<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>St Joseph’s Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000575</td>
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<tr>
<td><strong>Centre address:</strong></td>
<td>Millstreet, Cork.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>029 70 003/029 70 050</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:berm.power@hse.ie">berm.power@hse.ie</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>The Health Service Executive</td>
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<tr>
<td><strong>Registered provider:</strong></td>
<td>Health Service Executive</td>
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<tr>
<td><strong>Lead inspector:</strong></td>
<td>Breeda Desmond</td>
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<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>20</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>2</td>
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About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

The inspection took place over the following dates and times
From: 07 January 2020 09:30
To: 07 January 2020 18:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self-assessment</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
<td>Non-Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
<td>Non-Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Substantially Compliant</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Substantially Compliant</td>
<td>Compliant</td>
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<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Non-Compliant - Moderate</td>
<td>Non-Compliant - Moderate</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Non-Compliant - Moderate</td>
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Summary of findings from this inspection
This report sets out the findings of an unannounced thematic inspection that focused on six specific outcomes of dementia care. In addition, the inspector followed up on progress of the action plan from the last inspection.

The person in charge completed the self-assessment on dementia care and the judgments of the self-assessment and the inspection findings are stated in the table above. The centre did not have a dementia specific unit and at the time of the inspection there were 12 people living in the centre with a formal diagnosis of dementia.

Overall, this was a lovely service with a relaxed atmosphere were residents and staff positively engaged with each other in a friendly and comfortable manner.
Care practices and interactions between staff and residents who had dementia were observed using a validated observational tool. The inspector viewed that some residents required a high level of support and attention due to their individual communication needs and dependencies. All care staff had responsibility to help residents exhibiting aspects of responsive behaviours; observations demonstrated that staff actively engaged in a positive connective way to enhance residents’ quality of life.

New assessment and care planning documentation was introduced with the support of the clinical practice co-ordinator. While there was some person-centred information to inform individualised care, further attention was needed to ensure that the information reflected each individual to support them to achieve their specific wishes and goals in all aspects of their life, including end of life care.

The inspector found that residents’ healthcare needs were met. Residents had access to general practitioners (GPs) and support services such as the geriatrician, psychiatry, physiotherapy, pharmacist, speech and language therapists, dietician, chiropody, dental and ophthalmic services and community health services were also available.

Phase one of Condition 8 of Registration to reconfigure the physical environment was completed in accordance with timelines stated and these will be discussed under Outcome 5 Safe and Suitable Premises.

All staff and volunteers had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Staff training was up-to-date and the programme of on-going training was available for 2020 to enable and ensure staff maintained a current certificate of training.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
January each year the person in charge met with the public health nurses and discharge co-ordinators for the catchment area to set out a schedule of admissions for respite care for people for the year where each person’s care needs were discussed to ensure the service could provide the appropriate care. Information such as an up-to-date prescription, medical history and specialist equipment specific needed was requested to be available for people wishing to be admitted to the centre. Minutes of meetings showed ongoing communication throughout the year regarding updates and additional information to enable the smooth transition into the service.

The inspector tracked the journey of residents with dementia and also reviewed specific documentation of care such as nutrition, medication management, end-of-life care and management of responsive behaviours. Pre-admission assessments were completed and documentary evidence showed that residents and their families were involved in planning care and assessing care needs.

Assessments were carried out on admission of all residents, including those people with a diagnosis of dementia. Validated assessment tools were used to support assessments and care and these were timely completed in accordance with the regulations. Observation on inspection showed that staff had good insight and knowledge of residents and their needs, with kind and sensitive interaction.

While some care plans were developed that incorporated the information available, some care plans did not reflect other pertinent information available such as the resuscitation decisions and transfer wishes if the resident became unwell. While resuscitation decisions were included in another end of life care plan, residents individual wishes for what they would like during their end of life care, were not elicited. While consent was sought, this was not consistently done in line with best practice.

Following review of healthcare records and residents' feedback, residents had timely access to health care services including GP services, geriatrician, psychiatry, physiotherapy, speech and language, dietician, dental, ophthalmology and chiropody. There were processes in place to ensure that when residents were admitted, transferred
or discharged to and from the centre, that relevant and appropriate information was readily available and shared between services.

The inspector reviewed practices and documentation relating to medicines management in the centre. There were gaps in the medication administration record so it could not be determined if residents received their prescribed medications, which had the potential for negative outcomes for residents. Two signatures were not in place for all controlled drugs administration. Following near-miss medication episodes the person in charge had introduced a control measure to minimise the risk associated with controlled drug patches, whereby the nurse signed twice a day upon checking that the patch was in place – this was not routinely recorded in the drug administration record.

Meals and mealtimes were observed including snacks, lunch and tea. Residents gave positive feedback regarding the quality of food. Issues raised in residents’ meetings relating to meals were dealt with immediately and to the satisfaction of the residents. Residents had timely access to speech and language and dietician services to support them.

While the restraint policy referred the reader to appendices relating to assessment tools and behavioural support charts, they were not available as part of the policy. This policy did not reference current legislation, national policy and best practice.

**Judgment:**
Non-Compliant - Moderate

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There were policies in place for safeguarding vulnerable adults including information relating to responsive behaviours and restrictive practice.

Documentation reviewed indicated that the least restrictive alternatives were not always trialled before bed rails were put in place. Where a resident exhibited behaviour that challenged, the actual behaviour was not detailed to provide a comprehensive overview to better inform care.

Records maintained showed oversight of usage of restraint including bedrails. A risk assessment was completed prior to using bedrails, however, this assessment required that any risk, specific to the resident, be documented in the care plan and this was not completed.
Residents’ finances were discussed with the person in charge. Petty cash was not maintained in the centre.

**Judgment:**
Non-Compliant - Moderate

### Outcome 03: Residents' Rights, Dignity and Consultation

**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:**
The person in charge chatted with each resident every morning to ask how they were and to see if there was anything they wanted or needed.

Completing residents’ life stories ‘Let Us Get to Know You’ was a new initiative to enhance residents’ care planning documentation. These life stories were used to actively engage with residents on a one-to-one basis, and inspectors observed life stories being used as part of de-escalation process. Residents’ interests informed the activities programme such as movies, documentaries and videos relating to farming and country living; arts and crafts, five MP3 players were available for residents that enjoyed music and families were involved in compiling music lists for their relatives. Residents’ art was displayed in the dining room. Older people and dance was facilitated once a week and live music sessions were usually at the weekends. The Red Cross and Legion of Mary visited the centre on a weekly basis; there was a health care assistant designated in the afternoons and evenings to facilitate socialisation and activities in accordance with residents’ preferences. Nonetheless, there was very little activity during the mornings; the inspector sat and chatted with residents in the conservatory and while morning snacks of tea/coffee/soup were offered, there was no further supervision or interaction with residents (until 12 mid-day) that would brighten their day and enhance their quality of life..

Signage regarding ‘Let Me Decide’ and Advocacy services was displayed in the centre. The residents’ information booklet was being updated at the time of inspection with current information regarding governance and management, services available and access to information including inspection reports.

Residents’ meetings were facilitated by an external group. Minutes of these meetings showed that they were reviewed by the person in charge with written feedback given by the person in charge as well as answering any queries. There was a set format with set questions for the residents’ meetings; some questions were not asked and other
questions had no answers. The inspector suggested that the person in charge attend a residents’ meeting to ensure the format was appropriate and that questions were asked in a way that residents would understand what was being asked, to ensure residents were enabled to freely express their wishes and give feedback on the service they receive.

The inspector used a validated observational tool to rate and record, at five minute intervals, the quality of interactions between staff and residents in the centre. The observational tool was the quality of interaction schedule (QUIS). These observations took place in the day room, conservatory and dining room. Each observation lasted 30 minutes. A variety of interactions were observed: most were positive and kind, where staff positively engaged with residents and adapted their approach to reflect the individuality of each resident.

Dementia signage and colour schemes were introduced to enhance the environment in line with dementia-specific care. Residents were consulted in the decorating and there was ongoing information sharing regarding the new extension.

**Judgment:**
Substantially Compliant

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### Outcome 04: Complaints procedures

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

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
A complaints policy was in place and a summary of the procedure was displayed throughout the centre; a copy of ‘Your Service Your Say’ was displayed at the entrance along with the residents’ information booklet and the statement of purpose.

The complaints log was reviewed and this showed that issues were logged, investigated appropriately, issues were followed up and the outcome was recorded. Residents reported that they could raise anything with staff and it would be dealt with immediately. A review of the complaints formed part of the quality and patient safety committee meetings to provide good oversight of the service delivered.

**Judgment:**
Compliant

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### Outcome 05: Suitable Staffing

**Theme:**
Workforce
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge full time and had the relevant experience and qualifications for the position of person in charge. She was involved in the governance, operational management and administration of the centre. Deputising arrangements were in place whereby the clinical nurse manager assumed responsibility when necessary. Observation showed that residents and relatives were familiar with the person in charge and deputy person in charge.

Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were on file for staff including volunteers.

Staff had up to date mandatory training completed. Six nurses had completed a two-day dementia care training in 2019 and four nurses in 2018. Other training completed to support dementia care included challenging behaviour and restrictive practice; the clinical development co-ordinator provided ongoing training with the associated documentation for this.

Minutes of staff meetings showed that there was open communication where everyone’s opinion and input was sought to improve the service, both for residents and staff.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
Phase one of Condition 8 of Registration to reconfigure the physical environment, to be accomplished in accordance with timelines state, was completed; with Phase two due for completion in March 2021. The following summarises the new layout of the centre from large nightingale wards to:

* two x four-bedded rooms
* three x three-bedded rooms
* two x two-bedded rooms and
* one single bedroom.
Sanitary facilities were upgraded and consisted of two assisted showers, assisted bathroom, and assisted toilets. Communal areas comprised the newly enclosed conservatory, dining room, day room and quiet room. There was no storage space in the centre for clinical equipment and specialist chairs, so while there was a ‘quiet’ room available, it contained no furniture as it was used as a storage place for specialist chairs at night time; oxygen cylinders and ‘sit-down’ weighing scales were also stored here.

While the smaller occupancy rooms enabled better privacy to ensure the dignity of residents and the personal storage space had improved, overall, residents had poor access to personal space and personal storage space in all the multi-occupancy wards. Residents’ wash basins were stored on top of wardrobes and presses which was undignified.

Residents had access to an enclosed courtyard which could be access via the patio doors in the dining room.

There was a new laundry which was financed by the ‘Friends of Millstreet Community Hospital’. The kitchen was refurbished with new equipment throughout. These upgrades were done in compliance with fire safety precautions including compartmentation.

**Judgment:**
Non-Compliant - Moderate

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**Outcome 07: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Storage in both sluice rooms was inadequate for appropriate storage of urinals and bedpans.

Sluice rooms were maintained unlocked even though there were clinical waste bins accessible.

A resident was discharged the previous day and while the bed was cleaned and fresh linen in place, the wardrobe had not been cleaned and it contained several items including incontinence wear.

**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:

Breeda Desmond
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**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 01: Health and Social Care Needs**

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
While the restraint policy referred the reader to appendices relating to assessment tools and behavioural support charts, they were not available as part of the policy. This policy did not reference current legislation, national policy and best practice.

1. **Action Required:**
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The Restraint Policy has been revised and updated in accordance with best practice and National Policy. All appendices have also been revised and updated.

Proposed Timescale: 07/02/2020
Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While some care plans were developed that incorporated the information available, some care plans did not reflect other pertinent information available such as the resuscitation decisions and transfer wishes if the resident became unwell. While resuscitation decisions were included in another end of life care plan, residents individual wishes for what they would like during their end of life care were not elicited.

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

Please state the actions you have taken or are planning to take:
A phased introduction of Advanced Care Directives (ACD) has commenced with seven directives completed. All residents will be offered the opportunity to complete the ACD and we will have this completed by 16/03/2020.

Nursing staff have received education from the Clinical Development Co-Ordinator (CDC) to assist in the recording of individual wishes. All residents care plans will be revised and updated in accordance with the residents wishes

Proposed Timescale: 16/03/2020
Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were gaps in the medication administration record so it could not be determined if residents received their prescribed medications, which had the potential for negative outcomes for residents. Two signatures were not in place for all controlled drugs administration. Following near-miss medication episodes the person in charge had introduced a control measure to minimise the risk associated with controlled drug
3. **Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
All nurses have received training/education on the management and recording of CD2 medications on the drug chart.

Drug charts: A weekly audit of CD2 administration is being undertaken by the Clinical Nurse Manager 2 (CNM2) and the Director of Nursing (DON).

All nurses have received training on the practice of reviewing patches and recording of same. A weekly audit of practice is being undertaken by the Clinical Nurse Manager 2 and the Director of Nursing with policy and best practice.

**Proposed Timescale:** 14/02/2020

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Documentation reviewed indicated that the least restrictive alternatives were not always trialled before bed rails were put in place.

Where a resident exhibited behaviour that challenged, the actual behaviour was not detailed to provide a comprehensive overview to better inform care.

A risk assessment was completed prior to using bedrails, however, this assessment required that any risk, specific to the resident, be documented in the care plan and this was not completed.

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

**Please state the actions you have taken or are planning to take:**
The nursing staff have received education from the Clinical Development Co-Ordinator in relation to assessment and documentation pertaining to bedrails in accordance with the National Restraint Policy Legislation and best practice. All Residents Care Plans are
being reviewed to ensure that least restrictive practices are exhausted prior to bedrail use.

All residents Care Plans are being reviewed to ensure that any responsive behaviour exhibited was correctly captured and documented to enhance the care delivered to that resident.

**Proposed Timescale:** 28/02/2020

**Outcome 03: Residents' Rights, Dignity and Consultation**

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Assurances could not be provided that the format of residents’ meetings was appropriate and that questions were asked in a way that residents would understand what was being asked to ensure residents were enabled to express their wishes and give feedback on the service they receive.

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

**Please state the actions you have taken or are planning to take:**
The Person in Charge has met with the Facilitator of the residents meetings and it has been agreed that questions to the residents will be set in a language that is resident friendly, easily understood and age appropriate.

It was also agreed that the Person in Charge will observe one of the residents meeting to ascertain if it is resident supportive and interactive.

**Proposed Timescale:** 29/02/2020

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There was no storage space in the centre for clinical equipment and specialist chairs, so while there was a ‘quiet’ room available, it contained no furniture as it was used as a storage place for specialist chairs at night time; oxygen cylinders and ‘sit-down’ weighing scales were also stored here.
While the smaller occupancy rooms enabled better privacy to ensure the dignity of residents and the personal storage space had improved, overall, residents had poor access to personal space and personal storage space in all the multi-occupancy wards.

Residents’ wash basins were stored on top of wardrobes and presses which was undignified.

6. 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:
1. The hospital has been granted planning permission for a new extension and further refurbishment of the original building. Building work will commence before end of June 2020.

2. Residents wash hand basins will be now stored at the back of the residents bedside locker.

Proposed Timescale: 31/03/2021

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Storage in both sluice rooms was inadequate for appropriate storage of urinals and bedpans.

Sluice rooms were maintained unlocked even though there were clinical waste bins accessible.

A resident was discharged the previous day and while the bed was cleaned and fresh linen in place, the wardrobe had not been cleaned and it contained several items including incontinence wear.

7. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
New storage units for bedpans and urinals will be purchased and put in place in both sluices by 29 Feb 2020.
The Clinical waste bin has been removed until required. The door to the sluice will be locked if the Clinical waste bin is in use.

Staff members responsible for the deep cleaning of resident’s bedrooms when a resident is discharged will ensure that all items are removed, prior to the cleaning of the room.

**Proposed Timescale:** 29/02/2020