**Centre name:** St. John's Community Hospital  
**Centre ID:** OSV-0000660  
**Centre address:** Ballytivnan, Sligo.  
**Telephone number:** 071 914 2606  
**Email address:** nuala.gallagher1@hse.ie  
**Type of centre:** The Health Service Executive  
**Registered provider:** Health Service Executive  
**Provider Nominee:** Frank Morrison  
**Lead inspector:** Marie Matthews  
**Support inspector(s):** Geraldine Jolley;  
**Type of inspection** Announced  
**Number of residents on the date of inspection:** 91  
**Number of vacancies on the date of inspection:** 9
About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times

<table>
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<tr>
<th>From:</th>
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<tr>
<td>29 April 2015 10:00</td>
<td>29 April 2015 19:30</td>
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<tr>
<td>30 April 2015 09:30</td>
<td>30 April 2015 18:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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

Summary of findings from this inspection

This report set out the findings of a registration renewal inspection, which took place following an application to the Health Information and Quality Authority (the Authority) Regulation Directorate, to renew registration of the designated centre. It was the 12th inspection of this centre by the Authority. Inspectors met with the provider, person in charge and staff members.

Questionnaires from 10 residents and 15 relatives were reviewed prior to the inspection and inspectors also spoke with residents during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided although staffing levels were described as inadequate in several questionnaires.
The person in charge and the director of Nursing were fully engaged in the management of the centre. There was evidence of individual residents’ needs being met and staff supported residents to maintain their independence where possible. Inspectors found that the residents were well cared for and that their nursing and care needs were being met. Residents had good access to general practitioners (GP) and to specialist support services.

Some improvements were identified during the inspection to comply with the regulations and improve the service provided as follows:
The physical environment continued not to comply with the specifications of the National Quality Standards for Residential Care Settings for Older People in Ireland or the requirements of regulations. This issue has been identified on all previous inspections by the Authority. Staffing also required review to ensure there are sufficient staff and they are effectively deployed according to the areas they are needed. Some staff had not completed recent training to give them the skills to respond appropriately and manage behaviour that challenged.

Systems were in place to manage risk and regular fire training took place however residents did not have personal emergency evacuations plans (PEEPS) completed. The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) 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 Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The Statement of Purpose was revised in April 2015. The Statement of Purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations.

**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:**
There was a defined management structure in place to ensure the effective governance of the service. The inspector found that the management structure was appropriate to the size, ethos, purpose and function of the centre. Roles and responsibilities were defined and implemented in the centre in terms of oversight of the delivery of care. Frank Morrison, Manager for Older Peoples Services is the provider nominee on behalf of the Health Service Executive. He has over 20 years experience in Older Persons services. The Person in Charge is Nuala Gallagher who is the acting Assistant Director of Nursing and reports directly to the provider. Together with an acting Director of Nursing and
another Assistant Director of nursing they manage the centre. A team of 10 clinical nurse managers are responsible for overseeing the delivery of care in the four units. On a daily basis they manage the nursing and care staff, catering, maintenance and administration staff. Physiotherapy, occupational therapy, speech and language therapy, social workers and dietician staff report through their professional line managers who are responsible to the general manager.

A system for quality assurance and continuous improvement was in place and inspectors saw that various monthly and quarterly audits were undertaken on several aspects of the service including falls, risk, wounds, weight loss, medication, complaints, residents’ finances, restraints use. A report was produced at the end of each quarter which contained useful information on key clinical indicators. For example, inspectors were told that restraint use had reduced from 44 to 26 as a result of other less restrictive preventative strategies been introduced however, this information was not clearly reflected in the analysis. Further analysis and a clearer format that described the improvements in a meaningful way for residents was required.

Residents were consulted with through a residents’ committee which met every six weeks and was chaired by an independent chairperson external to the service. Feedback from residents and relatives in the questionnaires returned to the Authority were generally very complimentary of the service provided and the staff team.

Judgment:
Substantially Compliant

**Outcome 03: Information for residents**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A copy of the Residents’ Guide was provided on an information notice board alongside a copy of the Statement of Purpose and past inspection reports by the Authority. The notice board also contained details of an advocacy service available to residents and a copy of the centres’ complaints procedures. Inspectors found that each resident had an agreed written contract on their file which included the details of the services provided and the fees charged. However any additional costs or fees were not described in the contracts reviewed. All contracts were signed by the resident or their next of kin and by the PIC. A copy of the contract was kept on the resident’s file.

**Judgment:**
Non Compliant - Minor

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge holds the post of Acting Assistant Director of Nursing for the centre. She is a registered nurse with 16 years experience in older persons care and works full time. She was well known by the residents spoken with. She has maintained her professional development and attended mandatory training required by the Regulations and had protected time to manage the clinical governance and administration duties required by the post of person in charge. The person in charge is supported in her role by a team of senior managers including an Acting Director of Nursing, an Assistant Director of Nursing and nine clinical nurse managers. She had good knowledge of the care needs of residents in her care.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors reviewed a range of documents, including residents’ records and the directory of residents and staff documents including personnel files and training records. Inspectors found that generally records were maintained in a manner so as to ensure completeness accuracy and ease of retrieval.
Judgment:
Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days. Arrangements were in place for either the acting Director of Nursing or the Assistant Director of Nursing to deputise while the person in charge is absent. Both of these staff were identified in the Statement of Purpose and had significant management experience.

Judgment:
Compliant

**Outcome 07: Safeguarding and Safety**
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe care and support

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

**Findings:**
A policy on adult protection was available which included information on protected disclosure procedures and prompted staff to report any suspicion of abuse. The PIC was aware of the newly launched National Policy & Procedures on protecting vulnerable adults in nursing homes and the Acting Director of Nursing was representing the centre on a local group established to review the centres policy against the new national document.
The PIC confirmed that there were no allegations of abuse currently under investigation. Staff spoken with were able to inform the inspectors of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. Inspectors
viewed records confirming all staff had up to date refresher training in protection of vulnerable adults. Residents spoken with said that they felt safe in the centre. In the questionnaires returned to the Authority residents indicated that they felt very safe in the centre.

A policy was available to guide staff on the management of residents’ personal property and possessions. The controls in place to ensure residents’ finances were protected were reviewed by inspectors. A petty cash system was in place to manage small amounts of personal money for residents. Records of all transactions were available and inspectors confirmed that these were appropriately signed by two staff members.

There was a policy on the management of behaviour that is challenging available. Staff spoken with were very familiar with resident’s behaviours and could describe the preferred daily routines and identify any triggers that might cause behaviours to escalate very well to the inspectors. However, inspectors observed that some staff had not received recent training to give them the skills to respond appropriately and manage this aspect of care.

The centre had adapted the national policy on a restraint free environment to ensure residents were prevented from potential harm as a result of restraint use. Significant progress has been made in reducing the number of restraint in use from 44 last year to 26 at the time of the inspection. The restraints in use were mainly bed rails and lap belts. Inspectors saw from the assessments completed that other options such as low beds, crash mats and sensor alarms were used instead and the PIC said that as new residents are admitted they are encouraged to try these options first. Restraint risk assessments were revised routinely and the rationale for using the restraint was recorded in the risk assessment reviewed.

From talking with staff and reviewing resident files, there was good evidence of links to mental health services. A policy was available which provided guidance to staff on how to manage behaviours that challenge, was also available.

**Judgment:**
Non Compliant - Moderate

**Outcome 08: Health and Safety and Risk Management**

The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support

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

**Findings:**
The actions from the last inspection by the Authority in relation to risk management and emergency procedures and infection control were addressed by the provider. There was a corporate HSE health and safety policy and an adapted centre specific health and
safety statement provided in each unit. A safety committee is also established and there were two designated safety representatives. A risk management policy was also available which outlined the roles and responsibilities of each grade of staff in relation to managing risk and ensuring a safe environment. The policy was reviewed by inspectors and was found to be comprehensive and include guidance on manual handling, behaviour challenging and infection control.

Arrangements were in place to ensure learning for all staff from serious or untoward incidents or adverse events outlined in the risk management policy. A quality, risk and safety management group was established. In addition a centre specific risk register was maintained which identified risks throughout the centre and the controls necessary to minimise risk.

The Acting Director Of Nursing had introduced a new initiative to monitor the safety of residents. A quality and safety report monitoring form was completed daily by staff in each unit and included information on key health indicators such as falls, pressure sores or infections. The forms were reviewed by the PIC weekly. Staff also told inspectors about another safety initiative called a ‘safety pause’ designed to ensure all the residents were safe at the end of each shift.

The front entrance of the centre was a busy social area with a coffee shop used by both residents and relatives. An electronic monitoring system was fitted to the front door to alert staff if a resident left the centre unaccompanied or unknown to the person in charge. An alarm was fitted to the main entrance and close circuit television cameras monitored the front entrance. A visitor’s book was observed to be completed by relatives and others visiting the centre. There was safe flooring and handrails were provided in corridors to assist residents. Grab rails were provided in toilet and bathroom areas. Appropriate assistive equipment was provided for residents and service records indicated these were regularly serviced.

Inspectors saw that each resident was assessed on admission for clinical risks such as their likelihood of falling or wandering or developing a pressure sore and these risks were reviewed and assessed if there were any changes in their care. A certificate of fire compliance was previously submitted to the authority by a suitable qualified person to confirm that all the requirements under the building regulations were in compliance with this centre. All fire exits were observed to be unobstructed and there were records of daily inspections of all exits. Fire procedures were prominently displayed throughout the centre. Inspectors reviewed records which confirmed that fire fighting equipment, the fire alarms and emergency lighting were regularly serviced.

Directional signage was provided to indicate the nearest evacuation route however inspectors identified areas where these signs were not visible and some signs which were not illuminated. An emergency plan was displayed however there were no personal emergency evacuations plans (PEEPS) observed on resident’s file to describe how the resident would be evacuated in the event of a fire and the assistance they would require. Training records reviewed indicated that all staff had attended training on fire prevention and evacuation. The training records reviewed included details of the information covered in the training.
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:  
Medication was prescribed and administered in accordance with safe practice. The inspector observed one of the nursing staff on part of their medication round and found that medication was administered in accordance with the policy and An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) guidelines. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which included the management of ‘as required’ medication (PRN) medication.

Evidence was available that MDA drugs were checked twice daily by two nurses. The prescription sheet included the appropriate information such as the resident’s name and address, any allergies, and a photo of the resident. If medication was refused this was recorded on the medication administration record. The General Practitioner’s signature was present for all medication prescribed and for discontinued medication. Maximum does of PRN (as required medication) was recorded. Three medication trolleys were stored in one treatment room which compromised the space available for treatment and inspectors observed some trolleys were damaged and required replacement.

Judgment:  
Substantially Compliant

Outcome 10: Notification of Incidents  
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:  
Safe care and support

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

Findings:  
The inspector reviewed the accident and incident log maintained at the centre and cross referenced these with the notifications submitted to the Authority. Accidents or incidents which resulted in serious injury were appropriately notified to the Authority. Quarterly
notifications were submitted appropriately by the person in charge in a timely manner. The provider had submitted most notifications to the Authority within the required time frame.

**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:

Inspectors found a good standard of evidence-based care and appropriate medical and allied health care access. A sample of resident’s care plans were reviewed in each unit by inspectors and improvements in this aspect of care were identified since the last inspection. On admission a comprehensive assessment of needs was completed, reviewed and updated at regular intervals. There was evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan when reviewed or updated. The assessments were observed to inform the care plans, and were linked to give a global view of the residents care. There was evidence that care plans were updated regularly and in response to a change in a resident’s health condition. Resident’s weights, Body Mass Index (BMI’s) blood pressure and oxygen levels were monitored and results recorded. Inspectors identified that the care plans for residents with dementia or cognitive impairment required review to ensure they are more person centred. Whilst the assessments recorded for residents with cognitive impairment gave an overall clinical picture of the resident, the care plans reviewed didn’t fully describe the range of memory function retained by the resident or the support that should be provided to ensure the residents well-being. Information such as who the resident still recognised or what activities could still be undertaken was not always evident. On speaking with staff members on duty the interventions described reflected the needs of the residents even though these were not always documented in the care plans. A review of residents’ medical notes showed that GP’s visited the centre regularly and there was evidence of medical reviews completed at least four monthly or more frequently when required. Medical records indicated that residents were seen by a GP within a short time of being admitted to the centre. There was also evidence that where referrals to support services such as physiotherapy, occupational therapy, dietetics or speech and language therapy were required these were made in a timely manner and the advice of the specialist was transferred into the residents care plan.
The consultant psychiatrist and their team visited the centre regularly to review residents in their care. Regular blood tests were completed to ensure where appropriate medication doses were at the optimum therapeutic value.

**Judgment:**
Non Compliant - Minor

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

**Findings:**
The centre was comfortably warm, clean and odour free but no changes had been made to the structure of the building since the last inspection and this centre has multi occupancy rooms which do not afford the residents privacy and dignity or provide room for adequate storage.
Inspectors found that the physical environment continued not to comply with the specifications of the National Quality Standards for Residential Care Settings for Older People in Ireland or the requirements of regulations. The physical environment consisted mainly of ward-type accommodation and was not fit for the purpose of achieving the aims and objectives as set out in the statement of purpose or to meeting the individual needs of residents.
St John’s Hospital is a single-storey building which was first established in 1971, it has reduced numbers over the last few years in response to action plans issued by the Authority. Accommodation is organised in four ward like units which are in multiple occupancy with four beds in some rooms and five in others. Clearly this impacts significantly on the privacy and dignity of residents and does not comply with the Authorities standards. There is not adequate storage provided for residents’ belongings in each bedroom and communal storage areas have to be used. Some equipment was found to be in poor repair, for example shower trays and chairs were seen to have exposed foam which posed an infection control risk.
There was an evident lack of regular maintenance and as a result paintwork on walls, door frames and skirting boards were badly chipped and damaged. Signage was poor throughout the building.
The provider has met with the Authority to discuss proposals to ensure that this centre will be in compliance with the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older Persons) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
A plan was available during the inspection for the refurbishment of the centre to address these issues and comply with the Authorities standards and the provider assured inspectors that approval for financing the development has been agreed by the HSE’s National Director for Social Services. A final plan has since been submitted to the Authority with regard to compliance in this area. This plan includes a commencement and completion date and assurance that finance has been agreed and sanctioned.

Judgment:
Non Compliant - Major

**Outcome 13: Complaints procedures**
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

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

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

**Findings:**
The complaints procedure was displayed at the main entrance of the centre. The complaints policy was based on the HSE policy ‘your service your say’. The policy gave details of the person to whom complaints could be made, a nominated person who monitored the complaints process and an independent appeals process if the complainant was not satisfied with the outcome of their complaint. Inspectors reviewed a log of complaints which included some minor and more formal complaints. Inspectors saw that staff ensured that complaints were promptly investigated and responded to. In a sample of complaints reviewed however, inspectors could not determine if the person making the complaint was informed of the outcome of the complaint or if they were satisfied with the outcome as the complaints form did not prompt staff to record this information. A monthly review of complaints was maintained by the person in charge. Residents and relatives spoken with and those who gave feedback in questionnaires submitted to the Authority in advance of the inspection confirmed that they would complain should the need arise and said they would feel comfortable speaking to any staff member or the PIC.

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

Findings:
This outcome was the subject of a thematic inspection in May 2014 and all aspects of end of life were examined in detail during the inspection. Inspectors reviewed the care plans of recently deceased residents and saw that care practices reflected the needs and wishes of the residents. Family and friends are facilitated to be with the resident when they are dying.
Residents had the opportunity to attend religious services. Two chaplains are regular visitors to the centre and a special service was held in November to remember deceased residents. Both catholic and church of Ireland oratories were available. Mass and the blessing of the sick took place every Friday.

There are procedures in place to ensure a resident’s resuscitation status is regularly reviewed. The documentation reviewed outlined the clinical judgement of the general practitioner. There was good access to specialist palliative care services through the north west hospice and this was evident in the care plans reviewed.

Judgment:
Compliant

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

Findings:
This outcome was the subject of a thematic inspection in May 2014 and all aspects of food and nutrition were examined in detail during the inspection. The areas identified for improvement from the last inspection were reviewed during the course of this visit. The centre had policies and procedures in place to guide staff on nutrition management and on hydration which were reviewed in March 2014. The policy guided staff to weigh residents on admission and monitor weights monthly. Oral assessments were also completed for all residents on admission. An assessment of the level of assistance the resident required with eating was documented.
Inspectors reviewed a sample of the care records. Assessments of nutritional needs were in place. Where a risk of weight loss was identified inspectors saw that weekly weighing was commenced and the resident was appropriately referred to the dietician.
for advice. On the last inspection only one weighing hoist was available and it was regularly out of service. An additional hoist had since been obtained and both hoists were in working order. Records of referrals were documented and residents care plans reflected the advice of the dietician was followed. A central kitchen provided meals for residents in the centre as well as 1400 additional meals for residents in day services, the rehabilitation unit, the Dementia unit and the community (meals on wheels). Inspectors saw that it was well equipped and stocked with meat, vegetables and fruit. A variety of fruit juices were available. Records of resident’s dietary needs were maintained and the catering manager was able to show the inspectors the systems in place to ensure that residents received specialised or modified consistency diets as prescribed. The catering manager said the menu was prepared in conjunction with a dietician and a speech and language therapist to ensure it was nutritional balanced. The planned menu cycle was rotated every three weeks. There was a choice of two main courses on the dinner menu. Tea time menus also included a hot meal if residents preferred. Snacks were available should any residents require food during the night. Care staff could access the kitchens on each unit at night time. Fresh fruit was incorporated into residents’ diet and smoothies were made every morning for residents however inspectors were told that home-made breads and scones were no longer provided for residents due to staff shortages. There was a separate dining room in provided in each ward area. A menu was provided on each table. Drinking water was provided in jugs in the dining areas and at resident’s bedside. Most residents had milk with their mid day meal. On the last inspection inspectors identified that dining facilities provided in each unit did not provide adequate space to allow all of the residents to have their meals together and some residents had their meals by their bedsides. This was identified on the last inspection. The staff told inspectors that as new residents are admitted, they are encouraged to have their meals in the dining room but some residents still preferred to eat in their bedrooms as this is what they were accustomed to. This made supervision of residents more difficult. The PIC told inspectors that the staff rota had been reviewed since the last inspection to ensure staff breaks no longer coincide with the residents lunch time. As discussed under outcome 12 the provider has submitted plans to the Authority for an extension and refurbishment of the centre which will include larger dining areas. The Authority had received two concerns regarding poor nutritional care since the last inspection. These were brought to the attention of the provider who investigated both concerns and submitted information to the Authority. The inspectors reviewed the care plans of two residents where nutritional problems were identified. Residents weights were monitored monthly and both had been referred and reviewed by both a dietician and a speech and language therapist. Food and hydration charts were maintained for these residents however inspectors observed that the fluid balance records were not totalled at the end of the day and there was no guidance provided to staff to indicate the quantity of fluids the resident should have and there was no early warning system to alert staff that if residents had inadequate fluids.

**Judgment:**
Non Compliant - Moderate
**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:
During the day residents were able to move freely around the centre and some chose to stay in their own area. Residents were dressed well and according to their individual choice however as previously stated some residents’ wardrobes were small and surplus clothing had to be stored away from their bedrooms which meant that staff had to assist residents in choosing clothing.

The coffee shop area at the entrance provided a pleasant social area and was valued by the residents able to use it. The new garden room was in use and also provided a pleasant social area for residents and much of the organised social activities were centred here. There were events and activities organised on each unit daily. An activities schedule was displayed which summarised the events planned for the week which included karaoke, a serenity group, bingo, exercise classes, music sessions and a craft exhibition. Staff were supported by volunteers from the community and one to one therapies such as hand massage and reflexology were provided for residents who were less mobile. 11 care hours per week were funded by the physical and sensory services for residents assessed as having sensory impairment. There was evidence that residents were brought on various trips to the local theatre, concerts on the services mini bus.

Residents had access to a variety of national and local newspapers and magazines to reflect their interests. These were located in easily accessible areas and available to residents daily. Arrangements were in place for consultation with residents on the running of the service. A residents committee was well established and met every 6 weeks. Minutes of these meetings were available.

The residents’ religious beliefs and values were facilitated. There was a large chapel centrally located where Mass was said on a weekly basis and a separate Church of Ireland chapel was also located nearby. Chaplains visited the centre regularly. The residents’ links with family members and friends was encouraged and facilitated and families and the local community also used these facilities. There were no restrictions on visiting and a number of relatives were seen to assist their family members at mealtimes.

Inspectors observed staff interacting with residents in a courteous manner and
addressing them by their preferred name. Staff made every effort to ensure privacy was maintained while delivering care in multiple occupancy bedrooms. Curtains were provided around each bed and notices were placed on the doors to multiple occupancy bedrooms when care was in progress. Those residents interviewed told inspectors they were able decide what time they got up could have breakfast at a time that suited them, however inspectors observed that for those in multiple occupancy bedrooms, the reality was that staff attending to one resident would disturb the other residents. An action requiring the provider to address issues relating to the premises has been added under outcome 12.

Feedback in questionnaires returned from relatives said that staff were caring and attentive and strived to meet the individual care needs in a timely manner but were very rushed and didn’t have much time to spend with residents. This is discussed further under outcome 18.

**Judgment:**
Non Compliant - Moderate

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### Outcome 17: Residents’ clothing and personal property and possessions

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

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

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

**Findings:**
Residents expressed satisfaction with the service provided and the safe return of their clothes to them. A policy on the management and safeguarding of residents personal possession was available. Each resident had a wardrobe/bedside locker in their room for storage of their possessions. However in multiple occupancy bedrooms these were small and surplus communal storage was provided.

Property lists were completed on admission and inspectors saw that these were updated at regular intervals thereafter. Some rooms were personalised with personal photographs, pictures and other personal belongings. The laundry room was located on the ground floor and was spacious and well equipped and laid out to minimise the risk of cross infection.

There were systems in place to safeguard residents’ property and money. Inspectors reviewed these procedures and found that the provider was compliant in this area. The person in charge stated that they followed the HSE’s policies on residents’ finances and residents received regular statements from the central accounts department.

**Judgment:**
**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):**

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

**Findings:**

The staff spoken with had a good knowledge and understanding of each resident’s background in conversation with inspectors. There was evidence of good communication with relatives when they visited and via the phone.

Inspectors viewed the staffing rotas for a three week period. The rotas showed the staff complement over a 24 hour period. There were a number of vacancies that had not been filled due to the Health Service Executive embargo on staff recruitment. Inspectors also observed several of the care assistants on duty were funded by the carers association.

Many residents in the centre had complex health care issues and several had more than one medical condition. Staffing levels varied between units and there didn't appear to be any rational applied to the allocation. Inspectors viewed the questionnaires returned to the Authority by the resident’s and by their families/relative in advance of the inspection. Although most comments in the returned questionnaires were positive about the care residents received and the kindness of staff, several of commented that staffing levels were inadequate. Comments included “...staff are very stretched” and “they are so short staffed...”, “....the staff are run off their feet yet they still try to give of their time to visitors”.

Overall, inspectors formed the view that staffing levels and the deployment of staff requires review in line with the dependency needs of residents to ensure appropriate levels of supervision and care for residents.

The provider advised that funding had been approved for an additional 7 posts and the successful candidates were expected to take up their new positions in the coming weeks.

A staff training programme was on-going. All staff had up to date mandatory training in fire safety, adult protection and manual handling in place. As stated previously some staff had not completed up to date training in the management of behaviour that
challenges. Inspectors reviewed a sample of staff files during the inspection. They were found to be complete and contained all of the information required by the Regulations to ensure that staff were suitable to work in a designated centre.

**Judgment:**
Non Compliant - Moderate

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**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:**

Marie Matthews  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

Centre name: St. John's Community Hospital
Centre ID: OSV-0000660
Date of inspection: 29/04/2015
Date of response: 13/07/2015

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Further analysis was necessary to give a meaningful overview of improvements in the quality of the service in a format that could be shared with residents.

Action Required:
Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

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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:
This report will then be made available to residents in a meaningful and purposeful manner. It will reflect the quality improvement initiatives in the Hospital. This will be provided twice yearly and the first version will be available from the 30th September 2015.

**Proposed Timescale:** 30/09/2015

<table>
<thead>
<tr>
<th><strong>Outcome 03: Information for residents</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The contract of care did not specify if any additional fees were charged to residents.

**Action Required:**
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

**Please state the actions you have taken or are planning to take:**
At present no additional fees are charged to the resident outside their weekly cost of care. This has been made clear in the Contract of care.

**Proposed Timescale:** 06/07/2015

<table>
<thead>
<tr>
<th><strong>Outcome 07: Safeguarding and Safety</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Safe care and support</td>
</tr>
</tbody>
</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff had not completed recent training on managing behaviours that challenge.

**Action Required:**
Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
A number of staff have completed training in relation to challenging behaviours and have completed it to Post Graduate level. We will source training in relation to behaviours that challenge and will ensure an appropriate number of staff have received training in this area.

**Proposed Timescale:** 01/10/2015

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The placement of a resident with behaviour that challenged who's' placement was not managed appropriately as an alternative, more appropriate placement had not been sought in a timely manner to reduce the risk and anxieties of other residents in the unit.

Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
All residents are assessed on a continual basis by the Multi Disciplinary team in relation to their care needs and their behaviours. If a resident presents with challenging behaviour they have a behaviour support plan put in place and their care needs and placement are reassessed as required by the team. The Hospital links closely with outside agencies as well as psychiatric services in relation to ensuring safe and suitable placements for our residents. Restrictive practices are not promoted within this facility.

Proposed Timescale: 06/07/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective directional signage was not provided consistently throughout the centre to indicate the nearest evacuation routes

Personal emergency evacuations plans (PEEPS) were not found on all residents files resident's file to describe how the resident would be evacuated in the event of a fire and the assistance they would require.

Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
Personal emergency evacuation plans are now in place for all residents and are easily accessible for staff in the event of an emergency. This was completed by the 6th July 2015

Directional signage will be provided consistently throughout the centre to indicate the nearest evacuation route.
### Outcome 09: Medication Management

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Three medication trolleys were stored in one treatment room which compromised the space available for treatment and inspectors observed some trolleys were damaged and required replacement.

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

**Please state the actions you have taken or are planning to take:**
All medication trolleys are locked and stored in a locked room. Medication trolleys have been repaired and will be replaced as necessary.

**Proposed Timescale:** 06/07/2015

### Outcome 11: Health and Social Care Needs

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
care plans for residents with dementia or cognitive impairment required review to ensure they are more person centred and give an overall clinical picture the range of memory function retained by the resident or the support that should be provided to ensure the residents well-being.

**Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
Care plans for those residents with dementia will be reviewed to ensure that they are more person centred and reflect the memory function of the resident and what support that resident requires to ensure their well being.

**Proposed Timescale:** 31/07/2015
<table>
<thead>
<tr>
<th>Theme: Effective care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The physical environment consisted mainly of ward-type accommodation and was not fit for the purpose of achieving the aims and objectives as set out in the statement of purpose or to meeting the individual needs of residents.</td>
</tr>
</tbody>
</table>

**Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**
Plans have been submitted to the Authority indicating the changes required to the building to ensure compliance with the Environmental Standards. Privacy and Dignity will be afforded to all residents with the required spacing as recommended. It is anticipated that works will be completed by the end Sept 2018 on the residential area within the Hospital.

**Proposed Timescale:** 30/09/2018

<table>
<thead>
<tr>
<th>Theme: Effective care and support</th>
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<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>Storage provided was inadequate. There was an evident lack of regular maintenance and as a result paintwork on walls, door frames and skirting boards were badly chipped and damaged. Signage was poor throughout the building.</td>
</tr>
</tbody>
</table>

**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:**
Each resident has a wardrobe and bedside locker provided, however larger wardrobes will be purchased and additional storage will be provided with the planned refurbishment of the Hospital. A wardrobe replacement plan will be put in place in advance of the hospital refurbishment.
A cyclical maintenance programme will be put in place to ensure paintwork is maintained throughout the centre.
Additional signage will be provided to guide residents and their families throughout the centre.

**Proposed Timescale:** Planned Paintworks to commence September 1st 2015, Additional Signage 1st September 2015 and Wardrobe replacement programme will
### Outcome 13: Complaints procedures

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

The **Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints log did not record if the person making the complaint was informed of the outcome of the complaint or if they were satisfied with the outcome as the complaints form did not prompt staff to record this information.

**Action Required:**
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

**Please state the actions you have taken or are planning to take:**
The complaints log will accurately reflect that any person who makes a complaint will be informed of the outcome and that the person was satisfied with the outcome or if any further actions are required.

**Proposed Timescale:** 06/07/2015

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### 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:**
Fluid balance records were not totalled at the end of the day and there was no guidance provided to staff to indicate the quantity of fluids the resident should have and there was no early warning system to alert staff that if residents had inadequate fluids.

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

**Please state the actions you have taken or are planning to take:**
For those residents who require a fluid balance, this will be totalled at the end of each day. Guidance will be provided for staff in relation to best practice and NICE guidelines in relation to Dehydration and daily fluid requirements unless a resident requires fluid restriction.

**Proposed Timescale:** 13/07/2015

**Theme:**
Person-centred care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Dining facilities provided in each unit did not provide adequate space to allow all residents to have their meals together and some residents had their meals by their bedsides.

Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
Residents choose where they would like to have their meals and some residents choose to have their meals at their bedsides which is respected. However staff do encourage residents to have their meals in the dining rooms. Each unit has at least 2 dining room areas. The requirement of Dining space will be incorporated into the plans for the new refurbishment planned for the hospital.

Proposed Timescale: 06/09/2015

Outcome 16: Residents’ Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
multiple occupancy bedrooms impacted on residents privacy.

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

Please state the actions you have taken or are planning to take:
There are a number of areas (other than bedroom space) on each unit. In addition there is a large Garden room that can be used by residents for private personal activities. The garden room is very well utilised by both residents and families.

Plans have been submitted to the Authority indicating the changes required to the building to ensure compliance with the Environmental Standards. Privacy and Dignity will be afforded to all residents with the required spacing as recommended. It is anticipated that works will be completed by the end Sept 2018 on the residential area within the Hospital.

Proposed Timescale: 30/09/2018

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
Some residents accommodated in multiple occupancy bedrooms could not exercise choice regarding the time they awoke

**Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**
For residents in multioccupancy rooms staff are mindful to be as quiet as possible when caring for other residents needs. All Residents are offered a choice in relation to the time they get up at each morning. Staff are mindful to respect every resident’s wishes and their privacy and dignity despite the multi occupancy rooms.

**Proposed Timescale:** 06/07/2015

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**Outcome 17: Residents' clothing and personal property and possessions**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Storage facilities provided in multiple occupancy bedrooms were not sufficient and surplus items of clothing had to be stored communally away from residents' personal areas.

**Action Required:**
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

**Please state the actions you have taken or are planning to take:**
A Wardrobe replacement plan will be put in place to ensure each resident has adequate space to maintain their personal clothing and possessions.

**Proposed Timescale:** 01/09/2015

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staffing levels and the deployment of staff requires review in line with the dependency needs of residents to ensure appropriate levels of supervision and care for residents.

**Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.
Please state the actions you have taken or are planning to take:
Staffing levels are reviewed daily and staff are redeployed based on need. An Additional 3 Health Care assistants have been employed in June 2015 and a further 7 Health care assistant Posts have been approved and will be appointed very soon. Staffing reviews take place on a regular basis and business cases and Form Bs are completed when staff resign/retire and are escalated to the Acting General manager in a timely manner.

Proposed Timescale: Under review 3 HCA appointed in June 2015 and further HCA to be appointed by end August 2015.

**Proposed Timescale:** 31/08/2015