

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St John's House
Centre ID:	OSV-0000101
Centre address:	202 Merrion Road, Ballsbridge, Dublin 4.
Telephone number:	01 269 2213
Email address:	admin@stjohnshouse.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	St Johns House of Rest
Provider Nominee:	Graham Richards
Lead inspector:	Nuala Rafferty
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	37
Number of vacancies on the date of inspection:	8

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 September 2017 08:00	25 September 2017 17:00
26 September 2017 08:00	26 September 2017 16:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was an unannounced monitoring inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to follow up on matters arising from the last inspection and to monitor progress on the actions required. Progress was found in all four actions from the last inspection. The inspection also considered unsolicited information received, notifications forwarded by the provider and other relevant information.

Over the two days, the inspector met and spoke with residents, administration, catering and care staff, clinical nurse managers and the person in charge. The views of residents and staff were listened to, practices were observed and documentation was reviewed.

The center was clean and well maintained in the areas inspected. Residents' rooms were personalised and those viewed were suitably equipped to meet their individual needs. At the time of this inspection, a large extension to the premises was in progress in order to meet the requirements of the Care and Welfare Regulations 2013 (as amended) and the National Standards for Residential Care settings for Older People in Ireland 2016. The inspector was told that the expected date for completion and sign off for the new building was 31 January 2018. The inspector was subsequently informed that this date relates to Phase 1 of the new build with Phase 2 to be completed in the latter half of 2018

Feedback from residents and their relatives on the level of consultation with them and access to meaningful activities was generally positive, although some relatives said that they were not informed of progress on the new build. All those spoken with praised the staff for the cheerful and respectful manner in which they delivered care. Residents said staff were quick to respond to their call bells and regularly enquired if they were needed anything.

However, improvements to the governance and operational management systems were required. The inspector found these were not effective enough to ensure the delivery of safe and suitable care to meet the full needs of all residents. It was also found that approved operational fire safety management policies were not fully implemented in practice.

The Action Plan at the end of this report identifies where improvements are required to comply 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.

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 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):

Findings:

A written statement of purpose was available that broadly described the service provided in the centre and contained all of the information required by Schedule 1 of the Regulations.

Copies of the document were available in the centre.

Some amendments to the document were required, to reflect recent changes to the layout of the centre and to the purpose and function of some rooms in the centre. These amendments were to be consistent with the existing floor plans of the centre. The inspector was given assurances that these amendments would be made and copies of revised floor plans and the statement of purpose would be forwarded. These have been received by the Authority.

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 governance systems in the centre were fully reviewed on the last inspection and found to be compliant. The governance structure and the management systems remained unchanged. These included regular management team meetings to review all aspects of service delivery. Auditing processes to review clinical care practice and promote improved outcomes for residents were ongoing.

However, the governance and management systems were not effective enough to ensure the delivery of safe and suitable care to residents. The inspector found that the operational management arrangements did not include appropriate, consistent and effective monitoring of staff to ensure oversight of the standard of care delivered to residents on a continuous basis. In particular, there was a lack of oversight that led to some institutional practices and a lowering of care standards.

Evidence that the hygiene and personal care needs of all residents were met, in line with their care plans, on the days of inspection, or over the previous weekend, was not available and assurances could not be provided by the nurse management team.

Approved operational fire safety management policies were not fully implemented in practice, to ensure resident and staff safety, identify and manage risks, or become competent in evacuation procedures.

An annual review of the safety and quality of care delivered in the centre for 2016, as required by the regulations was completed. The report identified quality care indicators to indicate the standard of and safety and quality of service being delivered. It included a quality improvement plan for 2017. However, the report did not identify whether this review was prepared in consultation with residents or their families.

Judgment:

Non Compliant - Moderate

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:

Each resident had a written contract of care signed in agreement with the provider which clearly stated the regular fee payable, the resident's contribution and the services to be provided under that fee. The contract also outlined the terms of residency, whether the room to be occupied was a single or shared room.

A guide to the centre was also available to all residents. This described the centre services, management, complaints procedure, and contact information for useful external bodies. However, the guide had not been updated since 2014 and the

information in the guide had not been updated to reflect changes to management, independent appeals or complaints procedures.

Judgment:

Substantially Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The centre was managed by a suitably qualified and experienced nurse who held authority, accountability and responsibility for the provision of the service. Through an assessment process it was noted that there was daily engagement in the governance, operational management and administration of the centre. The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions.

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):

Findings:

The centre maintained a suite of policies including those required under Schedule 5 of the regulations. Policies were reviewed on a regular basis and within the three year timeframe required by the regulations. General records, as required under Schedule 4, including fire drills, food records and notifications were also in place.

However, evidence that all policies were reflected in practice or were fully implemented was not found. Practice did not reflect policies in place related to the provision of information to residents; these findings are included under outcome 16 of this report and fire safety management policies which are included under outcome 8 of this report.

A directory of resident was maintained on the computerised system, due to external server difficulties during the inspection, the inspector was unable to review this record.

Documentation of testing and servicing of fire safety equipment and assistive technology for residents such as hoists and specialised chairs was viewed.

The centre kept a log book of visitors coming and going from the centre.

All records required under Schedule 3 of the Regulations were also maintained in the centre. These included staff rosters, accident and incidents, personal care, and nursing and medical records. However, improvements were required to the systems in place to record care interventions to ensure they were timely, accurate and sufficiently detailed. The full implementation of care plans and the recommendations of consultants, General Practitioner's and other health professionals are reliant on the accuracy and timely recording of care interventions such as monitoring of weight and food and fluid intake and output. These records also provide important information on the standard of care being delivered to residents and help direct improvements to the quality and safety of future care for residents.

Care provided to residents by staff, such as assistance with washing and dressing, intake of food and fluids, re-positioning and assistance with toileting, was recorded on an electronic touch screen system. The inspector reviewed a sample of care records at 4pm on the first day of inspection. The inspector found that none of the care interventions that were required to be delivered to four residents were recorded. For a number of other residents, only some of the care delivered was recorded, but it was noted that this was recorded in the afternoon, when all of the care delivered was inputted into the record at the same time. This meant that staff were not recording the interventions provided in a timely manner, but had to try to remember, in detail, care delivered over a period of several hours, to several residents.

The inspector had concerns for the accuracy of the care records, in particular where the records showed that interventions such as re-positioning were being recorded up to 12 hours after the time the intervention was due. The inspector also noted that personal care interventions for showers or washing and dressing were not recorded for a number of residents over the previous weekend.

Judgment:

Non Compliant - Moderate

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:

Promotion of a restraint free environment was maintained with bed rails in use for only one resident at the time of inspection. The inspector observed a high use of alternative measures such as ultra low beds; crash mats and mattress alarm systems. These alternatives combined with staff vigilance provided an effective alternative to falls management and resident safety.

Staff had received training on the prevention of elder abuse and all staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Procedures to protect residents, such as a robust recruitment system, staff induction and training were also in place and implemented.

In conversations with them, residents told the inspector that they felt safe and secure in the centre and relatives also confirmed that they did not have any concerns for the safety of their loved ones.

The inspectors reviewed the system in place to manage residents' money and found that reasonable measures were in place and implemented to ensure resident's finances were fully safeguarded. The provider was the nominated pension agent for a small number of residents and the inspector noted that some improvements to the systems in place were required to ensure transparency and security. It was found that guidance published by HIQA and available to all providers on the resource section of HIQA's website was not being followed. An interest bearing bank account, separate to the business account for the designated centre, was not established for residents personal funds. Residents were not facilitated to receive regular bank statements on the status of their financial position.

However, an internal computerised recording system was in place. The inspector found that there were robust checking procedures, implemented by the administration manager, to monitor transactions on residents' finances.

Systems were also in place to assist some residents to safeguard small sums of money. The inspector reviewed the system and found all monies given in for safekeeping and subsequently withdrawn, were recorded and signed by two persons. Receipts for purchases were retained. Copies of the computerised account balance with details of transactions were given to residents on a regular basis and on request.

Judgment:

Substantially Compliant

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:

The inspector reviewed the fire safety management practices in place, including some aspects of the physical fire safety features of the building. Records for maintenance, fire safety training of staff and policies and procedures relating to fire safety were also viewed.

Emergency lighting and fire-fighting equipment, and directional signage were available throughout the building. The internal and external premises and grounds of the centre appeared safe and secure, with locks installed on all exterior doors. A health and safety statement and related policies and procedures were in place. Risk registers were also in place. These included clinical risks, health and safety and fire risk registers.

A revised floor plan, that identified changes to the internal layout of the building and to designated fire exits, was displayed at various locations, on each floor. A revised fire procedure was also displayed.

Personal emergency exit plans (PEEPs) which identified the level of mobility and evacuation mode of each resident were in place for residents, but, all full-time staff were not aware or familiar with them. Staff were not provided with regular opportunities to become competent in evacuation procedures, and potential problems or hazards were not identified. This was evidenced by speaking to staff and documentation reviewed.

A fire safety management procedure and fire safety information policy was in use in the centre, however, the procedure or policy was not fully implemented in that:

- Regular practiced fire drills that included simulation of an actual evacuation to determine the competency of staff to evacuate residents in a timely manner were not being conducted. On review of the fire records and in conversation with the designated fire marshall and in-house fire instructor, the inspector found that, practiced drills to simulate evacuations, had not been conducted throughout 2016 or 2017 to date. There was a high turnover of staff during the year in the centre. A number of new staff were on duty during the inspection. Those spoken with, although familiar with the principles of horizontal and vertical evacuation, were not familiar with the use of evacuation aids.
- Training or instruction on the fire safety procedures in place, and familiarisation with the layout of the building including emergency exits, fire fighting equipment, location of fire alarm panel, or residents personal emergency exit plans was not provided to agency staff who were working in the centre during the days of inspection.
- The inspector was told that the nurse in charge on the ground floor takes control of any emergency event, irrespective of whether they are the most senior person on duty or not. However, not all staff were aware of this, and staff responses were inconsistent, when asked who they would go to for direction in the event of a fire emergency.

Staff were observed moving residents' in wheelchairs from one location to another throughout the days of inspection. The inspector saw that several wheelchairs did not

have footrests attached and residents' feet were dragging on the ground. This posed a serious risk of injury to residents, in particular where residents were being wheeled backwards or when changing direction.

Moving and handling practices involving the use of hoists was not observed on this inspection, although the inspector did observe good guidance provided to residents using assistive walking frames. Supervision systems were in place to monitor residents at risk of falls, wandering or negative interactions.

Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place

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:

Written operational policies were in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents.

Medicines were supplied to the centre by a retail pharmacy business in an individual monitored dosage system. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

Nursing staff were observed administering medicines to residents during the morning administration rounds. The administration practice was in line with current professional guidance, although the duration of the morning medication was considerably outside the recommended timeframe of one hour. The inspector observed it took up to two hours for nurses to complete the administration. However, the inspector acknowledged that this was due primarily because:

- the nurses were recording the administration on two different records to facilitate the changeover of prescription processes from hard copy to computerised software.
- the nurses on duty were relatively new to the centre and were only becoming familiar with processes and with residents.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

A small number of improvements to care planning were required from the last inspection. These included more details to guide staff on managing residents' needs and ensuring a care plan was in place for every need identified. These were addressed on this inspection.

Residents had access to medical care, an out of hours services and a full range of other services available on referral, including occupational therapy, speech and language therapy, dietician, chiropody, dental services and optical services. Evidence of referral and review were available and viewed. The inspector found that residents' healthcare needs were met through a good standard of nursing care and allied health professional monitoring.

Systems were in place for the assessment planning implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. The inspector viewed a small sample of clinical documentation and medical records. The clinical records are computerised and the server system was not accessible on the second day of inspection to enable a more complete review. The systems in place to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents' health were implemented by the nursing team. In the small sample of care plans viewed, they were detailed enough to guide staff, on the appropriate use of interventions to manage the identified need. Efforts to plan and deliver care in a person centred manner were noted.

The inspector noted that the standard of nursing documentation was co-ordinated sufficiently to provide a clear picture of residents overall condition.

However, the findings of this inspection as detailed under outcomes 8 health & safety and risk management, and outcome 16 right's dignity and consultation, reflects evidence, that a high standard of safe and suitable care was not being provided to residents, in accordance with their care plans, in respect of:

- Unsafe transfer of residents' in wheelchairs.
- Evidence was not available, that residents' personal care needs were being met in terms of hygiene, repositioning or at meal times.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

The centre was found to be well maintained, warm, comfortably and tastefully furnished and visually clean. All walkways were clear and uncluttered to ensure resident safety when mobilising. Grab rails and hand rails were installed where required. There was a functioning call bell system in place within the centre, and assistive equipment was in working order with service records available.

Communal facilities were available on the ground floor including two small bright sitting rooms, with access to a sunny patio room and garden, a large dining room and visitors room

All of the bedrooms were personalised to reflect residents' individual wishes with pictures photographs and mementos.

However, aspects of the premises required improvements in order to meet the requirements of the Care and Welfare Regulations 2013 (as amended) and the National Standards for Residential Care settings for Older People in Ireland 2016.

At the time of this inspection, a large extension to the premises was in progress in order to fulfil these requirements. The inspector was told that the expected date for completion and sign off for the new building was 31 January 2018. It was hoped that the new building would be commissioned and residents would transfer over by the end of February 2018. The impact of the current facilities is reflected in outcome 16 of this report.

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

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:

Actions from the last inspection were required to improve the standard of the breakfasts. These were partially addressed. The inspector found that the variety of breakfast options available to residents had improved with hot breakfast options available on a daily basis. On both days of inspection the inspector observed full cooked breakfasts or variations of the full cooked breakfast options such as sausage, bacon, boiled or scrambled egg being provided to several residents.

In conversation with care and catering staff, and on observation, the inspector found that measures were being implemented, to improve the service of breakfasts, to ensure they reached the resident at the optimal temperature. These measures included: individual tray service with teapot of tea per resident. All crockery pre-warmed for hot food options. Staggered tray service with no more than four trays to be served at one time on each floor. Hot breakfasts maintained under halogen heat lights in main kitchen, to maintain temperature until sent up to resident on tray.

However, despite the implementation of these measures, the inspector found that some breakfasts were still going cold before reaching the resident. On observation of service on the first floor the inspector observed a trolley with six breakfast trays sitting for over 15 minutes before being brought to the resident. Each tray contained one or more hot food option, such as porridge or scrambled egg.

The inspector found that other aspects of the management of residents' nutrition were appropriate.

Residents were provided with food and drink at times and in quantities adequate for their needs. A three week rolling menu was in place to offer a variety of meals to residents.

Assistance was observed and was offered to residents in a discreet, patient and sensitive manner by all staff.

Most residents took their meals in the dining room and tables were appropriately set with cutlery condiments and napkins. Residents spoken with all agreed that the food provided was always tasty hot and appetising. The main kitchen was located beside the dining room. Food was served directly from there by a team of staff and was well presented. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. Residents on modified consistency diets also received the same choice of menu options as others. Drinks such as water, milk, tea and coffee and fresh drinking water at all times were available. Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and there was a system in place to monitor the intake of residents

identified as at risk of malnutrition.

Judgment:

Substantially 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:

Systems to consult with residents were established and resident meetings were scheduled on a quarterly basis. A residents committee was also established. Records of the meetings were viewed and showed that the most recent meeting was held in August 2017. However, this was the first meeting held since September 2016. The inspector was told this was due to a variety of reasons, including the new build project. The meetings were chaired by a volunteer staff member.

Access to advocacy services was available and contact details for advocacy services were displayed.

In general, appropriate and respectful interactions were observed throughout the day. Staff respected residents' dignity and choice during care interventions and in their daily routine. Residents' personal choice for rising and returning to bed was respected with many residents choosing to remain in bed until late morning or early afternoon.

However, some institutional type care practices were found that did not respect residents' rights or dignity. These included:

- Commodes not being emptied or removed from some residents' bedrooms prior to breakfast being served.

- The inspector saw that staff were providing assistance to residents to meet their hygiene needs and residents looked well groomed and dressed. However, as referenced under outcome 5 documentation, evidence that all residents' hygiene and personal care needs were met, on a daily basis, in accordance with their personal preferences or care plans was not available. It was noted that this was due, in part, to a lack of suitable shower facilities and equipment for residents, with limited physical ability, to maintain an upright sitting position.

An activities programme was in place delivered by an activities coordinator each day. It included a mix of activities, intended to stimulate residents both physically and mentally, such as: arts and crafts, cards, exercise sessions, dog therapy, music and baking.

Dementia relevant activities were also included in the programme such as reminiscence. All activities took place in the ground floor sitting room. A review of the activity programme in addition to updates on information gathered in the form of residents' life stories was in progress, in order to include purposeful activities linked to their former interests or lifestyles.

Feedback from residents and their relatives on the level of consultation with them and access to meaningful activities was generally positive. Some relatives said that they were not informed of progress on the new build and the inspector found that a relatives forum for information or feedback on the service provided was not established. All those spoken with praised the staff for the cheerful and respectful manner in which they delivered care. Residents said staff were quick to respond to their call bells and regularly enquired if they needed anything.

Judgment:

Non Compliant - Moderate

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:

A higher turnover of staff, with 11 staff leaving during 2017 resulted in a continuous reliance on agency staff on a weekly basis. Planned staffing levels were found to be adequate, but all shifts were not always filled. This was due to the unavailability of both regular and agency staff to provide cover for unexpected absences.

The management team had conducted a successful recruitment process to replace the staff and most vacancies were now filled. However, a reliance on agency staff to provide cover was still required for sick leave and the person in charge expected there would be further turnover of staff, for the foreseeable future, for a variety of reasons.

The level and skill mix of staff was not appropriate to meet the assessed needs of the residents. There was evidence of negative outcomes for residents due to the level of inexperienced staff on duty, and shifts were not always filled. There was a lack of sufficient supervision by the nursing and management team.

Care staff, working in the centre for approximately three months, were inducting and mentoring new staff. This was an ongoing practice. Evidence that the nurses and clinical managers were providing direction and guidance to ensure safe and appropriate delivery of care was not found. During the delivery of morning care, the inspector observed that all care staff worked together, either in pairs, or alone. The nurses were administering medications and were not supposed to be disturbed. Medications took up to two hours to complete.

The clinical nurse managers were busy trying to arrange cover for shifts not yet filled and arranging residents' reviews, referrals and appointments. The inspector found there was no oversight of the standard of care being delivered to residents and some poor practices were evident.

Staff communication systems were in place. Staff met at shift changeover times between day and night staff and also at midday to exchange of information on residents status. However, the level of information provided to staff did not take account of staff who were returning from days off. Also, staff that were new or agency staff were not given any additional information, to ensure they could meet residents needs in full and prevent risks associated with falls or poor intake.

All staff had received mandatory training in areas such as moving and handling and safeguarding. Good recruitment processes were in place including a Garda Síochána (police) vetting process.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Nuala Rafferty
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 House
Centre ID:	OSV-0000101
Date of inspection:	25/09/2017
Date of response:	15/11/2017

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The annual review of safety and quality of care did not include consultations with residents or their families.

1. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

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

- A Residents Advisory Council (RAC) meeting will be held 3 times per annum on the 3rd Thursday of the month - February, June and October. In 2018 the dates are February 15th, June 21st and October 18th at 3pm. These meetings will be attended by the Chairman, Director of Nursing, General Manager and members of the management Committee. The Residents will be represented by residents and family/resident representatives. The RAC exists for feedback, consultation and improvement on all matters affecting the residents. Issues raised by the RAC are acknowledged, responded to and recorded, including the actions taken in response to issues raised. Minutes of the meetings are displayed on the notice board. An additional meeting is due to be held on January 16th because of changes associated with the New building.
- A notice board for residents and relatives is in place and all minutes of meeting and the annual report are displayed.
- A newsletter will be available in December 2017.
- A meeting for relatives is due on the 23rd November to provide an update on the new building development.

Proposed Timescale: 31/01/2018

Theme:

Governance, Leadership and Management

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

Effective governance was not in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. In particular, there was a lack of oversight that lead to some institutional practices and falling standards of care.

2. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

- An extra clinical nurse will be rostered most mornings up to 14:00hrs to cover clinical supervision and assistance to the carers thus ensuring the standard of care and delivery of care is at the optimum level. When an extra nurse is unavailable one CNM is assigned to carry out this function. This ensures clinical care and practices are supervised by an extra nurse every day.
- Any deficits in care delivery are documented and escalated to the PIC and CNMs. These are utilised to identify corrective actions. The role of the additional nurse is to work directly on the floor with the carers and to ensure all care is documented as it occurs in a timely manner after it has been delivered and not hours later.
- The focus of supervision is not only the delivery of and quality of care but also the monitoring of the care environment. This is in place currently with one CNM assigned to this function. The additional nurse will be in place from the 15th November.

- A list of duties for the nurse in charge and the nurse covering the clinical supervision is complete. This is to give guidance to their specific role. It is perceived as they become increasingly competent this will be required less. This role will be consolidated further with education on clinical supervision at the end of November.
- A clinical round led by the CNM and in their absence the nurse in charge is currently carried out at 11:00hrs to review the delivery and documentation of care delivered.
- Additionally, we have developed documentation for the introduction of intentional rounding. This concept is used internationally, in the NHS and to a lesser degree in Ireland. It is a documented round of key areas of care every two hours around the clock and includes pain management, skin care, nutrition food, falls and other elements of care. It has been found to be significant in improving the delivery of care. We have added checks of the documentation of care and of the care environment.
- Change over from a dual system of recording medicines to a fully electronic system has commenced in one area and this had reduced the administration of medicines by one hour in the morning. This has also increased the time available for the delivery of clinical care by the nurses. This will be extended to all areas shortly after all nurses are deemed competent with use of the electronic system by the pharmacy and PIC. This will give 2 hours in total back to clinical practice.
- The use of Do Not Disturb red tabards for drug rounds has been discontinued because these create a barrier and prevent carers consulting with nurses about care issues while doing medicines rounds.
- The PIC and the CNMs review the documentation daily and implement corrective actions with the nurses and the carers.
- The documentation will be audited and quality improvement and corrective actions noted weekly.

Proposed Timescale: 30/11/2017

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The guide available to residents did not reflect the current service management procedures or facilities in the designated centre.

3. Action Required:

Under Regulation 20(2)(a) you are required to: Prepare a guide in respect of the designated centre which includes a summary of the services and facilities in the centre.

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

The Residents Guide will be amended to reflect the current service management procedures and facilities in St John's House. It will also give information about how to make a complaint and the complaints procedure, including referral to the Ombudsman.

Proposed Timescale: 31/01/2018

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:

Evidence that all policies were reflected in practice or were fully implemented was not found. Practice did not reflect policies in place related to the provision of information to residents and fire safety management policies.

The risk management policy was not fully implemented, in that, footrests were not attached to wheelchairs to prevent accidental risk of injury to residents during transit.

4. Action Required:

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

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

The implementation of these policies will be improved to take into consideration the information available and given to residents.

A notice board specifically for relatives and residents had been installed. Information will be displayed on this regularly to inform relatives and residents.

Information meetings about the new development have been scheduled for Thursday 23rd November 2017 at 17:30hrs. This is to advise residents and relatives about the move to the new building early next year.

A Newsletter will be issued.

The annual report will be prepared in consultation with residents and their families.

Fire Policy

We have a duty to take all reasonable precautions to guard against the outbreak of fire on the premises and to ensure the safety of all persons on the premises in the event of an outbreak of fire. We continue to engage an outside Safety Training Service Provider who ensures that Fire Safety within the nursing home is in compliance with the relevant legislation and the guidelines contained therein. The Fire Safety Register meets the specific requirements of the nursing home and is a means of recording information regarding fire safety management, such as inventories of fire protection equipment, servicing arrangements and schedules of fire protection equipment, fire drills, water supplies, training, testing and maintenance of equipment, copies of certification and all other information pertaining to compliance with the legislation. The Health & Safety Committee meets the first Tuesday monthly and is attended by the General Manager, Person in Charge, Property Services Manager, Administrator, Maintenance and Clinical and safety representatives. This committee reviews the Fire Register and all outcomes and actions are documented and recorded in the minutes. All staff receive Fire Safety Training, Fire Evacuation and Emergency Fire Fighting from an outside provider on an annual basis. All new staff receive Interim Fire Safety Training on induction, this training now includes a Fire Evacuation Drill. Annual training is provided by an outside provider and scheduled weekly training takes place weekly on Fridays at 11:30hrs by Clinical/Trained Personnel.

- a. A review is currently taking place of the implementation of policies, and actions required taken, by the Health & Safety Committee.
- b. The provision of Evacuation Drills and sign off of Staff competence form part of the review.
- c. Evacuation Training forms part of the weekly fire training.
- d. The evacuation training and induction training of all staff will change from using a tick on the records for evacuation to using a detailed schedule of what training was provided.

Wheelchairs

It is the practice that all residents will have their feet on footplates. If a resident refuses this detail will be recorded on their care plan so that all staff will be vigilant in transferring the particular resident.

- A hazard form for the risk management of wheelchairs is being prepared for the risk register.
- Staff have been instructed on the safe use of wheelchairs and of the risks to residents associated with misuse of same. Supervision of use of wheelchairs and footrests is carried out by all nurses.
- A carer has been identified on each shift as a marshal for good practice of wheelchair use.
- This is included in the risk register

Proposed Timescale: 31/01/2018

Theme:

Governance, Leadership and Management

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

The systems in place for the documentation of care interventions did not ensure that records were maintained in terms of accuracy, completeness or timeliness so as to ensure that care plans in place were appropriately and fully implemented.

5. 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:

- Two hourly checks of documentation on EPIC touch are carried out by the staff nurses to ensure timeliness and accuracy of recording.
- Nurses are also checking touch records to inform their daily reports
- New icons have been added for bed bath and out in hospital
- Training of all new staff has taken place on the use of EPIC touch.
- The importance of accurate and timely recording is repeated daily to all staff.
- Feedback to the CNMs and PIC occurs daily and the records are reviewed daily and a

review is carried out of practice weekly

- All deficits are identified and fed back to individual staff member responsible for recording same and to the nurse responsible for supervising practice.

Proposed Timescale: 15/11/2017

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:

An interest bearing bank account, separate to the business account for the designated centre, was not established for residents personal funds. Residents were not facilitated to receive regular bank statements on the status of their financial position.

6. 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:

An interest bearing account, separate to any business account for SJH is to be used exclusively for resident's personal use. Pensions received from the Department of Social Protection on behalf of certain residents are to be mandated into this account.

Proposed Timescale: 31/12/2017

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:

Training or instruction on the fire safety procedures in place was not provided to agency staff who were working in the centre during the days of inspection.

7. 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:

- The nurse in charge is responsible for instructing all new staff and agency staff about the fire evacuation, exits, location of fire panel, firefighting equipment, PEEPs, and procedure to follow in the event of the alarm being raised.

•This is recorded in the fire register and a separate sheet is kept for agency staff.

Proposed Timescale: 15/11/2017

Theme:

Safe care and support

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

Drill practices and documentation were insufficient to demonstrate that the arrangements for evacuation in the event of a fire, were fit for purpose.

8. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

- Staff receives Fire Training with the specialist company annually. This includes theory and practice, location of fire alarm points, use of extinguishers and fire evacuation equipment, conducting an evacuation and extinguishing burning clothes of a resident. All staff are certified competent at the end of this training having used all the equipment and carried out an evacuation.
- All staff participates in practice drills which take place every week on Friday at 11:30hrs. This includes use of the fire panel, walkie talkie, raising the alarm, breaking the break glass, and dealing with fire scenario where they identify the correct extinguisher for certain fires. Documentation of the details of the drill is recorded in the fire register.
- A full simulated evacuation using the evacuation equipment to exit the building takes place at least 6 monthly ensuring all staff members attend.
- A record of the practice undertaken by each person is recorded in the fire register and a matrix of training is also be kept.

Proposed Timescale: 15/11/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

A high standard of safe and suitable care was not being provided to residents in accordance with their care plans in respect of:

- unsafe transfer of residents' in wheelchairs.
- evidence that residents' personal care needs were being met was not available in terms of hygiene, repositioning or at meal times.

9. 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:

- All staff have been instructed to ensure each resident using a wheelchair has foot rests in place. Where this is not compatible for the resident, that resident is to be referred to the occupational therapist for seating assessment. The outcome of the assessment is recorded in the care plan and all staff are informed of the change at handover.
- Care staff can access the care plan on EPIC touch and are instructed to do so.
- Turns Charts are available on the bed to record regular turns and these are also recorded on EPIC touch when the care is delivered
- Supervision by nurses to ensure the care plan is implemented is carried out at least every two hours. These checks are to be documented on a new form for intentional rounding and will provide evidence that the actions have been carried out. These charts will be checked by the CNMs daily and appropriate actions taken.
- Gaps found in the accurate, timely and comprehensive recording of care have been addressed. Nurses and carers have been instructed about the need for timely inputting of all personal care on EPIC touch at the time of delivery. The nurses then check this record at their intentional round and sign that it has been carried out.
- Supervisory instructions for nurses have been prepared in an action card and education will be provided on supervision skills early in December.
- Surveillance by the CNMs is carried out every morning and feedback to staff takes place immediately and at handover
- Records are kept as evidence and are also available for auditing. Failure to comply with these requirements will lead to the use of sanctions.
- A Standard Operating Procedure for wheelchairs will be prepared for seating in consultation with the occupational therapist which will guide practice on the best use of seating and wheelchairs.

Proposed Timescale: 31/12/2017

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

The systems in place to ensure all elements of residents' breakfasts were at the optimal safe temperature when received by each resident, was not effective. This is a recurrent action.

10. 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:

- All breakfasts leaving the dining room are only delivered after the resident is ready for breakfast.
- All food is checked before it leaves the dining room.
- Supervision by the nurse or CNM covering clinical duties will ensure the breakfast is fit for purpose
- An audit of breakfasts will take place every month to ensure quality of food delivered.

Proposed Timescale: 30/11/2017

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:

Institutional type care practices were found that did not respect residents rights or dignity.

11. Action Required:

Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

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

- A review of the culture of care delivery and attitude regarding the dignity and respect of residents with Dementia is central to a programme currently being undertaken in this nursing home. The focus on back to basics linked to human rights, person centred care and dignity and respect is central to the education and training being undertaken by staff. The objective of the programme is to give staff an opportunity through reflective time to focus on person centered care and what it means to the individual resident in the delivery of care on a daily basis.
- As part of the supervision by nurses a number of areas of practice which have a direct impact on upholding the dignity and respect of individuals have been identified as requiring urgent attention and oversight regularly during every shift and these are built into the intentional rounding every two hours.
- Checks and oversight will also be carried out during the day by the PIC and/or the CNMs to ensure reliability of the implementation of the above procedure.
- Documentation will be reviewed by the CNMs with the nurses daily and a report will be given to the PIC every Monday Morning.
- Corrective action reports will be addressed at the Quality Improvement meeting with representatives of all groups of staff.

Proposed Timescale: 30/11/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The level and skill mix of staff was not appropriate to meet the assessed needs of the residents. There was evidence of negative outcomes for residents due to the level of inexperienced staff on duty, and shifts were not always filled. There was a continuous reliance on agency staff on a weekly basis.

12. 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:

- An additional nurse is now in place which will allow for an extra nurse on duty to supervise care.
- The numbers of carers has increased enabling the reduction of agency to a minimal level. We will continue recruiting suitable staff up to the end of the year increasing the numbers of staff available on a permanent basis to that required to deliver safe and appropriate care.
- We will eliminate the use of agency staff except in exceptional cases as this has proven to be less than satisfactory and unreliable over the last six months.
- Continuous training of new staff is essential and this is being delivered on a regular basis.

Proposed Timescale: 31/01/2018

Theme:

Workforce

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

There was a lack of appropriate supervision by the nursing and management team.

13. 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:

- Nurses have been advised of their statutory role in supervision of staff and have been reminded of the policy on Supervision.
- Actions cards identifying key roles of the nurse and managers are being developed currently. These have been found useful to guide individuals with the key components of their role. These are expected to be complete by the end of the year and are being developed in order of priority.
- The PIC and CNMs are currently undertaking an education programme on management for Directors of Nursing with the IMI.
- These combined with the introduction of an extra nurse, the introduction of intentional rounding, the documented evidence of checks carried out including the recording of care every two hours and the improved numbers of regular staff will

change the focus and level of supervision.

- The oversight by the CNM during the day and the reporting to the PIC will ensure the involvement of all levels of management in ensuring improvement in practice.
- Feedback to staff of progress will provide reinforcement of good practice and this will assist in embedding good practice changes in the culture and practice of care delivery.

Proposed Timescale: 31/12/2017