

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St John's Community Hospital
Centre ID:	OSV-0000604
Centre address:	Munster Hill, Enniscorthy, Wexford.
Telephone number:	053 9233 228
Email address:	margaret.nowlanoneill@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Stephanie Lynch-Meany
Lead inspector:	Kieran Murphy
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	108
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 14 October 2014 11:00 To: 14 October 2014 17:00

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

Outcome 05: Documentation to be kept at a designated centre
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on two specific outcomes End of Life Care and Food and Nutrition. In preparation for this thematic inspection the provider received evidence-based guidance and undertook a self-assessment in relation to both outcomes.

St John's Community Hospital was part of a group of three centres under the overall management of the Health Services Executive. It was a purpose built unit which consisted of:

- Beech ward, a 32-bedded ward providing continuing care to 12 residents and rehabilitation services to 20 residents
- Oak ward had beds for 32 residents
- Elm ward provided accommodation for 32 residents
- Ivy ward was a dedicated 20-bedded dementia care unit.

Due to the size and layout of the centre, for the purposes of the review of food and nutrition the inspector recorded the findings in relation to lunch in the rehabilitation unit of Beech ward and observed tea in the Ivy ward. The inspector met residents and staff and observed practice. Documents were also reviewed such as policies, procedures, training records, care plans, medication management charts, menus and minutes of residents' meetings.

In relation to end of life care the centre had assessed itself as having a minor non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and National Quality Standards for Residential Care Settings for Older People in Ireland. The inspector found evidence to support this assessment. In relation to food and nutrition the centre had assessed

itself as compliant with the regulations during the national self assessment on food and nutrition undertaken by the Authority. The inspector found evidence to support this assessment.

While the thematic inspection focused on two outcomes as described above, there was a requirement for the inspector to review other outcomes in so far as they related to end of life care and food and nutrition. A minor non-compliance was identified in relation to the end of life care policy.

The Authority was also in receipt of unsolicited information which was explored during the inspection. The inspector reviewed documentation in relation to the unsolicited information such as care plans, medical records and prescription sheets and was satisfied that the issues raised had been dealt with appropriately by the person in charge.

The Action Plan at the end of this report identifies where improvements were needed.

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

Outcome 05: Documentation to be kept at a designated centre

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was an end of life care committee which had overall oversight of residents care in this centre and two other centres. The minutes of the most recent committee meeting in September 2014 were available and indicated that the end of life policy was in draft format and under review.

Judgment:

Non Compliant - Minor

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The draft end of life care policy highlighted issues like early identification of residents nearing end of life and advanced care planning both of which had not been fully implemented in practice.

There was evidence that some, but not all, residents on admission had their spiritual

needs and wishes for dying recorded in their biographical information. Care plans reviewed by the inspector identified spiritual needs of residents including visits from pastoral care. As any change occurred or health deterioration the end of life care plans were updated and recorded as "variances" (i.e. changes to the care plan). However, in the sample of healthcare files reviewed not all residents had an end of life care plan.

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

In the healthcare records reviewed there was evidence of appropriate assessment and review of residents at end of life by the GP. Staff indicated that the community palliative care team were available if required.

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

The person in charge indicated that single en-suite rooms were made available for residents at end of life. If any resident was at end of life discrete symbols were placed on the door with the purpose of creating a culture of calmness on the ward where the symbol was displayed. The inspector found this initiative to be respectful both of the resident and their family. Two units had designated end of life care rooms. There was unrestricted access for families with showering and dining facilities. Comfort baskets, which included toiletries and towels, were made available to families who stayed with residents. Hospice friendly handover bags were available for resident's personal property.

There was a written procedure available for staff following a resident's death which outlined arrangements for contacting:

- Family
- medical officer
- coroner (if required)
- pharmacy
- undertaker.

Records seen by the inspector showed that all of these guidelines were being implemented appropriately by staff.

The person in charge outlined that 60 staff had received training on the new end of life care policy. Following a resident's death there was a newly introduced review of care by staff. This identified things that went well but also areas for improvement. Issues

included a delay in putting up the end of life symbol in the ward when a resident was dying. Staff spoken with found this review to be a good learning experience.

Judgment:

Non Compliant - Minor

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

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

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

On admission each resident had an assessment of eating and drinking recorded in their biographical information. This assessment informed the nursing care plan around the activity of eating and drinking. The care plans seen by the inspector had been updated at least every four months. If there was any change in the meantime the care plans were updated and recorded as "variances".

On admission each resident also had an initial malnutrition universal screening tool (MUST) assessment. There was also recording of weight and body mass index. In the sample of healthcare records reviewed residents had a MUST score recorded monthly. There was a monthly communication folder on the ward to inform staff of any change in residents' weight. Residents who were identified as having a change in nutritional status were referred to the dietician. All referrals were being recorded on computer and reviewed at the end of every month to see the current status of the referral. Nutritional care plans were available following dietetic review. These care plans outlined the aim of the nutritional plan, the type of diet the resident required, if the resident's diet required fortification and does the person require assistance with eating.

A number of residents had been identified in documentation submitted to the Authority as having special diets:

- 21 residents required pureed diets
- 8 residents were diabetic
- 11 residents were on weight reducing diets
- 12 residents had their meals minced
- 4 residents had meals that were high protein/high calorie.

There was evidence of appropriate referral being made for speech and language review. Swallow care plans were available for residents following this assessment. There was a specific policy on the care of residents requiring enteral (directly to the stomach) feeding. The nutritional care plans for residents requiring enteral feeding were up to date with evidence of appropriate review by both the dietician and speech and language therapist.

Recommendations from the dietician and/or speech and language therapist were communicated to the catering staff via an order sheet for special/therapeutic diets. This order sheet was sent monthly to the kitchen from each ward or if a resident had any specific dietary changes in the meantime. There was a communication board in the main kitchen outlining residents' requirements.

The inspector met with the catering manager who oversaw the preparation of 1100 meals per day. This included not just St John's but a number of other centres in the community. There was a four weekly menu and while the inspector observed a choice of at least three meals available at lunch, some residents said that the choice was limited. The menu plan had been developed in conjunction with the dietician to ensure adequate nutritional value. There was a residents' council with food as an agenda item at the most recent meeting in September. Residents had asked for apple tart, scones and jelly to be made available more often and the catering manager had altered the menu to accommodate these requests. One resident was a vegetarian and a specific menu was available for vegetarians. The catering department had received a quality award in January 2014.

The inspector observed mealtimes including mid morning refreshments, lunch and tea. On some wards due to residents' dependency levels and the need for assistance with eating, a number of residents were assisted with their meals at their bedside. At lunch in Beech ward the inspector observed that a choice was offered to residents and meals were well presented. Staff were available to provide assistance if required. There was access to fluids and snacks throughout the day and tea trolleys were seen in circulation.

The most recent Environmental Health Officer report was available. A record of staff training indicated that 16 staff had recently received nutrition training and 21 staff had received training on MUST assessment. All catering staff had completed basic food hygiene training and three managers had completed the management of food hygiene training.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St John's Community Hospital
Centre ID:	OSV-0000604
Date of inspection:	14/10/2014
Date of response:	09/12/2014

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The end of life care policy was in draft format.

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.

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:

The End of Life Policy is in draft format because there is training required in order to support the full implementation of this Policy. The training that we have contracted is via The Gold Standard Model UK and this training will be completed in April 2015. Following the completion of this training the existing draft policy will be implemented in full

Proposed Timescale: 01/05/2015

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

Not all residents had their end of life wishes recorded on admission.

Action Required:

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

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

It takes 72 hours to for the full assessment of the resident in order to complete a care plan.

The capacity of the resident dictates the timeframe for completion of the care plan– the first is where the resident has full capacity and the care plan commences on admission with the nurse who admits the new resident. It is completed within 72 hours of admission by a nurse on the ward where they are admitted to. The CNM2 or CNM1 then checks all care plans of new residents to the ward within 24 hours and again at the end of 72.

In other circumstances some residents choose the bed in St Johns without capacity to advise and in those circumstances in the first instance their next of kin are invited to meet with the Director of Nursing or her delegate. In some circumstances there may be no next of kin available to assist. Where there is a resident with diminished capacity and or a relative or next of kin that's named on documentation but is not present during the first four weeks following the admission care plans have been devised without end of life care wishes completed. All attempts are made by the CNM2/CNM1 and nursing staff on the ward to contact any know next of kin.

In circumstances where it is not possible to elicit the wishes of the individual we firstly look up the census to see can we identify any known relative. Secondly we would request the assistance of the Elder Abuse Social Worker to advise. Where there is no possibility of identifying an advocate a Multi Disciplinary Team meeting is convened including the Geriatrician, the Elder Abuse Case Worker, the Director of Nursing, the ADON , the CNM2 of the ward and a care plan would be devised.

The Policy which is in draft will include the above steps to fulfil the criteria as above.

This policy will be fully implemented in May 2015. The ADONs and Director of Nursing will do random audits of Care Plans on a weekly basis where a care plan of each ward will be audited weekly. As part of this audit a focus will be put on the end of life care. In addition training regarding identification of next of kin will be rolled out by the Elder Abuse Case Worker Karsten Kohl in February 2015.

Proposed Timescale:

Policy Implementation 1st May 2015

Training in identification of relatives commences Feb 2015

Audit of Care Plans by DON/ADON is done on a weekly basis and outcomes of audit will be recorded commencing from Monday 8th December 2014

Proposed Timescale: 01/05/2015

Theme:

Person-centred care and support

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

Not all residents had an end of life care plan.

Action Required:

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

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

Policy Implementation 1st May 2015

Training in identification of relatives commences Feb 2015

Audit of Care Plans by DON/ADON is done on a weekly basis and outcomes of audit will be recorded commencing from Monday 8th December 2014

Proposed Timescale: 01/05/2015

Theme:

Person-centred care and support

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

Care plans in relation to do not attempt resuscitation did not always comply with the centre's guidelines.

Action Required:

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

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

As above regarding the policy and training

Proposed Timescale:

Policy Implementation 1st May 2015

Training in identification of relatives commences Feb 2015

Audit of Care Plans by DON/ADON is done on a weekly basis and outcomes of audit will be recorded commencing from Monday 8th December 2014

Clinical Ward Managers on each ward will inspect and record the status of each care plan on a planned basis per week on their ward. Ongoing

Proposed Timescale: 01/05/2015