been assessed as being suitable for them. A copy of the nutritional plan for the unit is included for your perusal.

**Proposed Timescale:** 31/10/2014

**Theme:**

Governance, Leadership and Management

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

There was not a complete record of each medicine administered signed and dated by the nurse administering the medicines.

**Action Required:**

Under Regulation 21(3) you are required to: Retain the records set out in Schedule 3 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

All medication charts will be fully completed, signed and dated with all administration of medications.

**Proposed Timescale:** 10/10/2014

**Theme:**

Governance, Leadership and Management

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

The medication management policy was not implemented in practice in relation to crushing medications.

**Action Required:**

Under Regulation 21(1) you are required to: 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.

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

We will continue to review our policy and practice in relation to the crushing of medication. Both the pharmacist and pharmacy technicians available to the hospital will guide our practice, this will be done in collaboration with our assigned General Practitioners.

**Proposed Timescale:** 30/11/2014

**Theme:**

Governance, Leadership and Management

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

There were inconsistencies in the recording of resident's end of life care, for example; some staff nurses were writing nursing notes in two separate care plans for a resident that was dying.

**Action Required:**

Under Regulation 21(1) you are required to: 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.

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

As highlighted in the "Self assessment" document in March 2014-the process of introducing an end of life care plan is to be complete in 6-12 months and we are working toward that for all residents. The use of two care plans being used concurrently has ceased. Ward Managers have been instructed to supervise the use of care plans during end of life and ensure correct procedure is followed in relation to the End of Life Care Plan. We will continue to review our procedures in response to the timely introduction of the end of Life care plan.

Staff will be attending "Final Journeys training" over the next 8 months (Nov 14-June 15) –in Sligo this includes module on end of life conversations, dealing with difficult questions, end of life care planning.

**Proposed Timescale:** 10/10/2014

**Outcome 07: Safeguarding and Safety****Theme:**

Safe care and support

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

Chemical restraint was not used in line with national policy.

**Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

Nursing Administration is of the belief that Chemical restraint is not being practiced in St Patricks. However to ensure this statement is correct, the Pharmacy service have been requested to verify the use of certain medications and to audit their use and match these against the presenting conditions of all residents. Staff will also ensure that a full assessment of the resident prior to each episode of chemical restraint (if required), monitoring of residents during any episode of chemical restraint, adverse events resulting from chemical restraint and a detailed record of each episode of chemical restraint will be documented. Training will be extended in 2015 to include further training on medication management, restraint and challenging behaviour which staff have previously been exposed to.

**Proposed Timescale:** 30/11/2014

**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:**

Storage arrangements for medication trolleys were inappropriate

**Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

Medication trolley on the unit identified as being stored in Room unattached to wall –is normally stored in appropriate area ,has appropriate attachment (i.e. chain) and is locked to the wall.

**Proposed Timescale:** 10/10/2014

**Theme:**

Safe care and support

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

There was inadequate accountability and governance in relation to medication stock levels.

Appropriate controls were not in place to manage the risk of medication misappropriation.

**Action Required:**

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

The Pharmacy department in Sligo Regional Hospital manage pharmacy stocks within the Hospital. Pharmacy stocks have been guided by the pharmacist / pharmacy technicians who have created a stock list based on the resident's charts. This service has been in situ in St Patrick's Hospital for the past 8 yrs approx and our stock levels are reviewed twice weekly. We are currently reviewing all of the available stock levels to ensure continued governance of medications within the hospital. The Person in Charge has recently met with the Pharmacy Management team in Sligo Regional Hospital who are presently auditing the Pharmacy Service stocks etc, to ensure that the control measures are in place to rapidly identify if there any issues with stock levels. The time frames for audits will be agreed once the Pharmacy have undertaken a baseline review

**Proposed Timescale:** 20/12/2014

**Outcome 11: Health and Social Care Needs**

**Theme:**

Person-centred care and support

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

In one unit, over a two week period, there were four days each week, where no residents received a bath/ shower.

**Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

A comprehensive process of staffing review is presently being undertaken to ensure the correct utilisation of the staffing complement in St Patricks for the delivery of safe and effective care during the 24 hour period and also the replacement of staff that have left. These changes with the present staff will initially be on two units in St Patricks commencing on the 19th January 2015 this will include roster change to ensure staff

are available to the residents at times when they require assistance with personal hygiene, thereby increasing the numbers of staff to carry out showers safely and giving the residents choice.

**Proposed Timescale:** 30/01/2015

**Theme:**

Person-centred care and support

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

1. Some residents' malnutrition universal screening tool (MUST) scores had not been reassessed despite residents losing weight.
2. The residents MUST scores were not documented in all of the residents nutritional care plans.

**Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

The MUST scores will be reassessed on all residents where indicated and the scores will be entered on to the residents care charts.

Regular monthly auditing by the Person in Charge/Clinical Nurse Managers will ensure that the BMI and weights of the residents are recorded and that if any changes are noted that the relevant referrals has been commenced to ensure that treatment plans and interventions are timely and person centred.

**Proposed Timescale:** 20/10/2014

**Theme:**

Person-centred care and support

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

In one unit, the resident's up to-date weights and BMI's were not recorded in the residents food and nutritional care plans,

**Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

**Please state the actions you have taken or are planning to take:**  
The MUST scores will be reassessed on all residents where indicated. MUST scores AND BMIs will be entered on to the residents food and nutritional care plans.

**Proposed Timescale:** 20/10/2014

**Theme:**  
Person-centred care and support

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

1. The quality of nursing documentation varied considerably across all of the units in the centre. For example; there was no consistent nursing care plan template in use across all of the units.
2. Inspectors found a lack of appropriate monitoring of nutritional inputs and outputs for residents.

**Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

The standardised care plan will be used across all units

The care plans will ensure that residents nutritional inputs and outputs will be included in all care plans with evidence of nursing care provided

**Proposed Timescale:** 30/11/2014

**Theme:**  
Person-centred care and support

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

The nursing care provided to the residents was not adequate to meet the needs of the residents, particularly for residents receiving end of life care.

**Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

A comprehensive process of staffing review is presently being undertaken to ensure the correct utilisation of the staffing complement in St Patricks for the delivery of safe and effective care during the 24 hour period and also the replacement of staff that have left the service. This has included the review of our present Wte and matching that with the agreed dependency and ratio tools. Advanced discussions have been undertaken with the Provider to look at methods by which replacement staff can be accessed if required urgently.

**Proposed Timescale:** 30/12/2014

**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:**

One resident was accommodated in a multi occupancy room which did not provide them privacy or dignity near end of life.

**Action Required:**

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

The appropriate care and comfort of the two residents identified unit approaching end of life were addressed. This included assessing their physical, emotional, social, psychological and spiritual needs.

The resident identified had been resident on the unit since early 2014, and not identified the wish for single accommodation in discussion with staff. However prior to this stage, the resident was situated in a multi occupancy area on the ward and staff moved the residents to an area of the ward that permitted single occupancy to ensure as much privacy as possible.

The End of Life self assessment identified that we only have two single rooms in that unit and one is occupied by a resident on a continual basis and the other was occupied by a resident at end of life.

Plans have been presented to the Authority outlining our intention to increase single rooms in that unit.

**Proposed Timescale:** 20/10/2014

**Theme:**

Person-centred care and support

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

Residents viewed mass daily via video link from the onsite church, however in one of the units the television screen was fuzzy and difficult for residents to view.

**Action Required:**

Under Regulation 13(1)(b) you are required to: Ensure the religious and cultural needs of the resident approaching end of life are met, in so far as is reasonably practicable.

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

Action taken prior to receiving the report as identified by staff-and was highlighted and rectified. This did not impact on the residents end of life care.

**Proposed Timescale:** 30/10/2014

**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 not suitable facilities available for residents or their family members experiencing end of life; particularly residents that were accommodated in multi-occupancy rooms in this centre.

**Action Required:**

Under Regulation 13(1)(c) you are required to: Inform the family and friends of the resident approaching end of life of the resident's condition, with the resident's consent. Permit them to be with the resident and provide suitable facilities for them.

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

Plans have been presented to the authority outlining our intention to increase the private space by way of single rooms.

The families of the two residents who were end of life on the day of inspection, stayed overnight and were given access to private space, informed fully of the condition of both residents, had access to food ,fluids and were involved fully in the end of life care. This happened up to the time of death and afterwards, including meals, provision of phones for contacting undertakers and the use of the chapel and facilities for the removal to their local parishes.

Families can utilise the available visitor's rooms. There is also a conference room where larger families can be accommodated, and also a church to cater for their religious and cultural needs.

**Proposed Timescale:** 20/10/2014



## Outcome 15: Food and Nutrition

### Theme:

Person-centred care and support

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

There were limited dining room facilities available for residents to eat their meals in the in each of the units.

### Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

Plans have been presented to the authority outlining our intention to increase and improve the dining room facilities to ensure these are welcoming and homely for the residents to use.

### Proposed Timescale: 20/10/2014

### Theme:

Person-centred care and support

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

Residents were not offered adequate opportunity to discuss menus, food choices or nutritional issues with staff or managers.

### Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

Residents are fully included in food and nutritional choices and are members of the meal and mealtime group. Staff will be reviewing the documentation used and ensure that the residents choices are fully documented and that discussion will be documented including satisfaction / dissatisfaction of meals.

### Proposed Timescale: 30/11/2014

### Theme:

Person-centred care and support

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

There was not sufficient variety and choices of meals for residents on pureed diets, for example; residents were being served the same flavoured dinners every few days.

**Action Required:**

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

All pureed foods are safely managed and their availability to residents within the hospital have been designed with the assistance of the Dietetic department. They have afforded the resident who require pureed foods a range of tastes and textures including red meat, chicken, fish, and other items such as stews and curries, with relevant available nutritional values. We will continue to seek feedback from the residents regarding their use.

The meal and mealtime group are monitoring the rotation of the pureed food choice for the residents and including this in the audit cycle being designed for meal and mealtime choice. Results of this audit and resident feedback will guide in the devising of the rotational menu

**Proposed Timescale:** 20/11/2014

**Theme:**

Person-centred care and support

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

1. The meals for the supper in the evening required review as foods offered were often not nutritional, wholesome, or particularly suitable for older residents that have swallowing and chewing difficulties.
2. Two evening per week, there was no hot supper offered to the residents, for example; there was only a salad or sandwiches on the menu.
3. The timing of the evening tea requires review.

**Action Required:**

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

The meals at present offer the residents a range of tastes, textures and food choice. There is also choice available for any resident requiring other meals not identified on the menu. The times of the evening tea will be reviewed with the Meal and Mealtime group a comprehensive process of staffing review is presently being undertaken to ensure the correct utilisation of the staffing complement in St Patricks for the delivery of safe and effective care during the 24 hour period and also the replacement of staff that have left.

**Proposed Timescale:** 30/11/2014

**Theme:**

Person-centred care and support

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

The kitchenette in one of the units had limited food available for residents that may request an evening or midnight snack.

**Action Required:**

Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

The Person in charge confirms that there are sufficient quantities of food for residents throughout the day and at night in St Patricks including choice of menu and also including all residents with specific needs for modified diets, including pureed food.

On the day of the inspection the food for the night time would not have been delivered to the kitchenette at the time the inspector viewed the area. This is normally done as late as possible in order to ensure that the food is as fresh as possible for the residents.

**Proposed Timescale:** 10/10/2014

**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 not jugs of water or juice left on all of the resident's bedside tables or lockers, for them to access fluids.

**Action Required:**

Under Regulation 18(1)(a) you are required to: Provide each resident with access to a safe supply of fresh drinking water at all times.

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

Jugs of juice and water will be available where deemed suitable to the needs of the residents in question.

**Proposed Timescale:** 30/10/2014

## Outcome 18: Suitable Staffing

**Theme:**  
Workforce

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

The number and skill mix of staff was not appropriate to meet the needs of the residents.

**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 comprehensive staffing review has been completed for St Patrick's hospital utilising a number of different staffing allocation tools. The result of this review was put forward to the local HR monitoring group and the following posts have been submitted to National Social Care Team for final approval. 1 Clinical Nurse Manager II. 3 Health Care Attendant at FETAC 5 level.

In addition a further two Health Care Assistants have commenced employment at the Hospital on the 11.1.2014 having received approval to fill at the previous HR monitoring Committee meeting. These staff have received induction and orientation to the hospital and have commenced work in both RMU and MYU

Extensive work has also been carried out in conjunction with the CNMIII at Arus Carolan. The Day Hospital services have been reorganised which has allowed for the transfer of a CNMI to the Day unit in St Patrick's. This transfer has allowed for the existing CNMII in the Day Hospital at St Patrick's to move to Dr McGarry Ward to cover a vacancy on this unit.

Staffing on each unit is reviewed daily and allocated / organised in such a way to ensure that the needs of the residents are met and that staff are available when the residents require personal care, assistance with meals, activities and at end of life.

### Proposed Timescale: 19/01/2015

**Theme:**  
Workforce

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

Staff required training/ refresher training in end of life care, and resident's food and nutritional needs. Staff also require training in documenting and reviewing nursing care provided, risk assessments, and risk rating of patients.

**Action Required:**

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

In January-April 2013 –All Health care assistants were trained and updated in “End of Life” care with CNME as part of the FETAC Level 5 training “Activities of Living Module” this was facilitated by Tutor who was responsible “Final Journeys” training in conjunction with Hospice.

Further training is being provided for all staff on “Final Journeys” over the next 8 months (Nov 14-June 15) –in CNME in Sligo this includes module on end of life conversations, dealing with difficult questions.

We continue our training on Safe assisted mealtimes facilitated by the Speech and Language Department this includes all staff and outlines dysphagia, assisting with meals, ensuring recommendations are clear and residents are identified

Training is also required on care planning, risk management for the nurses in this centre. Risk Management update for managers are on the 12th December 2014 in St Patricks Hospital. Care Planning training will be discussed with the Centre for nursing and midwifery education to devise education that will meet our needs as we review our documentation.

**Proposed Timescale:** 19/12/2014