

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Joseph's Unit, Bantry General Hospital
Centre ID:	OSV-0000597
Centre address:	Bantry General Hospital, Bantry, Cork.
Telephone number:	027 52904
Email address:	stjosephsward.bgh@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	James A McNamara
Lead inspector:	Mairead Harrington
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	1

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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:
21 June 2017 10:45	21 June 2017 18:00
22 June 2017 09:15	22 June 2017 15:45

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

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

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection. Registration for this centre is due to expire on 31 October 2017. The inspection took place over two days. The centre had previously been inspected on 24 November 2016 as part of an application to vary the conditions of registration in relation to layout of premises. That report, including the provider's response and action plan,

can be found on www.hiqa.ie.

Members of the management team were in attendance throughout the inspection and demonstrated an effective understanding of the statutory duties and the responsibilities associated with their respective roles. The person in charge, and members of management, were found to be actively involved in the day-to-day running of the centre and were readily available and accessible to both residents and staff. The inspector met and spoke with staff members, and observed practice and communication in the delivery of care. As part of the process, the inspector also reviewed completed questionnaires by residents and relatives, and met with those who wished to provide further feedback. Feedback was consistently positive and complimentary of staff and the quality of service delivered.

The centre was located on the same site as Bantry General Hospital and had access to shared facilities and resources, such as allied healthcare services that included physiotherapy, podiatry and speech and language therapy. A medical practitioner was accessible and in regular attendance at the centre. The report is set out under eighteen outcome statements. These statements describe what is expected in a designated centre and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People 2016.

Overall, the inspection identified that the provision of care within the centre was to a high standard. All staff were well trained and appropriately resourced to undertake their work effectively. Staff spoken with understood their duties of care and demonstrated a conscientious approach to their responsibilities. Supervision was effective and systems were in place to monitor the safety and quality of the service, and to demonstrate accountability as necessary. Areas for improvement identified on previous inspections had been addressed, particularly in relation to premises related issues. Further areas for improvement were identified on this inspection in relation to the maintenance of security vetting documentation for staff, and privacy issues where residents were accommodated in multi-occupancy rooms; these issues are further detailed in the body of the report.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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):

Findings:

There was a centre-specific statement of purpose dated 3 April 2017 and a copy was available for reference at the entrance to the unit. It set out the aims, objectives and ethos of the centre and summarised the facilities available and services provided. The person in charge confirmed that the statement of purpose was kept under review. The inspector reviewed the statement of purpose and found that it complied with the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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:

Service at this designated centre was provided by the Health Service Executive (HSE).

The HSE provides service across a number of centres nationally. The organisational structure included tiered, managerial oversight on a local, regional and national basis. A nominated person with responsibility for representing the HSE was in place. Care on the unit was directed through the person in charge, who was also supported by the senior management team for the acute service, including the director of nursing and hospital manager. An organisational structure that identified the lines of authority and accountability was set out in the statement of purpose. Members of staff with responsibility for deputising for the person in charge were appropriately experienced and qualified.

The centre was appropriately resourced to deliver a service in keeping with its statement of purpose. There was evidence that facilities were developed and improved as necessary. Systems were in place to monitor the quality of care and experience of residents, including a schedule of audits that reflected the requirements of the standards. Communication systems at a local level included regular staff and management meetings. An executive board met on a monthly basis and minutes of these meetings were available for reference. Committees with designated responsibility for specific areas were in place, for example on infection control. Quality management systems to monitor the delivery of service included regular and relevant auditing procedures in areas such as falls, infection control and medication management. The designated centre operated within the general hospital and management systems were in place to ensure that the services provided were safe, appropriate to residents' needs, consistent, and effectively monitored. An annual quality review had been completed that reflected themes from the standards and identified areas for development as part of an improvement strategy, such as the continued development of care plans and education around the management of medicines. There was also evidence that residents and families had been engaged in processes of consultation, particularly around care planning and initiatives to develop the new environment.

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):
No actions were required from the previous inspection.

Findings:
There was a comprehensive guide that outlined the services and facilities of the centre available to residents. Each resident had a written contract, that set out the terms and conditions of residency, including details of the overall fees to be paid and any services

that might incur additional costs if provided in relation to care and welfare.

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 designated centre was managed by a suitably qualified and experienced person in charge, with authority, accountability and responsibility for the provision of service. The person in charge worked on a full-time basis and had extensive experience in clinical care. Throughout the course of the inspection the person in charge demonstrated a professional approach to the role that included a commitment to a culture of improvement along with a well developed understanding of the associated statutory responsibilities. The person in charge was personally committed to continuous professional development and enabled access for professional improvement, where possible, for all staff.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Significant work had been undertaken in developing documentation following findings on previous inspections. Up-to-date, site-specific policies were in place for all matters detailed in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Copies of the relevant standards and regulations were maintained on site. The inspector spoke with members of staff about their understanding of policy and practice around responding to emergencies, or managing residents who might have difficulty with communication. Staff demonstrated a competent knowledge and understanding in all circumstances.

Records checked, in respect of documents to be held in relation to members of staff, were generally in keeping with requirements. The centre had in place a verification form from the HSE Garda Vetting Liaison Officer, confirming that related vetting disclosure documentation was in place for employees. However, this was not in keeping with a disclosure as required by Schedule 2 of the 2013 Care and Welfare Regulations. Other records to be maintained by a centre such as records of incidents and accidents, notifications and a directory of visitors were also available.

Resident records checked were complete and contained information as detailed in Schedule 3, including care plans, assessments, medical notes and nursing records.

Policies, procedures and guidelines in relation to health and safety were maintained as required by the regulations, including fire procedures, emergency plans and records of fire-safety training and drills. Maintenance records for equipment including hoists and fire-fighting equipment were also available. Records and documentation were securely controlled, maintained in good order and retrievable for monitoring purposes.

The directory of residents was viewed by the inspector and found to contain comprehensive details in relation to each resident such as biographical information and relevant contact details.

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:

Both the service manager, and the person in charge, understood the statutory requirements in relation to the timely notification of any instances of absence by the person in charge that exceed 28 days. Management were also aware of the required deputising arrangements necessary in such circumstances and appropriate cover was in place in the event of such an absence. There had been no such period of absence by the person in charge since having been appointed to the post.

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:

There had been no change to the procedures for managing residents' personal property and finances since the last inspection. The centre acted as an agent for several residents and relevant documentation was in place in relation to these arrangements. Processes around the management and administration of resident funds were subject to a quarterly internal audit and an annual external audit. An inventory of personal belongings was maintained and residents were provided with secure storage in their rooms. Receipts for expenditure were retained, and transactions were signed for and witnessed by a second signatory. The inspector reviewed a sample of balances that reconciled with the recorded information.

There was a policy dated 11 February 2017 on the prevention, detection and response to abuse, that also referenced the relevant national policy and guidelines. The policy provided direction to staff on recognising the different circumstances and types of abuse, and how to report such instances. There was a nominated reporting officer for the receipt of such information. Procedures for recording and investigating were in place. Staff members spoken with were clear in their understanding of what constituted abuse and, in the event of such an allegation or incident, also understood the procedure for reporting the information. Residents spoken with stated that they felt safe in the centre and were clear on who was in charge, and who they could go to should they have any concerns they wished to raise.

A policy and procedure was in place on the management of behaviours that might challenge dated June 2017. Staff spoken with demonstrated the appropriate skills and

knowledge to respond to, and manage, behaviour that might challenge. The inspector reviewed the behavioural care plan for one resident and then spoke with several members of staff to assess their understanding of this resident's needs; these staff were consistent in their explanations of the assessed needs of the resident. They were also able to describe the circumstances that might lead to such behaviours and the range of strategies to manage the circumstances, including diversion, change of setting and the use of familiar possessions for reassurance.

The restraint policy, dated 12 April 2017, promoted a restraint free environment with the stated aim that underlying factors be considered and restraint used only as a last resort. Assessments had been undertaken to ensure that the use of restraint, such as bed-rails, was safe and appropriate. These assessments were documented on individual care plans. Regular nursing notes were in place that reflected timed monitoring of the use of bed-rails. Management and nursing staff also understood the criteria for use of chemical restraint and related records were maintained where required. Systems of oversight were in place with regular audits being undertaken.

Judgment:

Compliant

***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):

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

Findings:

The premises had undergone significant refurbishment and development. Additional sluice facilities, storage areas and fully equipped bathrooms were now in place that met the necessary requirements in relation to sanitary care and infection control.

A health and safety statement was in place dated 19 June 2017 that nominated specific safety representatives. There was a comprehensive suite of policies and procedures in relation to the management of infection control. A suitably qualified member of staff held responsibility for monitoring compliance with national standards for infection prevention and control. The inspector reviewed the arrangements for oversight and implementation of related practice with this member of staff. These arrangements included a report on Healthcare Associated Infections in Long-Term (HALT) that had been completed in February 2017. Monthly hygiene team meetings took place, the last on 9 May 2017, and minutes of these were available that summarised the issues addressed. There was evidence of regular hand hygiene audits. An environmental report was available dated 10 April 2017. Staff had received health and safety, and infection control training relevant to their role. Staff demonstrated a conscientious approach to

hygiene and the appropriate use of personal protective equipment in the course of their duties.

The fire-safety register demonstrated that daily, weekly and monthly checks took place to ensure effective fire-safety precautions. Emergency exits were clearly marked and unobstructed. Evacuation plans were easy to read and clearly identified the location of nearest exits. There were personalised evacuation plans in place for each resident. Fire drills were conducted regularly in keeping with statutory requirements, these took place both at night and during the day. Records of these drills included information on participants, the duration of the evacuation and any remedial action that might be necessary. Suitable fire-fighting equipment was available throughout the centre. There was an external smoking area with accessible fire-safety equipment. Appropriate controls were in place to manage the possible risks associated with residents who smoked, including managed access to cigarettes and lighters. Documentation was in place that confirmed equipment was regularly serviced and maintained. Alarms and emergency lighting were regularly tested. Regular fire-safety training was provided, most recently on 19 June 2017. A review of the training matrix indicated that all staff had received current training, except for a small number of staff on annual leave; the person in charge confirmed training was scheduled for 4 July to address these gaps.

The circumstances around incidents and adverse events were recorded and collated for analysis and review via a national incident management system. Management explained that learning from this process was circulated through alerts and also communicated at staff meetings. The system operated centrally and provided feedback on learning from all centres on a regional basis. The risk management policy outlined systems for identifying and assessing risk; however, it required further development to fully address the areas of risk as specified in the regulations. A comprehensive risk register was in place that identified environmental risks, and also outlined related control protocols. However, it required further development to reflect the levels of risk relative to the circumstances described. All staff had received appropriate training in manual handling.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

A comprehensive suite of policies and procedures around the management of medicines were in place that had been reviewed on 11 April 2017. This information provided

relevant guidance to staff on the ordering, prescribing, storing and administration of medicines. The centre had access to the pharmacy resource located on site within the hospital facility. A specific policy was in place that set out the working arrangements between the centre and the on-site pharmacy. A nurse prescriber held responsibility for the management of medicine related practice and procedures. The inspector met with this member of staff and reviewed related work practices. Medicines were securely stored in a clinical room. Where medicines were refrigerated, the temperature of storage was recorded and monitored; these records were available for reference. Medicines such as eye drops and ointments had the dates of opening recorded on the product. A system was in place to record and monitor medicine related incidents. A monthly medicines chart check took place that ensured all relevant information was recorded accurately. Prescribed medicines were regularly reviewed by both the prescriber and pharmacist. Oversight and audit procedures were also supported by the pharmacist. The centre did not operate a trolley system and the medicines for each resident were stored individually in secure lockers in each resident's room.

Prescription sheets contained the necessary biographical information, including a photograph of the resident. A sample of prescription records was reviewed. Where PRN (as required) medicines were prescribed, relevant maximum daily dosages had been indicated by the prescriber. Where residents required their medicines to be crushed prior to administration, authorisation by the prescriber was documented. The inspector reviewed processes for the management of controlled drugs with the nurse prescriber. These were in keeping with guidelines and included protocols for stock control at the start and end of every shift, and double signatures on administration. At the time of inspection there was no transcribing of prescriptions and no residents were responsible for the administration of their own medicine. The inspector spoke with members of nursing staff who confirmed that their training on medication management was regularly updated. Procedures to assess competencies in this regard were in place.

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:
A system for recording all incidents at the designated centre was in place and the person in charge was aware of the requirements to notify the Chief Inspector accordingly. Quarterly reports were also completed and returned 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):

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

Findings:

At the time of inspection the centre was in the process of adopting a new format of care plans, in keeping with a standardised template being implemented across the HSE organisation. The person in charge explained arrangements that were in place to ensure the transition of information was timely and appropriately managed by nominated nursing staff. The inspection established that there were suitable arrangements in place to meet the health and nursing needs of all residents. Pre-admission and admission procedures were completed by an appropriately qualified person. Care plans were developed in line with admission assessments. The inspector reviewed a sample of care plans and found that these were reviewed regularly in keeping with regulatory requirements, or as the needs of the resident changed. The care planning process used validated tools to assess residents' needs in relation to mobility, nutrition, skin care and cognitive function, for example. The results of these assessments informed specific care plans that provided guidance to staff on how best to deliver care in relation to needs around eating, drinking, moving and personal hygiene, for example. Residents with diabetes had relevant care plans in place that included the regular monitoring of blood sugar levels and nutrition. A weekly audit was in place that provided oversight of care arrangements for all residents. Examples of these included wound and pain management, and also the monitoring of residents on modified diets or for those who were using a percutaneous endoscopic gastrostomy (PEG).

The inspector spoke with nursing and care staff about the needs of individual residents and they were able to access information easily and describe care arrangements that were in keeping with the records reviewed. Signed consent forms were in place. There was evidence of good communication between residents and families, and that discussions around care took place. St Joseph's unit was located on the campus of Bantry General Hospital and therefore had access to a broad range of related services, including specialist care in psychiatry, geriatrics, palliative care and infection control. The centre also had effective access to allied healthcare in the areas of physiotherapy, dietetics and speech and language therapy. The centre could make arrangements for

private appointments with an occupational therapist. Residents were also routinely reviewed in relation to optical and dental care, and could access the services of both a podiatrist and chiropodist. Residents were regularly monitored and routine observations were recorded. An annual vaccine programme was in place. A consultant geriatrician attended the centre and reviewed residents as required. The healthcare, assessment and care planning processes, as demonstrated by this service throughout the inspection, were appropriate to meet the overall health and nursing needs of residents.

Judgment:

Compliant

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):

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

Findings:

Following an application to vary conditions the centre had been inspected in November 2016. Areas for development identified at that time had since been fully addressed. The centre was located on the first floor of Bantry General Hospital, on the outskirts of the town. There were car parking facilities for both visitors and staff. The development of the centre had created eight single rooms with en-suite facilities, extra office space, a sluice and utility area and a recreational day room. The centre had also undertaken an extensive refurbishment of the existing bathroom facilities, twin-bedded rooms, dining area and roof garden.

Bedroom accommodation now comprised 12 single, and two twin rooms, with en-suite facilities. There were also two four-bedded rooms with en-suite facilities. Single bedrooms were spacious, with large en-suite facilities that had motion sensor lighting and included a wheelchair accessible shower, a toilet with contrasting grab rails, and a wash-hand basin. Hydraulic beds had integrated divided bed-rails to promote safety and mobility, without restricting the resident's freedom to get in or out of bed. All rooms had a functioning call-bell and accessible lighting. The doors on single rooms were fitted with an adjustable viewing panel for privacy. Each bedroom was appropriately equipped with clothes storage and a lockable space for personal items. All bedrooms were bright, with a view of the outdoors. Each room had a television or radio and wall mounted clock. One of the single rooms was a palliative care suite that incorporated a small seating and kitchenette space for use by relatives as necessary.

The centre had two sluice rooms, wheelchair accessible toilets and showers, a clinical room and a small seating area adjacent to the lift entrance where residents were seen to sit and read or meet visitors sometimes. There were two nurses' stations and separate office space for the person in charge. A quiet room provided a snoezelen facility for residents' relaxation where residents could also meet visitors in private.

The new accommodation and facilities had been completed to a very high standard. The centre was bright and well decorated throughout. There was good natural light and residents had easy access to a sheltered roof terrace that overlooked the local countryside and bay. Overall, the premises were in keeping with the individual and collective needs of the resident profile, as reflected in the statement of purpose.

Judgment:

Compliant

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:

A written operational policy for the management of both verbal and written complaints was in place, dated 11 April 2017. This document referenced organisation wide protocols in relation to the management of complaints about either the service or members of staff. These procedures set out how to make a complaint and also outlined the expected time frames for resolution. It also identified the complaints officer responsible for receipt of any complaints. Arrangements were in place for oversight of the complaints process that included review by the executive board that convened monthly. A copy of the procedure was displayed at the access area of the first floor. Information was provided on the appeal process that included contact details for the office of the Ombudsman. A summary of this information was available in the statement of purpose.

The inspector met with the independent advocate during the inspection and confirmed that residents were supported in their access to this resource. The inspector met with residents who understood who was in charge and how to make a complaint. The centre operated a system for recording complaints and a review of the complaints log indicated that no complaints had been received since the previous inspection. There was evidence that issues raised by residents or their relatives were appropriately addressed and that concerns were resolved to the satisfaction of the parties involved. However, the documentation and recording of complaints did not consistently reflect the good practice

and responsiveness to complaints that was demonstrated during the inspection.

Judgment:

Substantially 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:

A centre-specific policy that provided relevant guidance to staff on the provision of care around end of life was in place, dated 20 June 2017. A record of staff having read and understood the policy was maintained. The policy was comprehensive and provided directions to staff in the provision of care that met the physical, emotional, social and spiritual needs of residents at end of life. It also referenced advanced care planning and bereavement planning.

The inspector reviewed a sample of care plans and noted that residents' wishes around spirituality and dying were documented and preferences in relation to end of life had been recorded. The inspector also reviewed the care plan of a resident in receipt of palliative care and noted that appropriate notes were maintained in the communication sheet, with regular review by a general practitioner, and input by the palliative care team around pain relief and wound management. The records indicated effective communication between health professionals and that the resident was appropriately consulted with in relation to the progress of care. Accommodation and facilities were in place that allowed friends and family remain continuously with their relative, if they wished. Staff spoken with understood their duty of care in communicating their observations, and the changes in care needs of residents, to other staff. They also understood assessment as an ongoing and proactive process, the outcomes of which should be regularly reviewed with the resident, where possible, and documented accordingly in the care plan.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Meals were prepared centrally and delivered to both patients in the acute hospital and residents in the designated centre. There was also a separate kitchen area within the unit with cooking facilities that supported residents in the provision of snacks and refreshments. Residents also had access to a canteen on the ground floor that they could go to with visitors. Members of staff were able to explain how relevant information about the dietary requirements of residents was made available to those staff with responsibility for preparing and serving meals. Staff were also able to demonstrate how this information was regularly revised, following communication at handover for example, if a resident's needs had changed. Records of dietary requirements were documented and maintained.

A policy was in place for the monitoring and documentation of nutritional intake dated May 2017. It provided relevant guidance on the use of validated tools to assess needs in relation to nutrition and hydration. It also included appropriate guidance on the provision of assistance, including the use of specialised utensils where necessary. The person in charge explained that a nutritional committee was in place that convened regularly to review issues relating to both the service for older people and the acute facility.

The inspector reviewed a sample of care plans and noted that all residents were nutritionally assessed on admission using an appropriate assessment tool. These assessments were regularly reviewed. Fluid and food intake and output charts were maintained and, when necessary, referrals were made to allied healthcare professionals, such as an occupational therapist or a speech and language therapist. Oral health was monitored and records indicated referrals were made as appropriate.

The inspector observed meals being served that were freshly prepared, nutritious and appetising in presentation. Residents were seen to be offered choice around their personal preferences. The inspector noted regular rounds of refreshments including snacks and drinks. Fresh fruit and smoothies were on offer. The inspector observed that there was an adequate number of staff to provide care and support as necessary around mealtime. It was also evident that residents exercised personal choice as to where and when they took their meals.

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):

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

Findings:

There was a policy on providing information to residents and a relevant residents' guide was available and up-to-date. The centre provided access to independent advocacy services and contact information was on display on notice boards in the centre. A monthly outreach programme providing information on rights and entitlements took place and the inspector met a resident who had attended these. Management and staff demonstrated a commitment to involving residents and their families in decision making in relation to the centre. There was good evidence of the involvement of residents in the consultation process around the recent refurbishment of the centre. Regular resident meetings took place and it was clear that consultation around the continued development of the environment was the subject of ongoing consultation. There were no restrictive visiting arrangements and on the days of inspection visitors were in regular attendance at the centre. Residents spoken with consistently commented positively of their experience and observation of care at the centre. The centre provided facilities for residents to meet with visitors in private and no restrictions on visiting hours were imposed.

As referenced at Outcome 12, significant work had been undertaken to develop the environment and residential space for residents, and a high standard of communal and individual accommodation was now provided for many residents. A quiet room provided a snoezelen facility for residents' relaxation where residents could also meet visitors in private. The day room was bright with natural light and opened onto a roof terrace, that residents could easily access, where they could sit and overlook the bay and countryside. There were also raised planting beds for residents with an interest in gardening. The centre had nominated staff with responsibility for delivering an activity programme. These staff had received training relevant to their role to support them in providing meaningful activities appropriate to the assessed abilities of individual residents. Regular scheduled activities included arts and crafts, Sonas, bingo and music sessions, for example. During the inspection residents were seen to engage in the activities at various times of the day. The centre also had access to a transport facility for outings and to access events in the local area. Residents were facilitated to visit the local town when they wished.

Throughout the inspection the inspector observed appropriate and courteous person-centred interactions between all staff members and residents. Privacy was observed and

staff routinely knocked on residents' doors before entering. However, the centre also continued to provide long-term accommodation in two multi-occupancy rooms for up to four people. Management and staff acknowledged the impact of these circumstances on the privacy of residents. There was evidence that management and staff went to great effort to accommodate the preferences of residents and their families. Where an issue had been raised around the impact of privacy screens on the available light for an adjacent resident, management had been responsive and arranged to provide the resident with the next available single room. Additionally, actions to address areas for improvement had been implemented; for example both wards now provided two televisions in each to ensure residents on either side had line of sight to what they were watching. However, the circumstances of shared occupancy for up to four residents did not support communication and the receipt of personal care in a manner that promoted and protected privacy and dignity. While privacy screens were in use in these wards, they were inadequate in ensuring privacy of communication for residents. Management made arrangements to facilitate residents' preferences for accommodation where possible. In these cases it was evident, from both care plans and discussion, that effort was taken to review circumstances on an individual basis. However, the practical availability of accommodation in less than a three-bedded space for residents on continuing care could not always be provided. Management and staff confirmed that, at the time of inspection, a number of residents in multi-occupancy wards were on a waiting list for availability of a single room.

Judgment:

Substantially 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:

There was a policy on residents' personal property and possessions that had been reviewed on 19 June 2017. An inventory of individual resident belongings was maintained on resident care plans for reference. Appropriately equipped laundry facilities were in place. There were effective systems of laundry management and labelling to ensure that residents retained control over their personal items of clothing.

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):

No actions were required from the previous inspection.

Findings:

The planned and actual staff rota was reviewed and the inspector was satisfied that the staff numbers and skill mix were appropriate to meet the needs of the residents having consideration for the size and layout of the centre. Staffing levels had been appropriately revised to take account of the increased size of the unit and to meet the requirements of care accordingly. Recruitment and vetting procedures were in place that verified the qualifications, training and security backgrounds of all staff. Documentation in relation to staffing records was generally well maintained, as per Schedule 2 of the regulations. Action in relation to vetting documentation for employees is recorded against Outcome 5 on Documentation. A record of professional registration details was maintained. The centre engaged a number of volunteers whose roles were set out in writing and who received supervision appropriate to their role. Volunteers appointed to a role since 29 April 2016 had been vetted appropriately in keeping with legislative requirements.

The system of supervision was directed through the person in charge with appropriate administrative and clinical support. Systems of line management accountability were in place and there was an annual appraisal process. Supervision was also implemented through monitoring and control procedures such as audit and review. An appropriately qualified, registered nurse was on duty at all times. At the time of the inspection staffing levels were in keeping with the planned roster. Staff spoken with were familiar with the standards and regulations and were aware of their statutory duties in relation to the general welfare and protection of residents. A regular programme of training was in place that captured all mandatory training. Additional training was provided appropriate to the role and function of staff. Staff spoken with confirmed that they were supported to attend training as required.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St Joseph's Unit, Bantry General Hospital
Centre ID:	OSV-0000597
Date of inspection:	21 and 22 June 2017
Date of response:	25 July 2017

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The centre had in place a verification form from the HSE Garda Vetting Liaison Officer, confirming that related vetting disclosure documentation was in place for employees. However, this was not in keeping with a disclosure as required by Schedule 2 of the 2013 Care and Welfare Regulations.

1. Action Required:

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

Under Regulation 21(1) you are required to: 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.

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

Further to recent communications regarding regulatory requirements in respect to Garda Vetting nationally the HSE has issued an interim procedures directive to ensure the availability of vetting disclosures from the national vetting bureau of the Garda Síochana on grades of staff recruited after 29th April 2016 are available through a Data Controller.

List of Staff recruited to the Unit since 29th April 2016 has been forwarded to the data controller for CH04 in respect of our Unit.

Proposed Timescale: 31/08/2017

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:

The risk management policy required further development in order to reflect the requirements around the provision of controls and measures in relation to the risks as specified in Regulation 26(1)(c)i-v.

2. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

The Hospital wide Risk Policy is being reviewed and will be upgraded upon the appointment to the hospital of a Quality and Risk Manager in September 2017.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

The risk register required review to fully reflect the levels of risk associated with the issues identified, relative to the circumstances and controls in place.

3. 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:

Risk Ratings will be part of the revised Risk Management procedure going forward upon the appointment to the hospital of a Quality and Risk Manager in September 2017.

Proposed Timescale: 31/12/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The documentation and recording of complaints did not consistently reflect the good practice and responsiveness to complaints that was demonstrated during the inspection.

4. Action Required:

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

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

Under regulation 34 (2) we will continue to adhere to the complaints policy. Opinions and comments will now be documented and forwarded to the complaints officer.

Proposed Timescale: 21/07/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The circumstances of shared occupancy for up to four residents did not support communication and the receipt of personal care in a manner that promoted and protected privacy and dignity

5. Action Required:

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

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

The centre complies with the Health Act 2007 S.I. No. 293/2016 – Health Act 2007

(Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 4 a (1B)

Management respect the rights of the Resident to have choice of shared occupancy while managing the resulting challenge to privacy and dignity.

All prospective residents are informed of whether the bedroom available for them is single or multi-occupancy.

Proposed Timescale: 21/07/2017