Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St John's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Munster Hill, Enniscorthy, Wexford
Type of inspection:	Unannounced
Date of inspection:	10 January 2024
Centre ID:	OSV-0000604
Fieldwork ID:	MON-0041977

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

St. John's Community Hospital is located on the outskirts of a busy town. It is a purpose-built single-storey centre which can accommodate up to 104 residents. It provides rehabilitation, respite and extended care to both male and female residents over the age of 18, although the majority are over 65 years of age. The centre is divided into four units. In total, there are 20 four-bedded rooms, two twin rooms and 20 single rooms. All have full en-suite facilities. Other areas include day rooms, a smoking room, kitchenettes, offices and treatment rooms. There is also a large main kitchen and laundry. There are enclosed external gardens which are spacious and well maintained. Seating is provided there for residents and their visitors. There is parking space provided for residents, staff and visitors. According to their statement of purpose, St. John's aim to provide person-centred care to the older population of County Wexford. They aim to provide quality care in a homely environment where everyone is treated with dignity and respect.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	97

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 10 January 2024	10:30hrs to 18:00hrs	John Greaney	Lead
Thursday 11 January 2024	08:30hrs to 16:30hrs	John Greaney	Lead

What residents told us and what inspectors observed

Residents living in St. John's Community Hospital gave positive feedback about the care they received in the centre. Residents were complimentary of the staff and described them as being helpful, caring and friendly.

This was an unannounced inspection carried out over two days. On arrival to the centre the inspector met with the person in charge and assistant director of nursing. Following an introductory meeting to discuss the centre, the current residents and to outline the plan for the inspection, the inspector was guided on a tour of the premises with the person in charge. The inspector was aware prior to the inspection that the centre had an outbreak of COVID-19, which was notified to the office of the Chief Inspector as required. At the opening meeting the inspector was informed that there were eight residents in Beech ward, four residents in Ivy ward and one in each of Oak and Elm that were currently in isolation having tested positive for COVID-19.

St. John's Community Hospital is a modern, single storey building situated on spacious grounds close to the town of Enniscorthy. In addition to the designated centre for older people, there is also a day centre for older people and a range of mental health service facilities on the same campus.

Bedroom accommodation in the centre is predominantly multi-occupancy with over 75% of residents accommodated in 4-bedded rooms. The centre is divided into four wards, Oak, Elm, Ivy and Beech. Ivy ward is the designated dementia ward and accommodates 20 residents in three 4-bedded rooms and eight single rooms. Beech ward is predominantly for short stay residents that are admitted for rehabilitation, respite or as step down from acute hospital prior to returning home or transitioning to long term care. Beech ward accommodates 32 residents in five 4-bedded rooms, two twin bedrooms and eight single bedrooms. Both Oak and Elm wards accommodate long stay residents. Oak comprises six 4-bedded rooms and two twin bedrooms. Elm also comprises six 4-bedded room and two twin bedrooms. Due to the number of residents accommodated in multi-occupancy bedrooms in both Oak and Elm wards, there is a designated palliative care room in each of these wards to accommodate residents that wish to have a single room as they approach end of life.

The inspector began the walk around on day one of the inspection in Oak Ward. The inspector found that bedrooms, predominantly the 4-bedded rooms, in this ward generally lacked personalisation with limited photographs and memorabilia. For residents that may have photos and memorabilia, there was limited place for them to place these items due to the design and layout of these rooms. There were no comfortable chairs in the 4-bedded rooms for residents to sit at their bedside should they wish to do so. Additionally, most bedrooms did not have chairs for relatives or friends to sit when visiting residents. There was a television in each bedroom, with some of the 4-bedded rooms having two televisions. However, these were not conveniently place as they were located high up on the wall and would be difficult

for residents to comfortably watch television. There was not always a remote control available for each television. While the centre was generally clean there were significant scuff marks on some walls as a result of damage from furniture.

The main communal sitting room in this ward is located at the end of the ward, separated from the main sitting room in Elm ward by an accordion like dividing screen. There is also a kitchenette here that is accessible from both wards. There are fire safety implications associated with this design and layout that are discussed in more detail under the Quality and Safety section of this report, including under Regulation 28. The dining room was originally a 4-bedded room that has been converted to a dining space, as it was found on previous inspections that there was insufficient dining space for residents. Despite efforts to make this an inviting place to have meals with the addition of a mural on the wall and some old style kitchen cabinets, it continued to lack a homely feel. Seven residents were observed having their lunch their on the first day of the inspection and six had there lunch there on the second day.

The inspector found that the Quiet Room in this unit was being temporarily used as a bedroom for a resident that was being isolated as a precaution due to being unwell. This is not in accordance with the centre's Statement of Purpose and reduces the available communal space to other residents in the ward.

Elm ward is a mirror image in design and layout as Oak. There is a somewhat more homely feel to this ward with more successful attempts to provide a homely environment. Bedrooms are more personalised with photos and memorabilia but still constrained by the limited places to store these items within view while the resident is in bed. A larger number of residents, approximately 12 each day, had their meals in the dining room here, which was also initially designed as a 4-bedded room.

All the residents living in Ivy ward were living with a cognitive impairment and were unable to detail and discuss their experience of the service. Most were observed by the inspector to be content and relaxed in their environment and in the company of staff. The inspector did note on the walk around that the activities room was being used as a bedroom for a resident that had tested positive for COVID-19. The resident had already been accommodated in a private room and when the inspector enquired as to why the activities room was being used, he was informed that it was to provide more space for the resident. The use of this room as a bedroom was not in accordance with the centre's Statement of Purpose. Access to the room from the corridor was through a coded lock. While the room was not locked from the inside, the door could only be opened by turning the top latch and bottom latch simultaneously. The inspector observed the resident trying unsuccessfully to leave the room but they did not appear to be able to do so. Additionally, there was a door from the activities room that led directly out to a secure outdoor space. This door was locked with a key and a staff member confirmed to the inspector that this was so that residents could not access the outdoor area independently. A second door leading to the outdoor space from the adjacent sitting room was similarly locked, meaning that these residents did not have access to outdoor space..

The inspector had the opportunity to speak with a visitor on Ivy ward on day two of

the inspection. The visitor was complimentary of the care that their family member received, particularly about the kindness of the staff working there and the very personalised care they received.

As already stated, Beech ward is used for short stay residents. On the day of the inspection there were eight residents in Beech that had tested positive for COVID-19. Adequate arrangements were in place for managing the outbreak and a section of the ward was designated for the residents that were in isolation.

Overall, residents spoken with by the inspector stated they felt happy and safe living in the centre. Residents spoke positively about the staff that cared for them. On the day of inspection, staff were observed being respectful, caring and attentive to residents' needs. There was a relaxed atmosphere and a number of residents were observed freely mobilising around the centre and chatting with other residents and staff. The inspector observed that some residents spent their time in the sitting rooms during the day while others preferred to spend time in their bedrooms. Community employment scheme staff were observed facilitating activities with the residents throughout the day in Oak, Elm and Ivy wards. There are no community employment scheme staff assigned to Beech ward and residents in this unit spend a significant part of the day in their rooms.

The next two sections of the report presents the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This was a two day unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older people) Regulations 2013. Overall, the inspection found that residents living in the centre received a high standard of healthcare and there was a defined management structure in place. However, action was required to comply with the regulations in relation to governance and management, staff training, the management of complaints and staff recruitment. These will be detailed under the relevant regulations of this report.

The registered provider of this centre is the Health Service Executive (HSE). There was a clearly defined management structure in place. The person in charge was a recent appointment and had only commenced in the role on the day before this inspection. This is the third person to hold the role in this centre in the past eight months, with the previous person being appointed in May 2023. The person in charge of a 30-bedded centre located in Enniscorthy reports to the person in charge of this centre. The person in charge also has oversight of the day centre, which is not part of the designated centre but is on the same grounds. The person in charge worked full-time and is supported by two assistant directors of nursing, one of whom is on long term leave. Senior management are supported by clinical nurse

managers and a team of nursing, health care assistants, multi-task attendants, household, catering, activity, administration and maintenance staff.

At a more senior level there is oversight by a general manager for older persons, who represented the provider. The service also has support from centralised departments, such as finance, human resources, fire and estates. There is a member of practice development located on site. There was evidence of good communication via quality and patient safety meetings, to discuss all areas of governance.

Improvements were required in relation to governance and management. There was not adequate oversight of isolation practices that restricted the movement of a resident in a manner that did not comply with the national policy on the use of restraint. The centre was also operating outside of the Statement of Purpose through the temporary use of communal space as bedrooms. These and other areas for improvement are outlined in more detail under Regulation 23 of this report.

There was a schedule of clinical audits in place in the centre to monitor the quality and safety of care provided to residents. There were associated actions plans to support the implementation of any required improvements identified through the audit process. Arrangements were in place to provide supervision and support to staff. However, training records viewed by the inspector confirmed that not all staff had up to date training in mandatory areas, which is discussed further under regulation 16.

The inspector found that the levels and skill mix of staff at the time of inspection were sufficient to meet the care needs of the residents living in the centre. The staffing resource, however, is dependant on agency staff. Clinical nurse managers provided clinical supervision and support to staff on each unit. Management cover in the centre at night and weekends is allocated to the senior nurse on duty but this is not supernumerary and are part of the ward staffing complement.

All requested documents were made available to the inspector throughout the days of inspection. Staff files were stored electronically and due to the manner in which they were stored, it was difficult to locate specific documents. Of a sample of three staff files reviewed, a Garda vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was not accessible within the centre for one member of staff, however, this was made available before the end of the day. These issues are outlined further under Regulation 21 of this report.

Regular management meetings were taking place to discuss key operational issues at the centre. Staff were seen to be knowledgeable about residents' care requirements and regular staff meetings took place.

Written policies and procedure as set out in Schedule 5 of the regulations were in place and updated as required. However, the policy folder on the wards was not always updated with the revised policies.

Registration Regulation 6: Changes to information supplied for registration purposes

A notification was not submitted notifying of the change of the person in charge of this centre until after their departure from the role.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The person in charge was full-time in post and had the necessary experience and qualifications as required in the regulations. The person had only commenced in the role on the day prior to this inspection.

Judgment: Compliant

Regulation 15: Staffing

From an examination of the staff duty rota and communication with residents and staff it was the found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of the residents living in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Action required in relation to training, included:

- 24% of staff were overdue attendance at training in managing responsive behaviour
- while 98% of staff had attended online training in safeguarding residents from abuse, the findings of this inspection indicate staff would benefit from face to face training.
- 21% of staff were overdue attendance at infection control/hand hygiene training

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents which included all the information as specified in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

A review of a sample of three personnel files found that a Garda vetting disclosure had not been accessible on site for one member of staff as required by the regulations.This was made available prior to the end of the inspection.

The provider had implemented an electronic system for storing staff files. Many of these had been scanned into the system without an indexing system and therefore it was difficult to locate specific documents, requiring staff to scroll through hundreds of pages to find requested documents.

Judgment: Substantially compliant

Regulation 23: Governance and management

Action required in relation to governance and management included:

- two communal rooms had been temporarily converted to bedrooms, which is not in accordance with the centre's Statement of Purpose
- there was inadequate oversight of isolation arrangements for a resident that tested positive for COVID-19 that negatively impacted on the rights of the resident and was not based on a valid risk assessment or in accordance with policy for the management of responsive behaviour
- there were repeat findings on this inspection, particularly in relation to fire safety and commitments outlined in the compliance plan by the provider were not implemented

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review and updating to ensure it contained the

details and information set out under Schedule 1 of the regulations. For example:

- it did not provide adequate details on the arrangements for dealing with complaints
- the organisation structure required updating to ensure it reflected recent changes in management

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The procedure for managing complaints that had been on display in the reception area had been temporarily removed and had not been replaced. Additionally, the procedure on display in each of the units did not provide adequate detail and did not reflect S.I. No. 628 of 2022 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

While all written policies and procedures were kept under review and updated at a minimum of every three years, the policy and procedure folders on each on the wards were not always updated with the most recently reviewed policy.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents living in the centre received a high standard of healthcare. Residents reported they felt safe in the centre. However, significant action was required was required to comply with the regulations in relation to management of responsive behavior, residents rights and fire safety. These and other areas of required improvements will be detailed under the relevant regulations of this report.

Significant improvement was required in relation to the management of responsive behaviour to ensure it was in line with national policy. There was a failure by staff to recognise restrictive practices and the impact this had on on the rights of residents.

This will be further discussed under Regulation 7 of this report.

Significant improvements were also required under fire safety. As identified in the previous inspection report, there are three 18-bedded compartments and one 20-bedded fire compartment. One of the 18-bedded compartments traverses Oak and Elm units and despite commitments give by the provider following the last inspection, adequate fire safety management systems were not in place to mitigate the risks associated with the large compartments, and in particular the fire compartment that traversed parts of two units. Arrangements were in place for the testing and maintenance of the fire alarm system, emergency lighting and fire fighting equipment. All records were made available for review and were up-to-date. Actions required in relation to fire safety are addressed in more detail under Regulation 28 of this report.

The centre had a paper-based resident care record system. A sample of residents' assessments and care plan records were reviewed regularly. Residents physical, psychological and social care needs were comprehensively assessed on admission to the centre using validated assessment tools. The outcome of the assessments informed the development of care plans that provided guidance to staff on delivery of care to residents. While care plans were generally personalised, further improvements were required to ensure that all information gathered on admission about residents preferences were used to support the development of the care plans.

Residents had access to health and social care professionals such as general practitioners (GPs), psychiatry of later life, dietitians, speech and language therapists, physiotherapy and occupational therapy. The GP visited the centre for a number of hours each day from Monday to Friday. Out-of-hours GP services were also available. A review of residents records indicated appropriate referral and timely reviews by allied health services.

Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions. There was a programme of activities and residents were observed to participate in a variety of activities over the course of the two days of the inspection. However, the inspector found that residents were not always free to exercise choice in how to spend their day. This particularly related to access to outdoor space for residents in Ivy ward. This is further discussed under Regulation 9 of this report.

Residents that spoke to the inspector were positive regarding the choice of food provided to them in the centre. There were systems in place to ensure residents at risk of dehydration and malnutrition were regularly reviewed and timely interventions provided.

Generally the centre was clean, bright, however, the paintwork on some walls required attention; this was observed to be scuffed and in places chipped. Communal space for residents in two units was negatively impacted by the temporary use of a quiet room and an activities room as bedrooms for isolation purposes. Issues identified for improvement are outlined in more detail under

Regulation 17 of the report.

Regulation 11: Visits

Visits by residents' families and friends were encouraged. Residents could meet their visitors in private outside of their bedroom in the communal rooms if they wished to do so.

Judgment: Compliant

Regulation 12: Personal possessions

Some of the bedrooms, in particular the multi-occupancy bedrooms, lacked personalisation. Personalisation of residents' bedrooms can have the effect of creating a homely environment for residents in long term care and this is supported with the use of photographs and mementos. Even in the multi-occupancy bedrooms that had a some degree of personalisation, photos were sometimes placed at the back of beds, where they were not always visible or accessible to the resident while in bed.

Judgment: Substantially compliant

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations. For example:

- a number of multi-occupancy bedrooms did not have a comfortable chair for a resident to sit at their bedside, should they so wish. Additionally, there were no chairs in some bedrooms for visitors to sit should they wish to meet with residents in their bedrooms
- there were scuff marks on some bedroom walls and required painting
- there was a broken wooden chair in the outdoor area with an exposed nail that would pose a risk of injury to residents
- there were no toilet roll holders in one of the toilets
- there was a section of the floor covering loose in the sitting area of Elm that could potentially be a trip hazard

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy in place to inform the management of risks in the centre. This contained reference to the five specified risks as outlined under Regulation 26.

Judgment: Compliant

Regulation 27: Infection control

The inspector found that some procedures were not consistent with the standards for the prevention and control of health care associated infections, including:

- action was required in some of the housekeeping rooms. For example:
    - the taps on one wash hand basin were not hands free
    - there was no running water or wash hand basin in the housekeeping room designated for the main corridor
    - there was inappropriate storage in one housekeeping room such as a tin of sweets in the wash hand basin; a mop was stored with the mop head resting on the floor; an open packet of unused dusting cloths were stored on a wash hand basin
- commode chairs were stored in a sluice room and some were not labelled to identify that they had been cleaned after use
- an unused incontinent pad was stored on the hand rail of a communal toilet
- sealed sharps boxes were inappropriately stored
- there were a number of packets of wet wipes stored inappropriately with the cover open.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Significant action was required in relation to fire safety management systems. For example:

- as found on the last inspection, there is a large fire compartment containing 18 beds, two communal areas and a kitchenette that encompass a section of both Oak and Elm wards. These units are separated by a wooden partition that does not constitute a fire compartment boundary. Commitments given after the last inspection to mitigate this risk, included conducting fire drills in this area on a monthly basis. Fire drill records seen by the inspector indicated

that fire drills were only conducted twice since the last inspection, once in March 2023 and most recently in December 2023. One fire drill record that simulated a fire in this area indicated that residents would be evacuated from one side of the partition to the other side, which would place the residents in the same compartment as the one in which the fire was simulated

- fire safety training comprised theory only and was done online. All staff were overdue attendance at the practical element of fire training and the inspector was informed that no practical fire training had been conducted since prior to the COVID-19 pandemic
- while fire drills were conducted regularly, there was inadequate detail in the records, such as mode of evacuation, to ascertain if all residents could be evacuated in a timely manner
- clarity was required in relation to the exits from the activity and sitting room in Ivy ward to the enclosed courtyard. While general signage from within the centre did not direct that these exits be used, there was a lighted exit sign within the room indicated that they were emergency exits. There is a large gate at the end of the external courtyard that is padlocked and staff do not have the key and therefore evacuees would not be able to leave the courtyard
- there was a sideboard in Elm sitting room containing items for religious services. This included a wax candle that could potentially be a fire hazard

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans did not always take account of residents interests and hobbies that were recorded as part of the residents' admission assessment. This is particularly relevant in the development of responsive behaviour and safeguarding care plans.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector was assured that residents were provided with timely and appropriate access to a medical officer . A review of resident care notes confirmed that residents also had access to other health care supports such as dietitian, speech and language therapists and tissue viability nursing (TVN).

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Adequate arrangements were not in place for the management of residents with responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). For example:

- a resident's movement was restricted by being isolated in a room in which the resident did not have the ability to open the door to leave the room, if they wished to. The resident's movement was further restricted by the locking of a door to a secure outdoor space to which the resident did not have a key
- the care plan for a resident with responsive behaviour identified that 15 minute safety checks would be completed, however, the record was only intermittently completed with long gaps during which no safety checks were recorded
- 24% of staff were overdue attendance at training in managing responsive behaviour

Judgment: Not compliant

Regulation 8: Protection

Items held for safekeeping were held in sealed envelopes in a locked safe. Many of these envelopes only had one staff signature attached and none of the sample viewed by the inspector had the resident's signature. This system could be enhanced by obtaining the resident's signature, where possible and appropriate, or by having two staff verify the contents of the envelope prior to sealing it.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents did not have ready access to secure outdoor space from the Ivy ward. The inspector found that both doors leading to the area were locked with a key and the inspector was informed that residents could only access this area when accompanied by staff. The Ivy ward is the designated dementia ward and most residents may not have the capacity to request access to the external courtyard.

The programme of activities is overseen by two activity coordinators and there is usually one present in the centre over seven days of the week. Activities are predominantly provided by community employment scheme workers that work each day from 09:30hrs to 15:00hrs Monday to Friday. One of the two activity

coordinators is present in the centre until 19:30hrs on two evenings a week. Outside of these days there were limited opportunities for residents to participate in activities after 3pm each day.

There are no staff assigned to Beech ward to provide activities and the inspector did not observe any activities taking place over the course of the inspection.

Televisions in the 4-bedded rooms were not conveniently located, as they were high up on the wall and would be difficult for residents to view from their beds. Additionally, the remote control was not available on the day of the inspection in at least one of the rooms.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 6: Changes to information supplied for registration purposes	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St John's Community Hospital OSV-0000604

Inspection ID: MON-0041977

Date of inspection: 11/01/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 6: Changes to information supplied for registration purposes	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: • All notifications will be submitted within the required time frame. Action complete.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Managing Responsive Behavior training will be provided to all staff to achieve 100% compliance in this area – all staff to receive training by 30 April 2024. There is an in-house qualified trainer in this area and they will work with Practice Development to ensure ongoing compliance. • All staff have completed online safeguarding training. Face to Face Safeguarding workshops are planned for 2024 with first planned date scheduled for 22nd February 2024. • Infection Control and hand hygiene training will be provided to all staff with support from in house IPC link nurses and the Wexford IPC Clinical Nurse Specialist is scheduling regular onsite visits to include further training. 100% compliance to be achieved by 30 April 2024	

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• All Garda vetting disclosure now on file as of 10 January 2024. Action complete.

• A request has been made to South East Community Healthcare HR Department for support in breaking down and indexing historical bulk uploads of files to the Therefore file management system which holds employee files. This has commenced at another Wexford unit and this person will commence St John's Community Hospital staff as soon as the first unit is complete. This is a time-limited issue as all new documentation is being uploaded individually.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• All rooms are confirmed in use as designated in the Statement of Purpose.

• The bed board panel will be removed from the Ivy Quiet Room to avoid any confusion that this could be used as an extra bedroom, this maintenance will be completed by 30 April 2024. The room will be enhanced to create a more relaxing space for residents and families and an integrated working group has been established with St Johns Director of Nursing and Senior Speech and Language Therapist and local Wexford Integrated Care of the Older Persons team members - Clinical Nurse Specialist in Outreach, Advanced Nurse Practitioner in Dementia and Occupational Therapist in Memory Technology – to review the space from a dementia friendly perspective and to support de-escalation and relaxation.

• Risk assessments will be completed for residents that cannot isolate and standard operation procedure updated in February 2024 to reflect the process in place. 1 to 1 special will be put in place if required via risk assessment.

• Monthly fire drills are in place on all wards with Oak and Elm ward completing monthly fire drill simultaneously with oversight from ADON to ensure the shared compartment is appropriately drilled.

• Senior Management met with HSE Fire Officers in February 2024 to plan to reduce compartment size in 3 units including the shared space in Oak/Elm with a planned completion date of December 2024. Follow up meeting planned for 13th March to

progress and will actively review, monitor and progress until completion.

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • Statement of Purpose is now updated including updated complaints management to meet Regulation 34 and to reflect the recent changes in management.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • Managing complaints and complaint procedure updated on all units and at Reception to meet Regulation 34.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • Policy and procedure folder will be updated on each unit to reflect up to date policies. • Ongoing review in place for policies and procedures in line with Regulation 4(3)	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: • A review of each ward is underway with emphasis on creating a homely environment in	

consultation with the resident and their families. This will be complete by 30/04/2024. In collaboration with the activity team, photos will be displayed in photo frames on the wall beside resident's bedspace to ensure they are within view.

• New pictures and mirrors have been hung on the walls to create a more homely environment in addition to new bedding in some areas.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• New chairs will be sourced for wards for visitors use and residents that require a bedside chair will have same provided and actioned by 30 April 2024.Other residents have custom designed personal comfort chairs.

• Areas that require painting will be identified and actioned by 30 May 2024
• All broken furniture has been removed – action completed January 2024
• All bathrooms will have toilet roll holders installed – action to be completed by 30 March 2024.
• Loose floor covering will be repaired and actioned by 30 March 2024.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Hand wash basin will be upgraded to one with hands free tap. – to be actioned by May 2024
• Housekeeping room is used for appropriate storage purpose only.
• An additional housekeeping room with washhand basin within has been identified to support cleaning of main corridor/communal area.
• Monthly IPC audits with action plan in place – aim for 100% compliance in all areas.
• Regular onsite education is planned for 2024 in collaboration with IPC team.
• IPC link nurses at ward level to monitor and support staff in all areas of IPC.
• The use of I am Clean Stickers will be audited to ensure 100% compliance – due March 2024.
• Monthly sharps audit in place and further in house education will be provided to all staff and SOP will be updated outlining the appropriate storage of sharps boxes – action completed February 2024.
• Issues raised re inappropriate storage have been addressed with CNM team and cascaded to the teams.

• Environmental audit is planned for March 2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Monthly fire drills are in place on all wards with Oak and Elm ward completing monthly fire drill simultaneously with oversight from ADON to ensure the shared compartment is appropriately drilled.

• Senior Management met with HSE Fire Officers in February 2024 to plan to reduce compartment size in 3 units including the shared space in Oak/Elm with a planned completion date of December 2024. Follow up meeting planned for 13th March to progress and will actively review, monitor and progress until completion.

• Fire Inspection report carried out by local authority Fire Officer 23/01/2024

• All staff have completed online fire training and funding has been approved for site specific in person fire safety and evacuation training to commence in March.

• Fire Drill template has been updated to include number of residents evacuated, mode of evacuation, dependency of residents and place of evacuation – action completed February 2024.

• Ivy ward enclosed internal courtyard is not an identified fire exit and will not be used as such in the event of a fire. Padlock on the gate of the external courtyard will be changed to combination type lock – to be actioned by 30 March 2024
• Battery operated candles only in use in the hospital. All other candles removed.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Care plans reviewed from a social perspective and a plan implemented to educate staff to link care plans back to the resident's hobbies and life book stories will also be implemented.
• Next audit of care plans scheduled for April 2024 and will particularly focus on responsive behaviours and safeguarding plan. Where necessary these will be revised

after consultation with the resident and family if appropriate.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• All staff to be provided with training in managing responsive behavior – aim to have 100% trained by 30 April 2024.
• Plan to develop the quiet room in Ivy ward to create a multisensory space to allow residents that require additional support with de-escalation process and to enhance their wellbeing. An integrated working group has been established with St Johns Director of Nursing and Senior Speech and Language Therapist and local Wexford Integrated Care of the Older Persons team members - Clinical Nurse Specialist in Outreach, Advanced Nurse Practitioner in Dementia and Occupational Therapist in Memory Technology. To be actioned by September 2024
• All locks on doors to garden have been changed to allow unrestricted access to the outside areas. These are now thumb-turn locks which will remain open during waking hours - action completed February 2024.
• Additional lighting will be installed in Ivy garden to support residents remaining outside later if they choose – to action by April 2024.
• 15 minute check record will be audited monthly and actioned, commenced February 2024.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Standard operating procedure for patient's property updated to reflect the process of 2 staff signatures on any valuables that are stored for safe keeping and a resident's signature where possible. Action completed February 2024

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• All locks on doors to garden have been changed to allow unrestricted access to the outside areas in Ivy. These are now thumb-turn locks which will remain open during waking hours - action completed February 2024.
• Activity timetable updated to reflect times of sessions and named staff associated with same and displayed in each area. Action completed February 2024.
• Beech ward staff will implement a schedule of activities with named staff assigned – Action completed February 2024.
• Plan to implement a review of the placement of the televisions with the possibility of additional televisions in line with resident's choice with a remote available with each television – action by May 2024.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 6 (1) (a)	The registered provider shall as soon as practicable give notice in writing to the chief inspector of any intended change in the identity of the person in charge of a designated centre for older people.	Substantially Compliant	Yellow	26/02/2024
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	30/04/2024
Regulation 16(1)(a)	The person in charge shall	Substantially Compliant	Yellow	30/04/2024

	ensure that staff have access to appropriate training.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/05/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/06/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/12/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections	Substantially Compliant	Yellow	30/05/2024

	published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/12/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	30/06/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and	Not Compliant	Orange	30/03/2024

	fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	28/02/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	28/02/2024
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated	Substantially Compliant	Yellow	28/02/2024

	centre, and where the provider has a website, on that website.			
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	28/02/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (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.	Substantially Compliant	Yellow	30/06/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	29/04/2024
Regulation 7(1)	The person in charge shall ensure that staff have up to date	Not Compliant	Orange	30/04/2024

	knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	28/02/2024
Regulation 7(3)	The registered provider shall 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.	Not Compliant	Orange	28/02/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	28/02/2024
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/05/2024
Regulation 9(2)(b)	The registered provider shall provide for	Substantially Compliant	Yellow	28/02/2024

	residents opportunities to participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	28/02/2024
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to radio, television, newspapers and other media.	Substantially Compliant	Yellow	30/05/2024