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:	Ballytivnan, Sligo
Type of inspection:	Unannounced
Date of inspection:	13 January 2021
Centre ID:	OSV-0000660
Fieldwork ID:	MON-0031664

About the designated centre

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

The aim of St.John's Community Hospital is to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their health and well-being. The objectives of St. John's Community Hospital include providing a high standard of care in accordance with evidence based practice, providing individualised care to residents and their families respecting the choices, values, dignity and beliefs and ensuring that the residents live in a comfortable, clean and safe environment. St. John's provides a multi-disciplinary approach to the care of residents. The services provided include on-going care of dependant older people, palliative care, dementia care, and physical and mental health care. The centre comprises of five units, Tir na nÓg, Rosses, Cairde, Curam and the Hazelwood unit. St. John's accommodates male and female residents over the age of 18.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	81

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 13 January 2021	11:00hrs to 17:30hrs	Catherine Sweeney	Lead

What residents told us and what inspectors observed

Due to the restrictions in place as a result of the COVID-19 pandemic contact with the residents was limited to short conversations on the day of inspection. The small group of residents spoken with were overwhelmingly positive about their experience of living in the centre.

The centre had remained free from COVID-19 since the start of the pandemic. Arrangements had been put in place to screen every person entering the centre. In line with public health guidelines, visiting was restricted. While residents stated that they found the COVID restrictions difficult, they told the inspector that the staff made sure that they felt safe, particularly with regard to the risk of COVID-19.

Residents were observed mobilising independently around each unit. Residents had unrestricted access to a safe outdoor garden area. There was a number of communal and private recreational spaces available to the residents. One resident told the inspector that she enjoyed meeting her friend, a fellow resident for meals and a chat a couple of times a day. She said that this 'keeps them both going'.

Residents were seen to be relaxed and comfortable in the company of staff. Staff were observed to speak with residents in a kind, and respectful manner.

Staff were very complementary of the food in the centre. A resident told the inspector that the meals were 'very delicious' and that there was always plenty to eat. The dining area was found to be in use and was observed to be a relaxed and communal area for the residents to meet in a safe and socially distanced way.

The inspector observed residents making video calls to families and other residents told the inspector that they speak with their family regularly on the telephone. The residents spoken with told the inspector that they did not feel isolated or lonely due to the restrictions as there was always plenty to do in the centre. A schedule of activities was in place and continued throughout the period of restriction.

The centre is currently undergoing an extension and refurbishment programme. Residents were consulted in relation to the refurbishment of the new Hazelwood unit. Residents meeting notes reflect on-going consultation in relation to the changes in the centre.

Capacity and capability

The Health Service Executive is the registered provider of this centre (HSE). The registered provider representative is the regional manager of the centre who

supports the Person in charge in the day-to-day running of the centre.

This inspection was an unannounced risk inspection by an inspector of social services conducted over one day. This inspection

- reviewed an application to vary the conditions of registration
- followed up on notifications received by the Chief Inspector in relation to the safeguarding of residents in the centre. A review of the residents daily progress notes found that some improvement was required in relation to the management of residents with responsive behaviours.

The centre is currently in the process of constructing twenty new single bedrooms and refurbishing the existing four units. Refurbishment work on the fifth Unit, Tir na nÓg, has been completed and is now accommodating residents. The provider has submitted an application to vary the registration of the centre to allow for the transfer of residents to return to the Hazelwood unit and to move residents out of the Cairde Unit so that the unit can be refurbished.

The inspector reviewed the newly refurbished Hazelwood unit. The works completed were finished to a high standard. The unit was warm and well ventilated. There was adequate communal area in the unit for residents to spend time together or alone. Toilets and shower rooms had been upgraded and were easily accessible.

There was a clearly defined management structure in the centre. The Person in charge was supported in the centre by two assistant directors of nursing and six clinical nurse managers including a night supervisor. Staffing was allocated to each of the five units. The COVID-19 contingency plan in the centre ensured that staff remained on one unit since the start of the pandemic.

Staff had received training in infection prevention and control and all mandatory training was completed on-line. Training in fire safety and safeguarding had been scheduled but was cancelled due to the level 5 COVID-19 restrictions. A review of the staff training requirements was required to ensure an appropriate level of training was received with special regard to the management of responsive behaviours.

The provider had robust systems of management in place. There was documented evidence of positive communication between the nurse management and the provider. Meetings were held weekly and on-going risks were discussed. An auditing system was in place but required review to ensure positive quality improvement outcomes.

The provider had a system in place to manage all complaints received in the centre. Complaints were well documented and identified areas of quality improvement.

Regulation 15: Staffing

The staffing in the centre was suitable for the needs of the residents and for the size and layout of the centre. Rosters reviewed showed that there was a nurse on duty on each unit at all times. The person in charge worked Monday to Friday and was supported by an assistant director of nursing and a team of clinical nurse manager including a night supervisor.

The centre had a staffing contingency in place in the event of an outbreak of COVID-19. Each unit in the centre was staffed independently.

A review of staff files found that staff had a Garda (police) vetting clearance certificate on file.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had completed on-line mandatory training during the COVID-19 restrictions. However, a review of the training matrix found some gaps in relation to on-site training in areas such as fire safety training. Fire drills had been completed by staff during this period and fire training updates were scheduled for February 2021. Training in the management of residents with responsive behaviours was also out of date for some staff.

Staff were appropriately supervised in the centre. A senior nurse was available on all units for each shift, including night duty. A practice development officer was available in the centre to support staff training and professional development.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had management systems in place to ensure the service provided was safe, appropriate, consistent and effectively monitored. A schedule of audits was in place and completed by the senior nurse management teams. Audits identified areas of improvement and developed an action plan to address outstanding issues. However, some action plans were not reviewed to ensure that the actions had been completed. A review of the auditing system was required to ensure that identified improvement actions are completed following the audit process.

A record of staff and management meetings were documented weekly. issues identified included COVID-19 contingency including visiting restrictions, staffing, cohorting and isolation arrangements, COVID-19 testing and vaccine roll out and scheduled training deficits.

Each unit had completed a daily COVID-19 checklist which included room ventilation, mask compliance, PPE compliance, and hand hygiene

An annual review for 2020 was available for review.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A review of the complaints log in the centre found that complaints were documented and managed in line with the requirements of Regulation 34.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the centre was providing a high standard of care and quality of life for residents. A review of the management of residents with responsive behaviours was required to ensure that the care delivered reflected the high quality, evidence based care plans there were in place.

This inspection took place during the COVID-19 pandemic. The centre had remained free from COVID-19 since the beginning of the pandemic. The centre was clean and well maintained. A domestic supervisor had been newly appointed and was rostered to provide cleaning oversight. Each unit had two cleaners available. A COVID-19 contingency plan included updated cleaning schedules and protocols. The cleaning schedule was in line with the Health Protection Surveillance Centre (HPSC) Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.

Residents health care needs were appropriately assessed and a comprehensive care plan was developed to address the health and social care needs of the residents.

The Chief Inspector was notified of a number of incidents of responsive behaviours which had the potential to put at risk the quality of life of other residents in the centre. A review of these incidents found that appropriate measures had been developed and documented in the residents care plans to manage the responsive behaviours of residents involved. Safeguarding plans had been activated for residents, where required, and assessments and care plans had been updated appropriately. However, a review of the daily progress notes of a sample of residents with responsive behaviours found that the daily care documented did not reflect the residents care plan. A review of staff training in the management of

residents with responsive behaviours was required.

The provider and person in charge had appropriate systems in place to manage risk in the centre. The risk register included the on-going building and refurbishment works. Identified risk was an agenda item on the centres weekly management meeting.

Residents were well supported by an on-site medical officer and a team of allied health care professionals. Access to the multi-disciplinary team was risk assessed and available to residents throughout the pandemic.

Residents rights were observed to be upheld. The inspector found that residents were free to exercise choice about how they spent their day. Some residents were observed in the communal areas of the centre while residents spent time alone in their rooms. Residents had access to television radios, newspapers, telephones and internet connection.

Regulation 26: Risk management

The centre had an active risk register in place which identified on-going and centre-specific risks including the risks associated with COVID-19, the on-going building works and the risk associated with reduced on-site training for staff. Risks were reviewed and updated.

Judgment: Compliant

Regulation 27: Infection control

All staff had received up-to-date training in COVID-19 management, Infection prevention and control, hand hygiene and the use of personal protective equipment (PPE). Hand gel was available throughout the centre. The inspector observed staff using PPE appropriately on the day of inspection.

A safety pause was held on each unit three times a day. These pauses were used to reinforce the infection prevention and control guidelines and were attended by all staff on the unit.

A strategy was in place to ensure all staff were tested for COVID-19 in line with national guidelines. A plan was also in place to facilitated the administration of the COVID-19 vaccine to residents and staff in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Each resident in the centre had a comprehensive assessment completed. The assessments were appropriate to the care needs of the residents and were used to develop the residents care plan. The care plans reviewed were detailed, person-centred, and were updated with the changing needs of the residents.

Judgment: Compliant

Regulation 6: Health care

All residents in the centre have access to an on-site medical officer. Allied health care services such as physiotherapy, occupational therapy, dietitian, psychiatry of later life and palliative care support had continued throughout the COVID-19 pandemic. A review of a sample of residents files found that multi-disciplinary team recommendations were well documented and incorporated into the residents care plans.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The care plan for residents with responsive behaviours were professionally and respectfully developed and documented. They included the identification of triggers and appropriate de-escalating and distraction techniques to be used for incidents of responsive behaviour. In contrast, a number of entries to the progress notes detailed the administration of once-of medications to manage responsive behaviours. The responsive behaviours were not detailed and no alternative intervention was documented. This was not reflective of best practice guidelines. It was therefore difficult to assess if the residents had received a high standard of care as prescribed by their care plan.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents had received letters from the person in charge updating them on the on-going works in the centre and COVID-19 restrictions including visiting. Residents told the inspector that they felt well informed about any changes that have

happened in the centre.

Residents were observed to be to be actively engaging in group and individual activities throughout the day of inspection.

The resident satisfaction survey had been completed in December 2020. This survey collected feedback from residents in relation to areas such as the facilities, comfort and choice, food, including times of meals, complaint management, privacy, safeguarding and relationships with staff. It also included feedback in relation to the COVID-19 access to information and restrictions. There was a high level of resident participation in this survey and overall satisfaction was found to be at a high level. An action plan was in place to address any issues raised in the survey.

Judgment: 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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. John's Community Hospital OSV-0000660

Inspection ID: MON-0031664

Date of inspection: 13/01/2021

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
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The Practice Development Co-Ordinater has supported the Person in Charge with the development of a revised training matrix. This can be filtered per unit and each unit Clinic Nurse Manager is responsible for ensuring the team members are up to date on mandatory training. The Person in Charge supported by the Practice Development Co-Ordinator review the training matrix to ensure staff are up to date with training.

• The Practice Development Co-Ordinator is responsible for the organising of training.

• The training schedule for St John's Community Hospital has been revised in consultation with the Practice Development Co-Ordinator and Infection Control Assistant Director Nursing ensuring compliance with mandatory training requirements.

• Each unit/department within St John's Community Hospital has been provided with their own specific training matrix to submit monthly to the Person In Charge for review and collation.

• Staff have been provided with protected time to complete mandatory online training.

• Funding has been made available to purchase additional IT equipment for use in the training room by staff to facilitate timely completion of online mandatory training
• Where staff have outstanding mandatory training outstanding despite opportunities provided to allow completion have ben communicated in writing by the Person in Charge and this is now ongoing procedure.

• In relation to mandatory Fire training, online fire training facilities have been provided for all staff through Fire Protection Ireland, and a practical on site session has been scheduled for March 2021. This is the earliest time slot available from training provider.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance with Regulation 23, the registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. To ensure compliance with Regulation 23, the Registered Provider has ensured the following:

• A planned audit cycle has been developed and is now in place.

• An audit schedule has been developed for each of the 4 individual units. Meetings have taken place between the Person In Charge and the Clinical Nurse Managers in each unit to agree their role in the audit cycle. Named staff responsible for individual audits have been allocated and timelines agreed to ensure compliance.

• Discussions and agreement has taken place with Clinical Nurse Managers and enhanced nurse to agree the format of Quality Improvement Plans to ensure these are SMART and provide actions for continuous Quality Improvement.

• The newly appointment Domestic Supervisor is role includes the carrying out of environmental audits and liaises directly with the Person in Charge regarding Quality Improvement Plans and additional resources required to ensure environmental standards are maintained.

• Links with Infection Prevention Control are in place.

• The Person in Charge is responsible for reviewing all audits to ensure appropriate Quality Improvement Plans are in place.

• All Audits results and Quality Improvement Plans will continue to be discussed at the weekly Clinical Nurse Managers meeting and the weekly communication forum.

• The Designated Centres Annual Review for 2020 has been completed and shared with staff and is available to family members.

• The Resident’s 2020 Annual Review document has been completed and distributed to all residents.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
To ensure compliance with Regulation 7 the Person In Charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging by ensuring the following:
• Staff had previously undertaken Professional Management of Aggression and Violence (PMAV) training. This has been replaced with Positive Behavioral Support Planning training as it is more appropriate to residents of the designated centre. Dates have been scheduled for training in Positive Behavioural Support Planning training virtually for the month of March 2021 and ongoing throughout the year to ensure all staff are up to date with training in this area.
• The Dementia Nurse Specialist has provided support to the Tir na nOg unit in relation to behaviours that are challenging and has provided education on the correct completion and use of the ABC chart.
• The Safeguarding E-module has also been completed by staff within the designated centre. Safeguarding incidents have been escalated to the Safeguarding team and formal safeguarding plans devised and in operation. At present all safeguarding incidents within the designated centre have been closed by the Safeguarding team.
• Additional safety measures implemented to ensure the safety of all residents are discussed at each units safety pause thrice daily, and are reflected in the specific residents nursing care plan.
• All safeguarding incidents are discussed at the weekly Clinical Nurse Managers meeting.
• In relation to the nursing progress documentation being medically focused as opposed to a bio-psychosocial focus, the Practice Development Coordinator has been working with each unit to provide training to ensure a person centred holistic reflection of the resident’s day has been captured. This work will be ongoing where new staff are recruited and where audit identifies the bio-psychosocial focus is not being implemented.

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
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2021
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.	Substantially Compliant	Yellow	09/02/2021
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/04/2021