<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>St John’s Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000604</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Munster Hill, Enniscorthy, Wexford.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>053 9233 228</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:margaret.nowlanoneill@hse.ie">margaret.nowlanoneill@hse.ie</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Health Service Executive</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Barbara Murphy</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Ide Cronin</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Unannounced Dementia Care Thematic Inspections 2015</td>
</tr>
<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>0</td>
</tr>
</tbody>
</table>
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.
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 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: 21 January 2016 09:30  To: 21 January 2016 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>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. The inspection also considered information received by the Authority in the form of unsolicited receipt of information, notifications and other relevant information. There was a special dementia care unit and 20 residents lived together in this unit. Overall, inspectors found the management team and staff working in the unit were committed to providing a quality service for residents with dementia. However, the provider had assessed the compliance level of the centre and the findings of inspectors did accord with the provider's judgements of a moderate non compliance in five out of six outcomes. Inspectors also judged that the sixth outcome to be moderate non compliance.

As part of the thematic inspection process, providers were invited to attend
information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Inspectors met with residents, relatives, and staff members during the inspection. They tracked the journey of a number of four residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined the relevant policies and the self assessment questionnaire which were submitted prior to inspection. Day to day management responsibilities are with the assistant directors of nursing who work closely with the person in charge, and both are nominated persons in the absence of the person in charge. One of the assistant directors of nursing had completed the self assessment tool.

There were policies and procedures in place around safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the steps they must take if they witness, suspect or were informed of any abuse taking place. There were also policies and practices in place around managing responsive and psychological behaviour, and using methods of restraint in the service. Residents were safeguarded by staff completing risk assessments and reviewing their needs in relation to any plans of care that were in place to support residents to live as independent a life as possible.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
The wellbeing and welfare of residents with a diagnosis of dementia were generally maintained to a satisfactory standard through the provision of evidence based nursing, medical and social care.

The inspectors reviewed a sample of residents’ nursing and medical records. These records confirmed that residents were assessed prior to admission to the centre by the community nursing and medical team. This pre admission assessment documentation was forwarded to the person in charge. However, the pre-admission process did not routinely involve the input of the person in charge until the resident was admitted to the centre.

However, on admission to the centre each resident’s needs were comprehensively assessed with evaluation of a number of risk assessment tools and set out in an individual care plan. The inspectors were told that the care planning documentation process in the centre was recently revised and implemented in the dementia care unit. All staff had completed training on use of the revised documentation. Each resident had a care plan completed that identified their needs and the care and support interventions that would be implemented by staff to meet their assessed needs. However, the inspectors observed some areas where improvements were required in the care planning process to ensure residents’ needs were met in all respects. Inspectors observed that there was some duplication of care plans and care interventions in some care plans were unclear.

Inspectors observed where a small number of residents exhibited aspects of behaviour that challenged, their care plans required improvement. The care plans did not describe effective positive behavioural strategies for use by staff to manage these behaviours. As a result, inspectors found that there were inconsistent approaches taken by staff to manage the behaviour using recognised de-escalation techniques prior to resorting to the use of prescribed anxiolytic medication. This is detailed and actioned under Outcome 2.
There were no residents in the centre in receipt of end of life care on the day of inspection. There was evidence that the end of life needs and wishes of all residents’ with dementia were discussed with them and/or their next of kin as appropriate and documented in a care plan. These care plans addressed the resident's physical, emotional, social and spiritual needs. They reflected each resident's wishes and preferred pathway as part of their end of life care. However, there were inconsistencies in relation to the resident involvement in the decision making process relating to end of life care.

There was a policy on consent however; inspectors were unclear if the process used to obtain a valid consent in accordance with legislation and current best practice guidelines. On the day of inspection a resident had to attend an appointment in the local hospital. There was no evidence available in relation to consent being obtained from the resident in relation to the pending procedure. There was no evidence of the residents’ wishes or choices relating to treatment and care being discussed and documented and as far as possible implemented in order to maximise the principle of autonomy.

Arrangements were in place where care plans were reviewed and updated on a regular basis. There was evidence of involvement by residents or their next of kin in this process.

Systems for monitoring the exchange and receipt of relevant information when residents were transferred to or returned from another healthcare setting were in place. Discharge letters for residents who spent time in acute hospital care and letters from consultants detailing findings following out-patient clinic appointments were available. While, there was evidence that staff made every effort to ensure residents were accompanied on their out-patient clinic appointments and hospital admissions, improvements were required. A letter was completed by staff in the centre for residents requiring in-patient care in the acute hospital care setting. Transfer documentation identified areas of physical care needs. However, it lacked detail in communicating their individual psychosocial needs.

There were assessment and care procedures in place to ensure residents' nutritional needs were met and that they did not experience dietary or hydration deficits. Residents' weights were checked on a monthly basis. However, a pre-printed generic care plan completed for residents assessed by allied health professionals such as speech and language therapy or/and the dietician did not adequately reference their recommendations. There was a potential risk of negative outcomes for residents as these recommendations were not readily available in this documentation. Diet and fluid intake records were used as appropriate. Reference sheets were available to all staff including catering staff outlining residents’ special diets including diabetic, modified consistency diets and thickened fluids.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Nursing staff were observed administering medicines to residents by sitting down at their level, clearing explaining to them what the medication was for and what they needed to do to take their medication. Details of
all medicines administered were recorded by nurses. However, some residents’ medication prescriptions did not meet prescribing documentation requirements in the following areas.

- some medications for administration were not signed and dated,
- some discontinued medications were not signed and dated,
- medications administered in crushed format were not individually prescribed by the prescriber.

Inspectors saw that a medication management audit had recently been completed. Staff told inspectors that the pharmacist would visit to check stock control but would not routinely see residents. Residents had good access to medical and allied health professionals. There was a good GP service to the centre and all residents automatically came under this 'medical officer's' care on admission. However, this practice was not in line with Regulation 6 (2) (a) of the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013 which requires that residents are offered a choice of GP.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
There were policies in place about managing behaviour that challenges, BPSD (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. Measures to protect residents from being harmed or suffering abuse were in place. A policy on, and procedures for the prevention, detection and response to allegations of abuse was in place in accordance with HSE procedures. The Trust in Care procedures and the Safeguarding Vulnerable Persons at Risk of Abuse documents were available and accessible to staff.

Staff spoken to by the inspectors confirmed that they had received training on safeguarding vulnerable adults and were familiar with the reporting structures in place. All staff had been trained in 2015. There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. Staff confirmed that there were no barriers to raising issues of concern. A review of incidents since the previous inspection showed that there were no allegations of abuse in the centre.
Inspectors reviewed a selection of care plans to include residents who displayed challenging behaviour. Staff who spoke with inspectors were very knowledgeable regarding behaviours and could identify potential triggers to an onset of BPSD. There was no standardised assessment tool to assess behaviour that is challenging with symptoms objectively documented and qualified. Clear strategies were not outlined to support residents to manage behaviour that challenges or that focussed on a proactive and positive approach. Strategies were not outlined to support residents in relation to all the behaviours specific to the resident. The care plans did not outline sufficiently the antecedents and communication functions of the behaviours displayed which, when identified promptly, would guide staff to support residents in preventing incidents of behaviour that challenged. Interventions were not always outlined to guide staff such as redirection, noise reduction, distraction and diversion. However, the clinical nurse manager told inspectors they would always consider the reasons people's behaviour changed, and would also consider and review for issues such as infections and or pain. A review of training records indicated that staff were not provided with up-to-date knowledge and skills, appropriate to their role to enable them to manage and respond to behaviour that is challenging.

Inspectors saw that expert advice from the relevant professionals was sought where necessary before commencing any psychotropic medication or any use of physical restraint. Inspectors saw that any medications used as a restrictive practice to manage behaviour that is challenging was used under controlled conditions that promoted the well being and interests of the resident. Inspectors saw that there a register of residents using chemical restraint which was reviewed by the multidisciplinary team on a regular basis.

Inspectors observed that some residents were being trialled on reducing doses of certain medications which for some residents had been very successful. There were some instances where medication had to be increased until a therapeutic level was reached to enhance the well being of residents. Where chemical restraint was used on a PRN (as required basis) there were clear indicators documented that may trigger the use of such medication and the indications of giving or withholding the medications were documented.

The centre had a policy on the use of restraint which was in line with "Towards a Restraint Free Environment" to ensure residents were protected from potential harm. The use of any measures that could be considered as restraints such as bed rails was underpinned by an assessment and was reviewed on a regular basis. There was evidence that discussion had taken place with the resident, his/her representatives and in instances where these measures were requested the staff provided information on associated hazards and offered alternative options such as low to floor beds. Staff could outline a range of hazards and were clear that any restraint was used as a measure of last resort and only considered when less restrictive interventions had not achieved the desired outcome to keep the resident safe.

Since the previous inspection systems in place to safeguard resident’s money had improved. The centre was not managing the finances of residents. However the Assistant Director of Nursing told inspectors that a transparent system was in place to
manage small sums of monies on behalf of residents. All transactions were appropriately documented with lodgements and withdrawals co signed by two staff members.

Judgment:
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 03: Residents' Rights, Dignity and Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme:</td>
</tr>
<tr>
<td>Person-centred care and support</td>
</tr>
</tbody>
</table>

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

Findings:
There was evidence of a good communication culture amongst residents and the staff team. Inspectors observed that residents were well dressed and personal hygiene and grooming were attended to by care staff. The inspectors observed staff interacting with residents in a courteous manner and respecting their privacy at appropriate times. Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move around the centre freely. There was good signage to help residents to find their way and rest rooms and bathrooms were clearly posted.

There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends in the dining areas or communal rooms. Staff were observed to interact with residents in a warm and personal manner, using touch and eye contact appropriately and calm reassuring tones of voice to engage with those who became anxious restless or agitated.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place in the activity room and dining area at tea time. The inspector observed during a period of observation that the staff members knew the residents well and connected with each resident on a personal level. Reminiscence and imagination gym were therapies used to improve and maintain memory function as observed by the inspector during an observation period.

During the tea time period staff were observed to offer assistance in a respectful and dignified manner. All staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal. Independence was promoted and residents were encouraged to eat their meal at their
own pace by themselves with minimal assistance to improve and maintain their functional capacity. The quality of interactions were found to be person centred. Staff were familiar with residents' care needs and family background and efforts were continuously made to chat to them about their family, previous interests or working life.

Inspectors found there was a varied activities programme with arts and crafts and exercise included. There were also a mix of group and individual sessions. Resident’s life stories were collated by staff and the activity programme was reviewed regularly to ensure that the programme was relevant to residents past lives and interests. However, inspectors observed that all the activities in the weekly programme were delivered from Monday- Friday until 17:00hrs only. Evening and weekend activities primarily depended on direct care staff having time to facilitate or supervise a session. The assistant directors of nursing acknowledged this at the feedback meeting post inspection. They informed inspectors that the plan was to increase activity hours to 19:00hrs.

There was evidence that residents and relatives were involved and included in decisions about the life of the centre. There was a residents' committee which met regularly. However, inspectors observed that there were no residents or relatives from the dementia unit on this forum; it was participants from the other units within the centre on the committee. The inspectors observed that letters had been sent out to all family members of the residents in the dementia unit inviting them to take part in a new forum on a bi-monthly basis.

Inspectors observed that some residents were spending time in their own rooms, and enjoyed reading and watching TV, or taking a nap. Other residents were seen to be spending time in the many communal areas of the centre. Newspapers and magazines were available and inspectors saw some staff reading to residents.

There was a notice board available in the unit providing information to residents and visitors. Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities. There was a large oratory with religious services being held regularly. Residents were facilitated to exercise their political and religious rights. External advocacy services were available to residents.

All residents had a section in their care plan that covered communication needs, and staff were seen to be familiar with them. There was a detailed policy on provision of information to residents. Residents were seen to be wearing glasses and hearing aids, to meet their needs. However, inspectors did not see any referrals to audiology or ophthalmology even on an annual basis to enable independence and functioning to the resident’s highest possible level. Inspectors also observed that residents’ privacy and dignity was compromised as some residents lived in multi occupancy rooms. This is outlined in detail and actioned under outcome 6.

**Judgment:**
Non Compliant - Moderate

---

**Outcome 04: Complaints procedures**

---

Page 10 of 23
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 complaint’s policy was in place and the inspectors noted that it met the requirements of the Regulations. The complaints procedure in leaflet format was on display in the unit. There was evidence from records and interviews that complaints were managed in accordance with the HSE “Your Service Your Say” policy. Issues recorded were found to be resolved locally at unit level or formally by the complaints officer as appropriate.

A record of complaints was maintained at ward level. However, inspectors observed that there had been no complaints documented since June 2015. The nurse manager told inspectors that she would always endeavour to resolve complaints locally and she did not record any verbal complaints. Satisfaction surveys reviewed by the inspector indicated that relatives found that the management and staff were approachable if they had a complaint. However, as on the previous inspection inspectors observed that the outcome of the complaint was not recorded as being resolved and there was not any recording of whether the complainant was satisfied or not. In one instance it was unclear of the process used and details of the investigation and action taken.

Judgment:
Non Compliant - Moderate

Outcome 05: Suitable Staffing

Theme: Workforce

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

Findings:
Recruitment processes were reviewed on this inspection and on review of a sample of staff files these were found to meet the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. There were no volunteers working on this unit. Mandatory training was in place and staff had received up to date training in fire safety, moving and handling and safeguarding vulnerable persons. The staff also had access to a range of
education, including training in specific dementia training courses. Four staff had completed dementia training in 2015 and the nurse manager was undertaking the dementia champions module in September 2016. All staff were to undertake challenging behaviour training in 2016. Inspectors saw that there were monthly in-house education sessions planned for 2016 which included end of life, restraint and challenging behaviour.

There was a clear organisational structure and reporting relationships in place. There were designated CNM posts of responsibility on the unit for the supervision of care and services to residents and the supervision and direction of staff. The inspector saw records of regular meetings between these post holders and senior nursing management at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the regulations and standards. In discussions with staff, they confirmed that they were supported to carry out their work by the provider and person in charge. The inspectors found them to be confident, well informed and knowledgeable of their roles, responsibilities and the standards regarding residents with dementia living in residential care.

However, it was found that at the time of this inspection, the levels and skill mix of staff were not sufficient to meet the needs of residents with dementia on this unit. There were an average of two nurses and four care staff on duty during the day until 17.00 hours to provide direct care to residents. After 17.00 there was a reduction in nursing and care staff on duty. The number of nurses reduced to one at 17.00 hours with three carers on duty until the night staff took over. There was one nurse and a care assistant on duty at night.

Given the complex care needs of the client profile on this unit inspectors formed the judgement that the staffing numbers and skill mix were not at all times appropriate to the assessed needs of residents, the size, layout and purpose of the unit. Inspectors were informed that on occasions due to staff shortages nurse managers were replacing nurses in direct care provision and agency staff were used on a regular basis.

Inspectors saw that the agency nursing hours for the unit in December 2015 and January 2016 was 303 hours which was an average of 34 hours per week or 15.4% of the current weekly nursing hours. The agency health care assistant hours for the same period was 54 hours which equated to 1.5% of weekly health care assistant hours. It is acknowledged that every effort is made to ensure that the same agency nurses were deployed to ensure continuity for residents but this could not always be guaranteed. There was evidence of times when unplanned staff leave was replaced with staff not directly employed by the provider.

**Judgment:**
Non Compliant - Moderate

**Outcome 06: Safe and Suitable Premises**

**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 inspectors focused on the dementia care unit in the centre for the purposes of this inspection. The design and layout of the dementia care unit in the centre was not in line with the statement of purpose in relation to three bedrooms that provided accommodation for four residents in each room. These bedrooms require improvement in line with evidence based care of residents with a diagnosis of dementia.

The dementia care unit is one of three units within the designated centre. The dementia unit provides long-term accommodation for 20 residents on a continuing care basis on ground floor level. Residents’ bedroom accommodation consisted of eight single en suite bedrooms and three bedrooms with four beds in each. Each of the three multi-occupancy bedrooms had an en suite facility. In addition to the en suite facilities provided, there were sufficient numbers of accessible shower/bathrooms and toilets. Doors and fittings to these areas were in contrasting colours to promote independent access for residents. These facilities were also located within easy access of communal areas. Clear signage with picture cues was displayed to identify the different communal areas.

The layout of the single bedrooms was observed to meet the needs of residents. Each resident had sufficient storage space for their personal clothing and possessions. Most of these eight residents’ bedrooms were personalised with items of value to them and reflective of their interests and personalities including photographs, decorative wall hangings, pictures and ornaments. While all residents’ bedrooms were adequately furnished to meet residents’ needs, inspectors did not observe any items of personal furniture into the centre for their use such as armchairs, dressing tables and occasional tables.

Four residents resided in each of three bedrooms, which were gender specific. A ceiling hoist was fitted in one of these bedrooms. The rooms were clinical in style and did not reflect evidence-based dementia care principles in their design and layout. Each resident’s personal space was defined by a screen curtain used for the purpose of providing them with privacy. The inspectors observed that many residents in these multi-occupancy bedrooms had personal ornaments and photographs displayed on a shelf along the back of their beds. These shelves were beyond most residents’ easy reach and were not visible to them when in bed. Screen curtains for each bed were the same colour. The inspectors were told that residents are encouraged to use their bedspreads from home but most of the beds had a bedspread with a common colour in each of these bedrooms. Inspectors observed that the bedroom doors were not painted in contrasting colours and did not have other personalised features displayed to make them more easily identifiable to residents with dementia.

The communal areas in the dementia specific unit were reflective of the needs of residents living there. Inspectors saw colourful textured and three dimensional wall
paintings and ornaments. The centre was found to be well maintained, warm, comfortably and visually clean. All walkways were clear and uncluttered to ensure resident safety when mobilising.

Residents’ accommodation and communal areas are located off a wide circulating corridor which was fitted with handrails on one side throughout. Inspectors observed that this facility promoted residents’ independence and safety with mobilising. A spacious communal sitting/dining room, an activity room, a quiet room and a kitchenette were decorated with domestic style features and furniture. Residents could access the kitchenette and one resident liked to make tea for her family when they visited. Another resident used the washing machine in the kitchenette with the support of staff to wash some of her personal clothing. Within the garden area there was a washing line for a resident who liked to hang out her washing.

There was a large enclosed garden with many sensory features. This included a pathway that meandered through patches of shrubbery and small trees. Seating areas were available to residents in the dementia specific unit. The communal areas were fitted with large windows that looked out on this garden.

**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:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St John's Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000604</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>21/01/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22/02/2016</td>
</tr>
</tbody>
</table>

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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors observed some areas where improvements were required in the care planning process to ensure residents' assessed needs were met in all respects. Inspectors observed that there was some duplication of care plans and care interventions in some care plans were unclear.

1. Action Required:

---

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
All Residents will have a DML care plan, therefore each resident, will be individually assessed regarding their needs, to ensure person centred care and these assessments will be carried out in consultation with the resident and the family. All assessments are evidenced based to ensure person centeredness for example key to me.

Proposed Timescale: 23/03/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Ensure that all residents are afforded a choice of GP.

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

Please state the actions you have taken or are planning to take:
On admission to St Johns Community Hospital, new residents will be given a choice of maintaining their own GP for the delivery of medical care.

Proposed Timescale: 21/03/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that the process used to obtain a valid consent is in accordance with legislation and current best practice guidelines. In one instance there was no evidence of the residents’ wishes or choices relating to treatment and care being discussed and documented and as far as possible implemented in order to maximise the principle of autonomy.

3. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
All Residents will have a DML Care plan where each resident will be individually
assessed regarding their needs to ensure person centred care and these assessments will be carried out in consultation with the resident and the family. All assessments are evidenced based to ensure person centeredness for example Key to me, restraint, falls and the use of Picture Education Communication Kits (P.E.C.Ks) where indicated.

**Proposed Timescale:** 21/03/2016  
**Theme:** Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
There were inconsistencies in relation to the resident involvement in the decision making process relating to end of life care.

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

**Please state the actions you have taken or are planning to take:**  
The decision making process of end of life care will be a consultation process with the resident, key worker, family member and medical officer.

**Proposed Timescale:** 25/02/2016  
**Theme:** Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Transfer documentation identified areas of physical care needs. However, it lacked detail in communicating their individual psychosocial needs.

5. **Action Required:**  
Under Regulation 25(1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre for treatment at another designated centre, hospital or elsewhere, to the receiving designated centre, hospital or place.

**Please state the actions you have taken or are planning to take:**  
New person centred transfer letter is being developed which will include the appropriate detail regarding individual psychosocial needs.

**Proposed Timescale:** 31/03/2016
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff told inspectors that the pharmacist would visit to check stock control but would not routinely see residents.

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

Please state the actions you have taken or are planning to take:
A review of the current provision of pharmacy services has commenced which, once complete, will provide further assurances that the residents requirements are met and that choice of pharmacy will be given.

Proposed Timescale: 30/04/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents’ medication prescriptions did not meet prescribing documentation requirements in the following areas;
- some medications for administration were not signed and dated,
- some discontinued medications were not signed and dated,
- medications administered in crushed format were not individually prescribed by the prescriber.

7. 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:
Meeting to be held with GP/Medical Officers to ensure that all medical products are prescribed in safe manner.
Pharmacist Support and Education is being sourced and dates will be put in place for Staff Education regarding Poly-pharmacology and pharmacy use within the Elderly Population. Mandatory education in medication management e.g. HSELAND Medical Officers will be met on a monthly basis from the 29/02/2016 as part of the Quality and Safety Forum at the Hospital.
<table>
<thead>
<tr>
<th>Proposed Timescale: 31/03/2016</th>
</tr>
</thead>
</table>

**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A review of training records indicated that not all staff had up-to-date training in challenging behaviour.

8. **Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
Training for both behaviours that challenge and person centred care has been organised and the same will be commencing on 22 March 2016 and 6 April 2016.

<table>
<thead>
<tr>
<th>Proposed Timescale: 30/04/2016</th>
</tr>
</thead>
</table>

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no standardised assessment tool to assess behaviour that is challenging with symptoms objectively documented and qualified. Clear strategies were not outlined to support residents to manage behaviour that challenges or that focussed on a proactive and positive approach.

9. **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:
Strategies to manage behaviours in a positive manner have been introduced to the unit. Each resident that exhibits challenging behaviour has a behaviour observation chart as part of his or her care plan (applied from The Cohen-Mansfield and ABC model).

<table>
<thead>
<tr>
<th>Proposed Timescale: 07/02/2016</th>
</tr>
</thead>
</table>

**Outcome 03: Residents' Rights, Dignity and Consultation**
**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors observed that there were no residents or relatives from the dementia unit on the residents' forum; it was participants from the other units within the centre on the committee.

**10. 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:**
Named resident and relative from dementia ward are now part of the residents' forum.

**Proposed Timescale:** 16/02/2016

<table>
<thead>
<tr>
<th>Theme</th>
<th>Person-centred 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>
<td>Inspectors did not see any referrals to audiology or ophthalmology even on annual basis to enable independence and functioning to the resident’s highest possible level.</td>
</tr>
<tr>
<td><strong>11. Action Required:</strong></td>
<td>Under Regulation 09(3)(c) you are required to: Ensure that each resident may communicate freely.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>All residents are referred as necessary for audiology and ophthalmology the service. &quot;Eyes on the Road &quot;ophthalmology service is being introduced to the service.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong></td>
<td>08/03/2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme</th>
<th>Person-centred 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>
<td>Inspectors observed that all the activities in the weekly programme were delivered from Monday- Friday until 17:00hrs only. Evening and weekend activities primarily depended on direct care staff having time to facilitate or supervise a session.</td>
</tr>
<tr>
<td><strong>12. Action Required:</strong></td>
<td>Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to</td>
</tr>
</tbody>
</table>
participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
Plan of action is being developed to provide activities on a seven day basis to ensure that opportunities for residents to participate in activities in accordance with their interests and capacities.

Proposed Timescale: 29/04/2016

Outcome 04: Complaints procedures
Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect: Inspectors observed that the outcome of the complaint was not recorded as being resolved and there was not any recording of whether the complainant was satisfied or not.

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

Please state the actions you have taken or are planning to take:
A process has been put in place to ensure that all complaints/ concerns are documented, actioned and evaluated. It is ensured that the resident is happy with the outcome. All outcomes are precisely documented in a timely manner.

Proposed Timescale: 07/02/2016
Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect: Inspectors observed in one instance that it was unclear of the process followed, details of the investigation and action taken.

14. Action Required:
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident’s individual care plan.

Please state the actions you have taken or are planning to take:
A process has been put in place to ensure that all complaints /concerns are documented, actioned and evaluated. It is ensured that resident is happy with the outcome, and all outcomes are precisely documented in a timely manner.

**Proposed Timescale:** 07/02/2016

### Outcome 05: Suitable Staffing

**Theme:**
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors formed the judgement that the staffing numbers and skill mix were not at all times appropriate to the assessed needs of residents, the size, layout and purpose of the unit. Inspectors were informed that on occasions due to staff shortages nurse managers were replacing nurses in direct care provision and agency staff were used on a regular basis.

15. **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:**
Review of staffing levels and skill mix is to take place to ensure appropriate skill mix is available.

**Proposed Timescale:** 31/03/2016

### Outcome 06: Safe and Suitable Premises

**Theme:**
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were three multi occupancy bedrooms that provided accommodation for four residents in each room. These bedrooms require improvement in line with evidence based principles of care of residents with a diagnosis of dementia.

16. **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:**
Funding will be sourced to ensure that premises conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Proposed Timescale:** 30/09/2016