Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	St John's House
Centre ID:	OSV-0000101
Centre address:	202 Merrion Road, Dublin 4.
Telephone number:	01 269 2213
Email address:	admin@stjohnshouse.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	The Trustees of St John's House
Provider Nominee:	Graham Richards
Lead inspector:	Deirdre Byrne
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	43
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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

From:	To:
11 November 2014 10:00	11 November 2014 19:00
12 November 2014 09:00	12 November 2014 19:30

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 inspection took place following an application to the Health Information and Quality Authority (the Authority), to renew registration. As part of the inspection, the inspector met with residents, relatives, and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The registered provider are the Trustees of St. Johns House and the person nominated on behalf of the provider is Mr. Graham Richards (the provider). The inspector met the provider who was new to the role at the inspection. A fit person interview was arranged with the provider on the 27 November 2014. The inspector

found the person in charge continued to demonstrate her fitness and had an adequate understanding of the Regulations, the National Standards and their statutory obligations at this inspection.

A number of areas for improvement in the management of risk were identified by the inspector. The risks related to the window openers and bedrails. The provider and person in charge were required to take immediate action, which was completed to mitigate the risk identified during the inspection.

There were improvements also identified in relation to the documentation of care plans. The management of residents' health care needs in relation to falls required improvement. The inspector also identified areas of improvement in aspects of the premises in meeting the requirements of the Regulations. The staff skill mix at night time required improvement. There were improvements also required to ensure all staff had up-to-date mandatory training.

The inspector found the health needs of residents were met to a good standard. The nursing care was provided by staff who were familiar with the care needs of residents. Residents had good access to general practitioner (GP) services and, a range of allied health services. There was a variety of activities for residents to do during the day, with good evidence of their involvement in the running of the centre. There were proactive practices in the management of complaints. There were good practices identified in the management of fire safety.

The inspector followed up on ten actions from the previous inspection. Five of the actions were completed, three partially and two were not completed. The actions not completed related to the multi-occupancy bedrooms and the implementation of the risk management policy.

These matters are further discussed in the report and in the action plan at the end of the report.

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

Outcome 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 inspector was satisfied a written statement of purpose was developed for the centre that met the requirements of Regulation 3 and Schedule 1 of the Regulations.

The statement of purpose outlined the aims, mission and ethos of the service. It provided a clear and accurate reflection of facilities and services provided.

Judgment:
Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The inspector was satisfied there was a clearly defined management structure that outlined the lines of authority and accountability, with systems in place to review the quality and safety of life of residents.

The centre was governed by a board of trustees who met regularly. The provider was not based in the centre, but met the person in charge frequently. There were monthly management committee meetings between the provider, the person in charge and the

board of trustees. Minutes read by the inspector confirmed meetings took place at frequent intervals and a range of issues were discussed regarding the operation of the centre, including residents health care needs, staffing levels and risk management.

There was a system in place to monitor the quality and safety of care and the quality of life of residents. The inspector reviewed documentation of internal and external reviews. A range of audits were carried out and included falls, wound care, medication management and infection control audits. In addition, the person in charge had completed end-of-life and nutrition assessments in preparation for thematic inspections carried out in 2014 by the Authority. There was evidence of the change and learning from the monitoring carried out. For example, the two clinical nurse managers (CNMs) had taken a theme each. The CNM reviewing end-of-life care had carried out two audits, and had identified areas of improvement required and what change was needed to be brought about such as the documentation of residents' wishes and care plans. The inspector met the nurse who showed the inspector the audits developed and outlined the action to be taken. These are discussed in more detail in Outcome 14 (End-of-Life Care).

Although an annual report on the safety and quality of care had yet to be completed the provider and person in charge were aware also of the requirement to consult with families and residents on its preparation. This was discussed with the person in charge at the opening meeting who was aware of the requirements to do same.

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

Findings:
The inspector was satisfied that a guide to the centre was available to residents and a contract of care agreed with each resident on their admission to the centre.

There was evidence a written contract of care was agreed with residents on their admission to the centre. A sample of contracts reviewed set out the services to be provided and the fees to be charged. An action from the previous inspection was completed, and the contract included a list of services that incurred an additional fee, along with details of what those fees were. The inspector was informed a new contract was in draft and would be rolled out to new residents on admission to the service.

The residents guide to the centre was reviewed and met the requirements of the Regulations.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspector was satisfied that the centre was managed by a suitably qualified and experienced person with accountably and responsibility for the service.

The person in charge was a registered general nurse who had the relevant length of experience required by the Regulations. She demonstrated adequate knowledge of the Regulations, and was clearly aware of her requirements therein.

The person in charge participated in ongoing professional development by attending seminars, conferences, talks on a range of topics in care of the elderly. She had attended end-of-life and palliative care courses organised by the local hospice. In 2007, the person in charge completed a masters degree in health care ethics and law.

The person in charge was based in the centre five days per week and fully engaged in the management of the service. She met with the provider regularly and participated in management meetings. There was evidence of regular staff meetings throughout the year, with a range of issues discussed and acted on. The person in charge was familiar with the residents health and social care needs, and was observed interacting with resident frequently throughout the inspection.

Satisfactory deputising arrangements were in place. The person in charge was supported in her role by two clinical nurse managers who deputised in her absence. The CNM's participated fully in the inspection process, demonstrated good clinical knowledge and adequate familiarity with the Regulations.

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

Findings:
The inspector reviewed the operational policies and procedures as required by Schedule 5 were in place. However, a number of policies reviewed did not guide practice, and some were not fully implemented in practice. There were gaps in the information to be contained in the directory of residents.

The policies and procedures as required under schedule 5 the Regulations were reviewed. An action from the previous inspection had been partially completed regarding polices guiding practice. At this inspection, policies on falls, restraint and infection control now not guided practice. However, some policies did fully provide direction to staff. For example, the policy on residents' finances and the protection of vulnerable adults, see Outcome 7 (Protection). In addition, the smoking policy as outlined under Outcome 8 (Health, Safety and Risk). The policy on restraint and falls provided guidance to staff however, they were not fully implemented in practice as discussed under Outcome 7 and Outcome 11 (Health care needs).

There was a system in place to ensure staff were suitably knowledgeable regarding the policies, and staff sign off sheets were read by the inspectors. Staff spoken with appeared to to be aware of the policies and reflected them in practice, with an area of improvement in relation to falls and restraint as outlined in the paragraph above.

The inspector reviewed the directory of residents. While it contained most of the information required by Regulations, entries were incomplete for some residents. For example, the address of residents, and their next of kin, the cause of death were not consistently recorded.

The inspector reviewed entries to the nursing and medication records for residents. However, medication administration records were not consistently completed in accordance with the relevant professional guidelines. This is discussed further under Outcome 9 (Medication Management).

There was evidence that records were maintained in the centre, were up-to-date, secure, but easily retrievable. Documents reviewed confirmed the centre was adequately insured against injury to residents, along with insurance against loss or damage to residents property.

Judgment:
Non Compliant - Moderate

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 any proposed absence of the person in charge for a period of more than 28 days. There were appropriate contingency plans in place to manage any such absence. One of the two CNMs deputised for the person in charge in her absence.

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:
The inspector found systems were in place to protect residents from being harmed or suffering abuse. However, there were improvements required in the overall management of restraint.

The practices in the management of restraint required improvement. Although there was a detailed policy on restraint it was not fully implemented in practice by staff. There were a high number of residents with physical restraint in place. For example, approximately 45 percent of residents used bedrails. The inspector was concerned that bedrails used in the centre had not been comprehensively assessed. There was no evidence they had been measured where required to ensure there was no risk of entrapment. The assessment tool in use was not comprehensive enough to guide

practice. The person in charge was requested to take immediate action to address this concern. Before the end of the inspection, appropriate measures had been taken to address this risk. The inspector was advised all bedrails not in compliance with the policy would be put out of use with immediate effect. While the person in charge was aware of and had a copy of the national policy on restraint "Towards a Restraint Free Environment", these matters were not fully in line with the national policy. An action from the previous inspection was addressed and the alternatives to the use of restraint were now documented.

The were good practices in the management of behaviours that challenged. The inspector read a policy that guided practice. A very small number of residents had behaviours that challenge. Although care plans were put in place, information such as the triggers and strategies to de-escalate behaviours that challenge were not consistently outlined, as outlined under Outcome 11. Evidence based tools were used to record incidents. The inspector spoke to staff who could describe residents behaviours that challenged and the interventions they would follow.

There was a policy on the protection of vulnerable adults that provided sufficient detail. While it provided sufficient detail, there were some gaps identified such as the requirement to notify the Chief Inspector of allegations of abuse and the person nominated to investigate allegations of abuse made against the person in charge were not outlined. This is discussed under Outcome 5 (Documentation). The person in charge and senior nursing staff were knowledgeable on the procedures to investigate an allegation of abuse.

The inspector read records that staff had received training in the protection of vulnerable adults, with an area of improvement to ensure all training records were in place as outlined under Outcome 18. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place.

The inspector found suitable arrangements were in place to safeguard residents' finances. There were documented procedures on the management of residents finances. However, the procedures did not outline the current system in place to withdraw residents' money and the procedure that only designated staff permitted to make transactions on behalf of residents where authorised to do so. This is discussed under Outcome 5.

All residents spoken to said that they felt safe and secure in the centre. Residents stated that they attributed this to the staff who said they were caring and trustworthy.

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

Findings:
The inspector found there were systems in place to promote and protect the health and safety of residents, staff and visitors. However, the management of risk required improvement, along with the risk management policy. There were suitable fire safety systems in place to protect residents.

There was a safety statement in place and the inspector reviewed the centres risk management policy. However, the policy did not fully meet the requirements of the Regulations. For example, it did not include the measures and actions in place to control risks such as abuse,accidental injury, missing resident, or self harm.

A risk register was reviewed by the inspector and contained clinical and non clinical risk assessments. However, areas of risk were identified by the inspector during the inspection which had not been identified and assessed. They included:

- windows were not provided with adequate restrictive opening devises. It was brought to the attention of the person in charge who undertook to address the matter immediately. The maintenance officer for the centre advised the inspector on the morning of the second day that all windows had been reviewed and new restrictors were being put in place.

There was a twice yearly safety check carried out of radiator surfaces. However, there was no formal system of ongoing monitoring and assessment of all other risks being out in the centre. This matter had also been an issue at the previous inspection.

- A hot water unit located in the dining room was a potential risk to vulnerable residents who used the room independently.

The inspector found that smoking risk assessments were completed for residents that smoked to assess their safety. However, they were not comprehensive enough. For example, the potential risks associated with each individual resident and the control measures were not outlined. There was a smoking policy in place, but it did not provide sufficient guidance to staff. This is discussed under Outcome 5.

The inspector reviewed incidents records and there was evidence of risk assessments completed for each. There was evidence that appropriate action was taken to address each incident and they were investigated in a timely manner. However, there was no evidence of the learning or improvement to prevent these incidents from happening again. For example, residents care plans were not consistently updated following incidents such as falls.

The inspector saw residents were encouraged to be actively mobile and were seen being escorted around the centre. Staff were observed following best practice in the movement of residents. The inspector found that there was safe floor covering and

handrails throughout the centre and a passenger lift accessed each floor.

There were documented procedures in place for the management of adverse events involving residents.

The inspector were satisfied that there were robust fire safety system were in place. There were regular checks and monitoring of fire safety procedures in place. Fire procedures were prominently displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. The inspector noted that the fire panels were in order and fire exits, which had daily checks, were unobstructed.

Training records read confirmed not all all staff had attended training within the last year. However, the person in charge had identified staff who had not completed training and a training date was planned for the end of November 2014 to address this. There were regular fire drills conducted including evacuation procedures, and records were maintained of the outcome and learning from the drills. Staff spoken with were knowledgeable of the procedure to follow in the event of a fire.

An emergency plan was in place which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency.

The inspector found that there were measures and policies in place to control and prevent infection. Staff were knowledgeable of infection control procedures. There were supplies of gloves and disposable aprons, and alcohol hand gels were available throughout the centre.

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

Findings:
The inspector found residents were protected by the designated centres' policies and procedures for medication management. However, improvements were identified in recording practices.

A comprehensive policy was in place which guided practice. The inspector read completed prescription and administration records. However, improvements were

identified in the recording of medications administered. For example:

- transcribed medications not consistently provided with second nurse signature
- some medications had not been provided with a prescribed time
- crushed medications were not individually prescribed.

These were not in line with policy or best practice guidelines and were discussed with the CNM and person in charge. These matters are discussed under Outcome 5.

Since the last inspection, an electronic medication administration system was being piloted in the centre. The pharmacy for the centre had devised the system. Training had been provided to nursing staff. The nursing staff continued to complete the hard copy version of the administration sheet. The person in charge informed the inspector this would not be rolled out until procedures, policies and a full review of the system were completed. The inspector advised the use of such a system would need to have a robust management system in place to mitigate any possibility of risk when using it, and would need to comply with the Regulations, professional guidelines and best practice guidelines.

Staff nurses involved in the administration of medications informed the inspector they had undertaken training updates in best practice. There was records of the training held on training files.

The person in charge informed inspectors medication errors were reviewed. There had been five errors since the previous inspection. The person in charge outlined the investigation completed for each error, along with the action taken and the learning for staff.

There were regular medication audits completed by the pharmacy and in-house by nursing staff, there was evidence of findings.

At the time of the inspection no residents were self medicating. There was written evidence was available that medications were regularly reviewed by residents GP were carried out.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. The inspector checked the balance of a sample of medication and found it to be correct.

Judgment:
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 was satisfied that a record of all incidents was maintained, and where required notified within specified time frame to the Chief Inspector.

The person in charge was aware of the requirement to notify the Chief Inspector of certain incidents. In addition, a quarterly report outlining other incidents in the centre was made to the Chief Inspector, as required.

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

Findings:
The inspector found residents received a good standard of nursing care from staff who were familiar with their health care needs. There was good access to GP services and a range of allied health professionals. However, there were improvements required in the documentation of care plans. Additionally, aspects of residents' health care needs were not met in relation to the management of falls.

The inspector reviewed a sample of residents care plans during the inspection. Residents were regularly assessed for a range of clinical needs and there was evidence of consultation with them. However, improvements were identified in the documentation of care plans. For example, practices and interventions carried out by staff were not consistently documented in care plans for the prevention of falls, the management of behaviours that challenge, end-of-life care and dementia. These matters were brought to the attention of the person in charge who assured the inspector that they would be reviewed. There was evidence of consultation with residents on their care plan which had been an issue at the previous inspection and addressed.

While there were good practices in the management of falls some were improvements identified. A falls policy was in place which provided direction to staff. It had been updated since the last inspection to include post falls procedures. However, it was not fully implemented in practice by staff. For example, falls prevention care plans for a resident who had multiple falls resulting in injuries did not include the interventions to prevent future falls occurring and additional monitoring and control measures had not been put in place. There were records of neurological observations completed post fall. However, they were not completed in accordance with the policy. Residents were regularly assessed for risk of falls and had care plans in place to guide their care. After each fall an accident/incident form was completed. Since the previous inspection falls training provided to staff, with plans for more training in the future.

The inspector found good practices in the management of wounds, with an area of improvement identified. A small number of residents had wounds at the time of the inspection. There was a policy which provided direction to staff. Where a wound developed, there were photos taken, and the wound was measured. There was evidence of regular assessments and treatment charts were completed at each dressing. While there was evidence that care plans were put in place to ensure a consistent and standard approach of care, one resident had no wound care plan developed. Residents were regularly assessed for the risk of pressures sores and care plans were developed where a risk was identified.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
The inspector found the centre generally met the requirements of the Regulations and the Authority's Standards. However, aspects of the building required improvement. These were discussed with the provider and person in charge who told the inspector they would be addressed. A detailed presentation was shown to the inspector of plans for a new building that would fully address the deficits in the centre. However, the plans had yet to receive planning permission. It was envisaged planning permission would be applied for on the 14 November 2014. The provider advised the inspector that the Authority would be updated as soon as they received a decision.

The issues are outlined as follows:

- there were four three-bedded rooms which will not meet the requirements of the Standards. There was no ensuite provided in these bedrooms. A bathroom was located in the hall close to the bedrooms. The majority of residents had their own wardrobe and locker by their bed for personal items. However, in one bedroom there was insufficient space to place a locker by one residents beds. There was sufficient space around each bed to access residents with a hoist if required. The bedrooms were pleasantly decorated and laid out.

- general storage space was not sufficient as equipment was stored in communal bathrooms and bedrooms.

The inspector found the centre was comfortable, homely and pleasantly decorated. It felt warm to be in. There were paintings, plants and lamps, and soft seating throughout. As outlined above, the residents' bedrooms were nicely decorated, and some with their own furniture and personal touches added. A call bell was provided by each bed. There were a number of two bedded rooms along with the four three- bedded rooms mentioned above and each were provided with suitable screening between beds.

The centre was kept in a clean condition, and was well maintained to a good standard of repair. There was a secure, enclosed garden, directly accessible from the centre.

There was provision of assistive equipment such as hoists and a chair lift. A lift provided access between all floors. Servicing reports read confirmed they had been recently serviced and were in good working order.

Judgment:
Non Compliant - Moderate

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 inspector was satisfied that the provider and person in charge ensured a proactive approach to the management of complaints.

There was a detailed complaint's management policy in place that met the requirements of the Regulations. The complaints procedure was displayed at the entrance of the centre, and it outlined the complaints process. An appeals process was in place, that

was fair and objective.

Residents who spoke to the inspector said they would have no problem making a complaint if they needed to. They were able to name the person in charge who was the complaints officer.

A complaints log was maintained and a sample of records were reviewed. There was evidence that each complaint was appropriately responded to, with details of the investigation carried out, the action taken, and whether the satisfaction of the complainant.

Judgment:
Compliant

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
The inspector found end of life policies and procedures were in place. There were system in place to record residents wishes and preferences, with an area of improvement identified.

A detailed policy was reviewed which provided guidance to staff. The inspector was informed that one resident was approaching end-of-life care on the day of inspection. Although there was a care plan developed the residents spiritual and emotional wishes were not outlined in their care plan, as outlined in Outcome 11. This was discussed with the person in charge and the CNM overseeing end-of-life care. They explained they had commenced auditing end-of-life practices and were in the process of illiciting residents wishes along with meeting their relatives and their families to discuss the residents preferences. It was envisaged all residents would be met, and if not their relatives would be invited to attend a meeting at some stage during the year. However, at the time of inspection, eight out of the 45 residents had been met with and their wishes discussed.

There was access to the local palliative care team who provided support and advice when required. There was evidence some staff had completed training in end-of-life care, and the person in charge was organising additional training with the local hospice for staff in the centre.

A visitor's room was available for relatives and friends for privacy if required. A single room was available to residents approaching end-of-life if this was requested or required. If residents passed away a discreet sign and flowers were displayed.

An oratory was available if families wished to use it. Staff and residents were informed of any residents passing.

Judgment:
Non Compliant - Minor

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
The inspector was satisfied that there were good practices in the management of nutrition, and resident's were provided with meals that were wholesome and in accordance with their assessed needs.

There was a nutrition management policy that had been updated since the last inspection. It now contained guidelines for monitoring residents at risk of malnutrition or who had lost weight. The inspector reviewed the files for a number of residents at risk of malnutrition, and care plans were in place to guide care. Evidence based assessments were completed and residents were weighted monthly or more frequently where at risk. There was evidence of regular review by a dietician and speech and language therapist (SLT), and recommendations reflected in care plans. Supplements were prescribed where required.

The inspector spent time with residents in the dining room at the lunchtime meal. The residents were discreetly assisted with their meals where required. A menu was displayed on each table that outlined the choice of meal for the day. A number of residents expressed their satisfaction with the quality of meals. A number of residents also expressed they were not happy with the choice provided. The inspector followed these up with the person in charge, who assured the inspector a good range of choice was available and was familiar with residents concerns. The inspector visited the kitchen and found sufficient choice of food was available. This was discussed with the chef who showed the inspector a four week rolling menu which was regularly reviewed by a dietician. Tables were pleasantly set and residents were served as they sat.

There was choice of meals for residents on a modified consistency diet. The staff were familiar with the special dietary requirements and preferences of residents' and were knowledgeable of the residents' assessed needs. As outlined above the inspector met the chef and found he was knowledgeable of special dietary requirements of residents and showed the inspector a list of residents most up-to-date dietary requirements. The

chef also was familiar with the types of consistency diets residents were on.

The inspector saw residents being offered a variety of snacks and fresh water, fruit juices and hot drinks during the day.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
The inspector found residents were consulted with and participated in the organisation of the centre. Their privacy and dignity was respected and had opportunities to participate in activities appropriate to their interests and preferences.

There were systems in place to ensure residents were consulted with about how the centre was planned and run and to facilitate participation in the organisation of the centre. A residents' committee met four times a year. The minutes of the last meeting held in September 2014 were read. Comments raised included mealtimes and laundry. The person in charge outlined the action taken to address each comment raised. Residents told inspectors they were aware of the meetings.

Voting rights were respected, and a polling booth was set up by the local county council at each election or referendum. The person in charge outlined details of the arrangements in place with the council.

Religious and spiritual needs of residents were respected. The centre had a Church of Ireland ethos and many residents chose to live in the centre because of this. The person in charge outlined the services available to the residents. Residents of other religious denominations were facilitated also.

There were no restrictions on visits except where requested by residents. There were arrangements in place for residents to receive visitors in private and a visitors room was available. The residents had access to telephones located on each floor. There were televisions provided and available in each bedroom. The newspapers were available each day including weekends.

Overall, residents received care in a dignified way that respected their privacy at all times. The inspector observed staff chatting and sitting with residents. The residents seemed comfortable and happy in their surroundings. The inspector spoke to a number of residents, families and staff who mostly expressed their satisfaction with the centre. There were a number of issues raised with the inspector during the inspection around specific issues with residents care needs, these were brought to the the person in charge who assured the inspector they would be followed up.

While staff outlined to the inspector how they would communicate with residents, some improvement was identified. For example, the communication needs of residents with dementia were not clearly outlined in their care plan. This is outlined in Outcome 11.

There were adequate facilities for recreation with a number of sitting areas for residents to choose to sit in, including a smaller sitting room where a weekly coffee morning took place for the female residents.

The inspector found residents had opportunities to participate in activities that were meaningful and purposeful and in accordance with their interests. An activities coordinators facilitated activities along with a second person who was on leave during the inspection. The inspector spoke to the coordinator who outlined the programme of activities, including reminiscence, art history, chatting and reading with residents. Some residents preferred to stay in their room and the coordinator said he would also visit these residents. The coordinator was a facilitator in sonas (a music and sensory therapy for residents with a communication impairment) that took place twice a week in the centre. The nursing staff were in process of developing a "key to me" for each resident, a document that outlined their background, family, interests, hobbies and likes. An activities assessment was also completed to ensure that activities were appropriate to their needs, likes and preferences.

Judgment:
Compliant

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:
The inspector found residents had adequate space for their personal belongings and their clothes were suitably laundered and returned to them.

There was a policy on residents personal property and possessions. The person in

charge confirmed that a list of residents personal possessions were maintained in hard copy on each file. One of the CNMs was also in the process of drawing up an electronic list of residents personal properties as part of their end-of-life care plan, it was envisaged a list would be in place for all residents by the end of the year.

Residents were encouraged to personalise their bedrooms. Many of the bedrooms were decorated with pictures and photographs from residents' own homes. There was adequate storage space for residents clothing and belongings.

Clothing items were clearly marked with the name of the resident. Residents personal clothing was laundered in house. The inspector spoke to residents who confirmed they were satisfied with the way in which their clothes were cared for and were happy with the service.

Judgment:
Compliant

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

Findings:
The inspector found there was appropriate staffing in place to meet the needs of residents. However, the skill mix at night was not adequate to meet residents needs and, to ensure adequate supervision. The completion of up-to-date mandatory training was an area of improvement also identified.

The inspector found the staff skill mix at night time was not adequate to met the assessed needs of residents and the layout of the centre. The roster for the centre was reviewed and it was noted one nurse and three health care assistants were on duty from 8pm till 8am. Although no negative outcomes were identified during the inspection, the majority of residents were of a high to maximum dependency and the centre was laid out over two stories therefore, the inspector was not satisfied one nurse was sufficient to deliver and supervise care for the current 43 residents at night. Furthermore, some residents and relatives commented that the number of staff at times was not adequate. These matters were discussed with the person in charge who was satisfied that both the staff number and skill mix met the residents needs, and that there was no risk to

residents in the centre.

The inspector reviewed staff training records. There was a training matrix that outlined the mandatory training completed by staff in fire safety, protection of vulnerable adults and movement and handling of residents. However, not all staff had completed up-to-date training in each of these areas. While the person in charge outlined scheduled dates for fire safety, dates had not been confirmed for staff who required refresher training in manual handling and protection. In addition, there was no confirmation on two staff files to verify completion of mandatory training and no record of medication management completed by staff.

There was a range of other training provided to staff since the last inspection. With training provided in areas such as palliative care, infection control, falls management, and restraint. Staff spoke with confirmed they attended training and were knowledgeable of these areas and the clinical needs of residents. An action from the previous inspection was completed, and staff were familiar with key operational policies such as fire safety, elder abuse and medication management.

The inspector reviewed a sample of staff files and found they contained the information required by the Regulations.

There was an induction process in place for all newly recruited staff. The person in charge explained all new staff were regularly appraised during their probationary period. These were viewed on residents files by the inspector. The person in charged informed the inspector that a new appraisal system was being developed. It was planned to be introduced to staff in the centre in 2015.

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:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	St John's House
Centre ID:	OSV-0000101
Date of inspection:	11/11/2014
Date of response:	15/12/2014

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies in place were not consistently implemented by staff for example, the falls and restraint policies.

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

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

Please state the actions you have taken or are planning to take:
1. Staff have received a copy and have been advised to use the Falls policy to guide practice in particular the prevention of falls, the taking of observations and the documenting of improved care plans. 31st December 2014
2. All falls are audited monthly. These will continue to be subject to the audit process with an improved focus on observations, prevention care plans and post falls care plans. Action plans will be completed and feedback of performance will take place at staff meetings. 31st January 2015
3. A new Comprehensive Assessment Tool for Restraint which includes measurements has been implemented. This is based on the HSE restraint tool. Completed
4. A new assessment for the restraint register has been activated by EPIC and all staff will be trained. 31st January 2015

Proposed Timescale: 31/01/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the protection of vulnerable adults and residents finances did not fully guide practice.

The smoking policy did not guide practice.

Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
1. The policy on vulnerable adults has been amended to include to whom allegations of abuse against the PIC or other management should be reported. The policy also includes notification to the chief inspector COMPLETED
2. Property Policy has been updated and includes:-
a. Recording of transactions on EPIC
b. Password protection
c. Staff authorised to access this section
d. Lodgement, withdrawals from pocket money account,
e. Management of Cash, statement of accounts, Audit of ledger.
f. Designated person with responsibility
g. Use of invoices and receipts
h. Approval signatures are by two people, the person in charge and the administrator for residents with capacity
i. Authorisation of the person in charge in consultation with next of kin for residents without the capacity to make decisions.
j. Persons authorised to co-sign COMPLETED

3. No Smoking Policy has been updated and now gives direction to staff on their own responsibilities on smoking on the premises. It refers to the national policy on Healthy Ireland and Tobacco free Ireland 2013. It provides guidance on the assessment of residents on the rules, safety management of cigarettes and lighter, use of safety apron, co-operation of relatives and visitors regarding safety and lighters and matches, Smoking cessation COMPLETED

Proposed Timescale: 15/12/2014

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in the information contained in the Directory of Residents as required by Regulations.

Action Required:
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

Please state the actions you have taken or are planning to take:
The Directory is now established on EPIC Solutions and replaces the paper version. This will ensure gaps are easily identified and immediately rectified. Staff has been instructed to do same.

Proposed Timescale: 15/12/2014

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Medication records were not completed by nursing staff in line with relevant professional guidelines.

Property lists were not maintained for all residents.

Action Required:
Under Regulation 21(3) you are required to: Retain the records set out in Schedule 3 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

Please state the actions you have taken or are planning to take:
1. Nurses have been reminded of their responsibilities in relation to An Bord Altrainais Medicines Management Guidelines in particular the administration of medicines from an incomplete prescription such as duration of short term medicines and crushed medicines. COMPLETED
2. Nurses have been advised of the requirement to use the medicines policy in relation

to the transcribing of medicines and have been shown the An Bord Altranais guidelines on Medicines management COMPLETED
3. The Medicines management policy has been circulated to all nurses with the particular areas highlighted and a reminder to adhere to these COMPLETED
4. A letter has been sent to all GPs reminding them of prescribing requirements when completing prescriptions/kardex COMPLETED

1. Property lists are in the process of being transferred from the paper version onto the EPIC System

Proposed Timescale: 31/01/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The overall management of restraint required improvement.

The assessment process for the use of restraint was not based on the National Policy.

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

Please state the actions you have taken or are planning to take:
1. New assessment tool for restraint which incorporates measurement now available and will be commenced for each resident. COMPLETED
2. Register and improvements in monitoring will be carried out on the EPIC Solutions utilising their new restraint assessment tool. This will provide the information required for regulatory compliance Education for staff on this will commence this month

Proposed Timescale: 31/01/2015

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:
A number of areas of risk had not been identified or assessed as outlined in the inspection report.

There was an inadequate system in place to ensure that comprehensive, individualised risk assessments were completed for residents that smoked.

Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
1. Windows gaps identified on the inspection are currently being addressed and a hazard identification form will be added to the risk register. 31st January 2015
2. A new improved risk management policy will be developed to replace the existing policy. This will incorporate the areas of risk not currently identified. 31st March 2015
3. Radiator temperature recordings will be increased from bi-annually to quarterly and will be itemised on the agenda of the health and safety meetings COMPLETED
4. The hot water boiler has been decommissioned and closed down. COMPLETED
5. A revised no smoking policy is now in place which guides practice .COMPLETED
6. A new smoking risk assessment tool is being sought currently. Request submitted to EPIC solutions. 31st January 2015
7. Learning from incidents will be recorded on the incident form will be utilised to identify improvements. Staff will be shown the benefit of completing this area and utilizing it for learning outcomes and improving practice. 31stJanuary 2015
8. An Annual report will be prepared which will outline for residents the Management of Risk and the quality improvements resulting from the process of audit. 31st March 2015

Proposed Timescale: 31/03/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not outline the measures in place to manage the risk of abuse.

Action Required:
Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

Please state the actions you have taken or are planning to take:
1. The policy has been amended to include to whom allegations of abuse against the PIC or other management should be reported. The policy now includes notification to the chief inspector COMPLETED
2. The Risk management policy will be amended to include the measures in place to manage the risk of abuse.

Proposed Timescale: 31/03/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not outline the measures in place to manage the risk of residents elopement.

Action Required:
Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

Please state the actions you have taken or are planning to take:
A missing persons policy is available in the emergency plan. The Risk management policy will be amended to include the measures in place to manage the risk of residents elopement.

Proposed Timescale: 31/03/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not outline the measures in place to manage the risk of accidental injury in the centre.

Action Required:
Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
The Risk management policy will be amended to include the measures in place to manage the risk of accidental injury.

Proposed Timescale: 31/03/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not outline the measures in place to manage the risk of self harm.

Action Required:
Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

The Risk management policy will be amended to include the measures in place to manage the risk of self harm.

Proposed Timescale: 31/03/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not outline the measures in place to manage the risk of aggression.

Action Required:
Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
The Risk management policy will be amended to include the measures in place to manage the risk of aggression.

Proposed Timescale: 31/03/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system of learning and improvement from adverse events such as falls required improvement.

Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
A clearer method of documenting the learning outcomes and improvements from the audits will be put in place in the form of outcomes and action plans.

Proposed Timescale: 31/01/2015

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 did not consistently guide practice for example, the management of falls, behaviours that challenge, end-of-life and dementia care.

Care plans were not consistently developed for wound care.

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

Please state the actions you have taken or are planning to take:
1. Work is continuous in the development of end of life care plans. We expect to have discussions with all residents regarding end of life care and Do Not Resuscitate and to develop these discussion to include spiritual emotional and end of life wishes. 31st March 2015
2. Improvements in the care plans for falls especially in prevention techniques will be discussed with nursing staff and the physiotherapist. 31st February 2015
3. Improved monitoring and controls for falls for individual residents have been reviewed and implemented Staff have received the falls policy and have been reminded to adhere to the guidance on recording of observations. COMPLETED
4. Continuous assessment to establish and document the triggers for challenging behaviour is under discussion and will be implemented. 31st January 2015
5. A wound care plan not in place for one resident identified during the visit COMPLETED

Proposed Timescale: 31/03/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were improvements identified in the management of falls.

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:
Improved monitoring and controls for falls for individual residents have been reviewed and implemented Staff have received the falls policy and have been reminded to adhere to the guidance on recording of observations. COMPLETED

Proposed Timescale: 15/12/2014

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The four three bedded rooms do not meet the requirements of the National Standards.

There was inadequate storage space provided.

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:
There are costed plans in place now submitted to the Council for planning permission which have been discussed with the inspector and which will address the four three bedded rooms and the storage issues. This development is over a three year period. The three bedded rooms provide dignity, privacy and allow for safe care for the individual residents and meet each of their individual medical needs.

Proposed Timescale: 31/12/2017

Outcome 14: End of Life Care

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system of discussing residents' end-of-life preferences and wishes required improvement.

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:
This is a continuous process and will be supported in 2015 with in-house training and development programme by the Hospice Foundation. It is proposed to continue to build on the good work carried out to date and to increase the Number of Do Not Resuscitate wishes and end of life care plans from the current 8 to 25 over the next three months.

We plan to have the education programme commenced early in 2015. This will address the needs of Nurses and Carers.

Proposed Timescale: 31/03/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staff skill mix at night time requires review.

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:
We are undertaking a review of staffing, resident dependency, incidents at night, medication times and roles. The spread of staffing will be examined. The role of the carer with FETAC level 5 will also be considered in the context of the Scope of Nursing Practice (An Bord Altranais).

Proposed Timescale: 28/02/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up-to-date mandatory training in areas such as elder abuse and manual handling.

Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
Dates have been set to commence the next training sessions in these areas 9th and 12th January for Manual Handling and the 29th January for Elder abuse.

Proposed Timescale: 31/01/2015