

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St John's Community Hospital
Centre ID:	OSV-0000604
Centre address:	Munster Hill, Enniscorthy, Wexford.
Telephone number:	053 9233 228
Email address:	margaret.nowlanoneill@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Barbara Murphy
Lead inspector:	Ide Batan
Support inspector(s):	Kieran Murphy
Type of inspection	Announced
Number of residents on the date of inspection:	116
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 April 2015 09:30	01 April 2015 17:00
02 April 2015 08:00	02 April 2015 13:30

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

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

Summary of findings from this inspection

As part of the application for renewal of registration the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). The inspectors reviewed this documentation, ascertained the views of residents, and staff members, observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Changes to the provider nominee had taken place since the last inspection and the Authority had been provided with full and complete information on the new provider nominee. The provider nominee is based at the Local Health Office and is onsite once per week.

The person in charge has also changed since the time of initial registration by the Authority. The fitness of the provider and the person in charge was determined by interview during previous registration inspections of other designated centres and on going regulatory work. The person in charge is supported in her role by two assistant directors of nursing.

Day to day management responsibilities are with the assistant directors of nursing who work closely with the person in charge, and both are nominated persons in the absence of the person in charge. Staff involved in the management of the centre demonstrated their knowledge of the legislation and standards throughout the inspection process. In the main, inspectors found that residents and relatives were positive in their feedback to the Authority and expressed satisfaction about the facilities and services and care provided. They were complimentary about the care and support provided by staff and management.

The experiences of residents were monitored to enhance the quality of care provided. They had good access to nursing, medical and allied health care and the administration of medicines was satisfactory. Staffing levels were found to be adequate on the day of the inspection.

Areas for improvement identified included mandatory training, submission of notifications and implementation of plans to address multiple occupancy accommodation. These areas for improvement are discussed further in the report and are included in the Action Plan at the end of this report.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector reviewed the statement of purpose submitted with application to register which was a detailed document, informative and easy to follow and clear in presentation. The statement of purpose contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspectors found that there was a clearly defined management structure that identifies the lines of authority and accountability, specified roles and details responsibilities for the areas of care provision. This was outlined in the statement of purpose, and staff were familiar with their duty to report to line management. The

person in charge worked closely with the assistant directors of nursing. The provider nominee had only recently taken over the role and is onsite on a weekly basis.

Management systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. Management meetings were well established and reviewed all aspects of service provision, staffing, health and safety, training, complaints and any other relevant issues.

The roles and responsibilities were clearly defined; evidence of audit and review of practice evident from this inspection and previous monitoring events confirmed this. During the inspection the management team demonstrated effective communication and provision of information and records when requested.

The person in charge was open to feedback given further to this monitoring event and demonstrated a pro-active approach. An annual report on quality and safety in line with legislative requirements was available at the time of the inspection and an action plan for 2015 had been generated as a result of this review to include:

documentation review
appraisals
medication management
staff training.

Judgment:

Compliant

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors read a sample of completed contracts and saw that they did fully meet the requirements of the Regulations. They included adequate details of the services to be provided and the fees to be charged, and included the cost for the additional services not included in the fee. Inspectors saw there was relevant information available for residents on notice boards and in each unit. Services provided for residents were outlined in a Residents' Guide that included a summary of the statement of purpose, terms and conditions within a sample contract of care, complaints procedure and visiting arrangements.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge is an experienced nurse and manager and is actively involved in the organisation and management of the service. In addition to significant experience in the care of older persons and management of a designated centre the person in charge had continued her professional development.

She was frequently observed meeting with residents, relatives and staff and ensured good supervision to all staff. The person in charge had suitable deputising arrangements in place. The inspectors were satisfied that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis and had demonstrated a commitment to improving outcomes for the resident group.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspectors found that in the main, the records listed in the legislation were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Inspectors were satisfied that the records listed in Schedules 2, and 4 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

Records including the statement of purpose, Residents' Guide, previous inspection reports, and a directory of residents, emergency procedures, and clinical documents along with records related to all residents and staff were available for inspection. The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations.

There was a visitors sign in book available in the front foyer. The designated centre was adequately insured against accidents or injury to residents, staff and visitors. However, in relation to records listed in Schedule 3 there was not a nursing record of the person's health and condition and treatment given, completed on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Information governance also required improvement. Inspectors saw that personal and sensitive information regarding residents was on public display on a notice board in a ward.

Judgment:

Non Compliant - Moderate

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

At the time of the inspection the person in charge had not been absent for more than 28 days which required notification to the Authority. The inspectors formed the view that there were suitable arrangements in place for the management of the centre in the absence of the person in charge. Both assistant directors of nursing took charge of the centre when the person in charge was absent or on leave.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors observed that not all staff had received training in elder abuse which is a requirement of legislation. At the last monitoring inspection in August 2013 it had been identified that not all staff had received training on protection of residents from abuse. Similarly on the current inspection training records indicated that in 2014-2015 54.9% of nursing staff and 42.8% of support staff had received training on the protection of vulnerable adults. A policy on, and procedures for the prevention, detection and response to allegations of abuse were in place. Staff who spoke with inspectors knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to.

A specific incident relating to an allegation of inappropriate staff conduct was outlined during the inspection. However documentation relating to this allegation had not been submitted to the Authority. Inspectors reviewed the matter while onsite and were satisfied that the provider and person in charge had investigated this issue.

There were guidelines available for staff on the management of behavioural symptoms associated with dementia. Training records indicated that 26 staff had been specifically trained in the management of behaviour that challenges. The person in charge outlined that further training was scheduled for April 2015. Ivy ward had 20 residential beds for people with a diagnosis of dementia. This ward was decorated with distinctive "street scenes" on the walls in the main corridor. There was also a tea room which the clinical nurse manager outlined was laid out like a kitchen at home so that residents could make a cup of tea and meet visitors if they wished. The Ivy Ward had a large dayroom with double doors leading out to a specially designed safe sensory garden.

There was a separate activation room adjacent to the dayroom used for daytime activity. There was also access to the secure garden from this room. Inspectors reviewed a sample of healthcare files of residents in the dementia unit. There was evidence that each resident was assessed on admission for issues including communication and pain assessment in advanced dementia. In the sample of care plans seen the assessments on admission informed the care planning process. The senior clinical nurse manager had begun a process of undertaking a more person centred approach to planning care of residents in the dementia unit.

A number of "brain-storming" sessions had been undertaken with the resident at the centre of the process. There were plans to develop these person centred plans in an easy to read format, with resident and family involvement in the setting of the goals following the care planning process. Each resident who required the use of a bedrail had an assessment undertaken. The rationale for use of the bedrails was clearly documented and consent had been obtained. Some residents had security and wandering tags in place. An assessment and rationale process was also in place for the use of these restraints.

Inspectors reviewed the measures that were in place to safeguard residents' money and found that the systems in place were not robust. Inspectors saw that records maintained of money and valuables deposited by a resident/relative for safekeeping were not sufficiently robust. Inspectors saw that money was stored in a safe and transactions were not co signed and witnessed by resident/relative and staff members which did not safeguard residents or staff

Judgment:

Non Compliant - Moderate

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

At the last monitoring inspection in August 2013 it had been identified that not all staff had received fire training. There was a similar finding on the current inspection with training records indicating that in 2014 50.7% of nursing staff and 53% of support staff had received fire training. The arrangements in place to monitor and record fire safety required improvement. On one ward inspectors saw that the fire register was incomplete as the daily checks on the fire panel, the weekly checks on fire extinguishers had not been filled in on a number of dates. In addition there was no record since 2013 of visual inspection of the fire doors and final exit doors. There was a valid fire certificate for the centre dated 08 October 2014. Inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:

- Servicing of fire alarm system and alarm panel March 2015
- servicing of the emergency lighting January 2015
- servicing and inspection of fire extinguishers January 2015.

The risk management policy contained the identification and management of risks and

there were measures in place to control risks including assault, accidental injury and self harm. However, the copy of the risk management policy contained references to another centre throughout the policy. There was an incident reporting system and the person in charge outlined that all adverse events were reported to the clinical risk manager in the Health Services Executive. Inspectors saw an analysis of all clinical incidents from 2012 to 2014. There had been a 33% reduction in the overall total of reported incidents between 2012 and 2014, with a 40% reduction in the amount of reported resident falls. The person in charge outlined that there was committee to prevent residents falling which had multi-disciplinary input. In the sample of healthcare records seen residents had received a falls risk assessment as part of the admission process.

There was an organisational risk register which contained three hazards. The first was a lack of appropriate seating for long-stay residents. The second issue was that two medical officers were on site for two days each with further cover provided by a locum doctor. The third item was the recruitment moratorium.

There was an organisational safety statement which outlined health and safety hazards including:

- Drafts at the front door
- aggressive behaviour/physical violence
- manual handling
- fire

Each identified hazard in the safety statement had been assessed in accordance with an outline of whether it was a low risk, medium risk or high risk. There were controls in place to manage the identified hazards. In some cases there was a need for additional controls, for example not all staff had received fire training.

There was an evacuation plan which identified how residents and visitors were to exit the building in the event of an emergency. There was also emergency plan which included instructions for staff in relation to issues including fire, power outage and a bomb threat. There was a personal emergency evacuation plan available for each resident which identified the supports required by each resident, their nearest exit and a detailed plan of evacuation.

In relation to the management of infection there had been three reported incidents of an outbreak of an infectious disease. In relation to the management of these outbreaks there was evidence that appropriate infection control plans had been put in place to prevent the spread of the infection. There was an infection control policy. Hand washing facilities were located in the main entrance lobby, and wall mounted alcohol hand gel was available throughout the centre. Household staff were knowledgeable in the area of infection control.

Judgment:

Non Compliant – Moderate

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 inspector was satisfied that each resident was protected by the designated centre's policies and procedures for medication management. There was a medication policy which guided practice and administration practices were observed to be of a satisfactory standard. Nursing staff were familiar with the arrangements around accepting delivery and appropriate storage requirements were fully implemented. The inspector viewed completed prescription and administration records and saw that they were in line with best practice guidelines.

Written evidence was available that regular reviews were carried out. There was a good GP service to the centre and all residents automatically came under this 'medical officer's' care on admission. However, this practice was not in line with Regulation 6 (2) (a) of the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013 which requires that residents are offered a choice of GP. This will be addressed under outcome 11: Health and Social Care Needs.

Medications that required strict control measures were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of all controlled drugs. The inspector confirmed that the stock balance was checked and signed by two nurses at the change of each shift. There were appropriate procedures for the handling and disposal of unused and out of date medicines. A system was in place for reviewing and monitoring safe medication management practices. Inspectors saw that a medication management audit had been completed in April 2014. Staff told inspectors that the pharmacist would visit to check stock control but would not see residents.

Judgment:

Substantially Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

It is a requirement that all serious adverse incidents are reported to the Authority. A specific incident relating to an allegation of inappropriate staff conduct was outlined during the inspection. However documentation relating to this allegation had not been submitted to the Authority.

It is also a requirement of the regulations that the Authority is notified at quarterly intervals of the occurrence of any occasion when restraint was used. This provision had not been complied with as the Authority was not being informed of occasions when bedrails or other methods of restraint had been used.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The inspectors were satisfied that residents healthcare needs were met to a good standard. Residents had access to GP services and a full range of other services was available on referral including speech and language therapy (SALT) and dietetic services. Chiropody, dental and optical services were also provided. However, inspectors observed that residents were not afforded a choice of GP as all residents automatically came under a 'medical officer's' care on admission which is not in accordance with the Regulations.

Systems for monitoring the exchange and receipt of relevant information when residents were transferred to or returned from another healthcare setting were in place. Medical records reviewed indicated that residents had access to equitable and timely medical reviews and treatment. However, inspectors observed in a sample of care plans reviewed that there was not a nursing record of the person's health and condition and treatment given, completed on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines. This is actioned under Outcome 5.

The arrangements to meet residents' assessed needs were set out in individual care plans. Recognised assessment tools were used to determine levels of dependency and care needs, and to assess levels of risk for deterioration, for example vulnerability to falls, nutritional care, and the risk of developing pressure ulcers and moving and handling assessments. There was good supervision of residents in communal areas and good staff levels to ensure resident safety was maintained. There was an adequate policy in place on falls prevention to guide staff. Questionnaires received by the Authority also indicated that there was good supervision of residents.

The inspector reviewed the records of residents at risk of skin breakdown, assessed as being at risk of pressure ulcers and noted that there were adequate records of assessment and appropriate care plans in place to monitor care. An evidence-based policy was in place which was used to guide the practice of nursing and care staff. Staff spoken to were knowledgeable of the strategies to be taken to prevent pressure ulcers, and appropriate pressure reducing strategies and care was in place for residents assessed as at risk, records of re-positioning and pressure relieving devices were found to be accurate and evidence based.

The inspector found that there was an emphasis on minimising the use of restraint, and implementing alternatives. Training had been provided to staff on the use of restraint. Risk assessments were completed and kept updated for the use of bed rails. There was evidence of alternatives available and alternatives were documented in all records reviewed. Documentation reviewed showed consultation with the resident or the resident's relative, the general practitioner and the nurse in charge.

Residents were seen enjoying various activities during inspection. A range of activities took place each day and there was a timetable of activities posted on the notice boards on each unit. The activity programmes in each unit were facilitated by FÁS staff and there was also a volunteer group who provided a comprehensive activity programme based on each resident's individual needs. Residents told an inspector that they enjoyed partaking in activities.

Overall care plans contained the required information to guide the care for residents. Residents and/or relatives were involved in the development of their care plans as observed by inspectors.

Judgment:

Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

St John's Community Hospital is a purpose-built single-storey building, which provides services for 116 residents. The premises is set in a large health campus, which also provides a day centre for older people and a range of mental health service facilities, some of which are currently under construction. According to the statement of purpose, St John's Community Hospital aims to provide person-centred care for members of the older population of Co Wexford. Residential accommodation is divided into four wards.

Oak Ward provides residential accommodation for 32 male and female residents and Elm provides accommodation for 32 male and female residents. Both wards were built to the same design. Residential accommodation in each consists of seven four-bedded rooms, one two-bedded room and two single bedrooms. Each of the rooms has en suite facilities with shower, toilet and wash-hand basin. Each of the bedrooms is equipped with ceiling track hoists. Communal facilities in each ward include a sitting room and dining room. Each ward has an assisted bathroom with a bath, a shower, a toilet and a wash-hand basin. There is also a separate toilet in each for residents. Each ward has a nursing station, a clinical nurse manager (CNM) office, a treatment room, a linen room, a housekeeper's room, a sluice room, a number of storage rooms and a relative's room, which has a reclining chair and en suite facilities including a shower, a toilet and wash-hand basin. A kitchen is shared between the wards.

Ivy ward is a dedicated 20-bedded dementia care unit for male and female residents. Residential accommodation includes eight single bedrooms and three four-bedded rooms. Each of the rooms has en suite facilities with shower, toilet and wash-hand basin. There is an assisted bathroom with a bath, a shower, a toilet and a wash-hand basin. There are three toilets, one for staff use only. There is a sitting room, a dining room and an activities room. There is a nursing station, a CNM office, a treatment room, a linen room, a launderette, a housekeeper's room, a sluice room, a number of storage rooms and a kitchen.

Beech ward is a 32-bedded ward which provides continuing care to 12 residents and rehabilitation services to 20 residents. Residential accommodation consists of seven four-bedded rooms, one two-bedded room and two single bedrooms. Each of the rooms has en suite facilities with shower, toilet and wash-hand basin. There is an assisted bathroom with a bath, a shower, a toilet and a wash-hand basin. There is also a separate toilet for residents. There are two sitting rooms, a dining room and an activity room. There is a nursing station, a CNM office, a clinical room, a kitchen, a linen room, a housekeepers' room, a sluice room and a number of storage rooms.

Other facilities include an oratory, a smoking room, administration offices, and staff changing facilities, a staff canteen, the central kitchen, a staff library, and the main reception area. Occupational therapy and physiotherapy offices and treatment facilities are provided for residents in the rehabilitation service and for outpatients. However, in the action plan generated from the monitoring compliance inspection of 2013 inspectors

requested that an additional review of the premises and facilities by the provider was required. This action plan was generated in order to meet the Authority's Standards in 2015, to reduce multiple-occupancy rooms including twenty four four-bedded rooms where no formal plans are in place to address and implement the Authority's Standards. The provider at that time indicated that a plan had been sought from Estates in the HSE.

To date the Authority has not been informed of any proposed plans to reduce the number of multi occupancy rooms. There are three enclosed, secure gardens which are accessible to residents and provide some shelter and seating. One of these was for the sole use of residents and visitors in the dementia unit.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The complaint's policy was in place and the inspectors noted that it met the requirements of the Regulations. The complaints procedure in leaflet format was on display in the units. There was evidence from records and interviews that complaints were managed in accordance with the HSE "Your Service Your Say" policy. Issues recorded were found to be resolved locally at unit level or formally by the complaints officer as appropriate.

An appropriate record was maintained at ward level. Residents who spoke with the inspector knew the procedure if they wished to make a complaint. Questionnaires reviewed by the inspector indicated that residents and relatives found that the management and staff were approachable if they had a complaint. However, in one unit inspectors observed that the outcome of the complaint was not recorded as being resolved and there was not any recording of whether the complainant was satisfied or not.

Judgment:

Substantially Compliant

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

At the time of inspection the inspectors were informed that there were no residents receiving end-of-life care. A thematic inspection had taken place in 2014 and two actions identified remain outstanding. The inspector reviewed the centre's policy on end-of-life care and noted that the policy was up to date and comprehensive. It provided good guidance on the management of the period prior to death and the care of the body. It outlined procedures for end of life care and provided guidance for staff on care planning for end of life and how to provide support to relatives.

There were guidelines available on do not attempt resuscitation which outlined that if a decision was made to restrict the nature or extent of cardiopulmonary resuscitation (CPR) it must be clearly documented as to the reason why provision of CPR would be detrimental to the resident. While some care plans seen by the inspector had recorded discussions around CPR with the resident and their family, not all were in accordance with the guidelines. One care plan outlined that the resident was not for CPR but there was no evidence of a reason for this or any indication of a discussion with the resident.

There was a policy on consent however; inspectors were unclear of the process used to obtain a valid consent in accordance with legislation and current best practice guidelines.

There was a large oratory with religious services being held regularly. Following a resident's death there was an end of life care box available which included sheets, candles and oils. Tastefully decorated hold-all bags were available for the return of a resident's property to family. There was an end of life committee in place and inspectors saw that following the death of a resident a letter of condolence was to be sent to the family with a memorial service being held one month later.

Care plans were found to reference the religious needs, social and spiritual needs of the resident. While care needs were identified on admission and documented accordingly there was limited evidence in some units of any advance planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell.

Staff told inspectors that residents had very good access to the specialist palliative care

services. This was a nurse led service which provided onsite visits to residents and also advice via telephone. There was good access to medical services as evidenced by the medical and nursing records. Documentation such as care plans reviewed by the inspector indicated that symptom control was effective for residents to ensure adequate pain relief and comfort.

Inspectors saw that single en-suite rooms were made available for residents at end of life. If any resident was at end of life discrete symbols were placed on the door with the purpose of creating a culture of calmness on the ward where the symbol was displayed. Two units had designated end of life care rooms. Staff were currently receiving end of life care training through the Gold Standard framework.

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:

There was a nutrition committee which included nursing staff, catering staff and dieticians from St John's and two other centres. This committee had responsibility to oversee nutritional care for residents. There was a policy on nutritional status and hydration care. This policy was supported by a range of specific policies on nutrition and hydration including guidelines for:

- The use of malnutrition universal screening tool (MUST) assessment
- use of oral nutrition supplements
- therapeutic diets.

On admission each resident had an assessment of eating and drinking recorded in their biographical information. This assessment informed the nursing care plan around the activity of eating and drinking. The care plans seen by the inspector had been updated at least every four months. If there was any change in the meantime the care plans were updated and recorded as "variances". There were good working relationships with specialist services such as the dietician and speech and language therapist. The inspector observed referrals for consultation to these services and from the records reviewed there was a timely response with assessments undertaken. There was access to fluids and snacks throughout the day and tea trolleys were seen in circulation. Inspectors observed that breakfast and lunch was served at suitable times for residents.

Residents could choose to attend the dining area or stay in their rooms if they so wished.

Access to diagnostic services was through the local hospital or outpatient department. Residents also had access to dental services as observed by the inspector. A sample of medication administration charts were reviewed by the inspector. These indicated that nutritional supplements were prescribed by the GP and administered by nursing staff accordingly. The catering department were responsible for the preparation of 1100 meals per day. This included not just St John's but a number of other centres in the community. There was a four weekly menu and while the inspector observed a choice of at least three meals available at lunch. However, some residents said that the choice was limited and some were not keen on the food. The menu plan had been developed in conjunction with the dietician to ensure adequate nutritional value. There was a residents' council with food as a standing agenda item as observed by inspectors. The person in charge said that she endeavoured to take any complaints in relation to food on board and would always meet with the catering manager in relation to any dissatisfaction with food.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors saw evidence that residents were consulted about how the centre was planned and run. There was a residents' committee which met regularly and residents who spoke with inspectors outlined that they would feel comfortable to raise any issues or concerns they had at this meeting or with the staff at any time. There was also a suggestions/comments box at reception if any resident, relative or staff member wanted to make any suggestions or comments.

Newspapers were available on request as observed by inspectors. There was an open visiting policy in the centre and residents confirmed that relatives were made to feel welcome in the centre. Inspectors saw many visitors coming and going during inspection. Inspectors saw that residents had access to daily entertainment and leisure facilities such TV, radio, newspapers and magazines.

There were notice boards available providing information to residents and visitors. Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities. Residents were facilitated to exercise their political and religious rights.

Inspectors observed staff interacting with residents in an appropriate and respectful manner. Many residents told inspectors that they were happy because all the staff were very kind.

Inspectors also observed that some care practices were not personalised. Inspectors observed that arrangements were not in place at all times to ensure that the resident's privacy, dignity and modesty were respected with particular regard to personal care giving. In shared wards there was adequate screening in place and each ward had an en suite bathroom. However, inspectors observed that each resident was not facilitated to use the bathroom, some residents were given commodes by their bedside even when the bathroom was empty. These care practices do not ensure a person centered approach to care nor do they maintain privacy and dignity for residents.

Judgment:

Non Compliant - Moderate

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy on resident's personal property and possessions. The inspectors saw that there was adequate space provided for residents' personal possessions and they had a locked facility in their bedrooms. There were arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Residents expressed satisfaction with the laundry service provided. There were procedures in place for the safe segregation of clothing to comply with infection control guidelines. Inspectors spoke with a staff member working in the laundry who was knowledgeable on infection control practices

Judgment:

Compliant

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

From an examination of the staff duty rota, communication with residents and staff the inspectors found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents. In discussions with staff, they confirmed that they were supported to carry out their work by the provider and person in charge. The inspectors found them to be confident, well informed and knowledgeable of their roles, responsibilities and the standards regarding residential care.

The inspectors examined the staff duty rota for a two week period on a ward. This described the staff complement on duty over each 24-hour period. The inspector noted that the planned staff rota matched the staffing levels on duty.

There was a clear organisational structure and reporting relationships in place. There were designated CNM posts of responsibility on each ward for the supervision of care and services to residents and the supervision and direction of staff. The inspector saw records of regular meetings between these post holders and senior nursing management at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the regulations and standards.

A staff training matrix was in place and the inspectors saw, based on the records reviewed, that staff had completed recent education and training such as health and safety, nutrition and the older person, basic life support and end of life care. However, as outlined under Outcome 8 not all mandatory training such as fire training and elder abuse was up to date. Inspectors observed that there was no formal support and supervision available for staff which would identify training needs of individual staff members.

There was a national HSE policy for the recruitment, selection and Garda Síochána vetting of staff. The current registration details were maintained for all nursing staff. An inspector viewed a sample of four personnel files. The files contained all the documentation required under Schedule 2 of the Regulations.

There were volunteers working in the centre at the time of inspection. Inspectors spoke with the supervisor of the volunteer group and found that all were supervised, recruited and vetted in accordance with best practice

Judgment:

Substantially Compliant

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:

Ide Batan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St John's Community Hospital
Centre ID:	OSV-0000604
Date of inspection:	01/04/2015
Date of response:	14/05/2015

Requirements

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

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

Outcome 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:

On a unit there was not a nursing record of the person's health and condition and treatment given, completed on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in

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

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:

This issue was addressed immediately and documentation is been completed in accordance with Schedule

Proposed Timescale: 07/04/2015

Theme:

Governance, Leadership and Management

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

Information governance required improvement. Inspectors saw that personal and sensitive information regarding residents was on public display on a notice board in a unit.

Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

This Notice board was removed from public display

Proposed Timescale: 14/04/2015

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:

Inspectors observed that not all staff had received training in elder abuse which is a requirement of legislation.

Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Training has been completed and there are 100% trained

Proposed Timescale: 14/05/2015

Theme:

Safe care and support

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

Inspectors saw that records maintained of money deposited by a resident/relative for safekeeping were not sufficiently robust. Inspectors saw that money was stored in a safe and transactions were not co signed and witnessed by resident/relative and staff members which did not safeguard residents or staff.

Action Required:

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

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

A system has been put into place to ensure compliance and guideline has been developed and displayed in the unit to ensure staff maintain compliance

Proposed Timescale: 08/05/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Ensure that all staff receive fire training.

Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Further fire training has been organised to ensure that all staff have completed their annual fire training

Proposed Timescale: 22/05/2015

Theme:

Safe care and support

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

Inspectors saw that the fire register was incomplete as the daily checks on the fire panel, the weekly checks on fire extinguishers had not been filled in on a number of dates.

Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

A system has been put in place to ensure compliance

Proposed Timescale: 20/04/2015

Outcome 09: Medication Management

Theme:

Safe care and support

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

Inspectors observed that residents were not afforded a choice of pharmacist as required by the regulations.

Action Required:

Under Regulation 29(1) you are required to: Make available to the resident a pharmacist of the resident's choice or who is acceptable to the resident.

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

A system has commenced whereby residents will be given a choice of Pharmacist

Proposed Timescale: 30/04/2015

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

The Authority had not been notified of a specific incident in relation to staff misconduct.

Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

All incidents of staff misconduct will be notified going forward

Proposed Timescale: 02/04/2015

Theme:

Safe care and support

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

The Authority had not been notified at quarterly intervals of the occurrence of any occasion when restraint was used.

Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

In place and will be completed on quarterly basis ongoing.

Proposed Timescale: 30/04/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Inspectors observed that residents were not afforded a choice of GP as all residents automatically came under a 'medical officer's' care on admission which is not in accordance with the Regulations.

Action Required:

Under Regulation 06(2)(a) you are required to: Make available to a resident a medical practitioner chosen by or acceptable to that resident.

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

Residents will be given choice to use their own GP if possible

Proposed Timescale: 05/05/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The majority of residents were accommodated in four-bedded rooms.

Action Required:

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

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

Plan has been developed to ensure compliance and has been progressed to HSE Estates nationally

Proposed Timescale: 30/04/2015

Outcome 13: Complaints procedures**Theme:**

Person-centred care and support

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

In one unit inspectors observed that the outcome of the complaint was not recorded as being resolved and there was not any recording of whether the complainant was satisfied or not.

Action Required:

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

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

The action was completed immediately and system in place to ensure compliance with Regulation 34(1)(f)

Proposed Timescale: 30/04/2015

Outcome 14: End of Life Care**Theme:**

Person-centred care and support

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

While care needs were identified on admission and documented accordingly there was limited evidence in a unit of any advance planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell

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 Gold standard for end of life is being rolled and this will ensure compliance with Regulation 13(1) Training will be completed in total on the 30 June 2015.

Proposed Timescale: 30/06/2015

Theme:

Person-centred care and support

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

Inspectors observed that a care plan outlined that the resident was not for recuscitation but there was no evidence of a reason for this or any indication of a discussion with the resident. There was a policy on consent however; inspectors were unclear of the process used to obtain a valid consent in accordance with legislation and current best practice guidelines.

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 Gold standard for end of life is been rolled and this will ensure compliance with Regulation 13(1)

Proposed Timescale: 30/06/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Inspectors observed that arrangements were not in place at all times to ensure that the resident's privacy, dignity and modesty were respected with particular regard to personal care giving.

Action Required:

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

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

A review is been untaken to ensure that all residents are afforded dignity and privacy undertaking personal activities

Proposed Timescale: 14/05/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Inspectors observed that there was no formal support and supervision available for staff which would identify training needs of individual staff members.

Action Required:

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

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

Performance appraisal system to be commenced for all grades of staff which will identify training needs of individual staff members

Proposed Timescale: 30/08/2015