Health Information and Quality Authority
Regulation Directorate

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

Centre name:	St James's Hospital Residential Unit, Hospital 4
Centre ID:	OSV-0000473
Centre address:	St. James's Hospital, James Street, Dublin 8.
Telephone number:	01 416 2262
Email address:	ceopa@stjames.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St. James's Hospital
Provider Nominee:	Brian Fitzgerald
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
02 July 2014 10:00	02 July 2014 20:00
03 July 2014 08:00	03 July 2014 16:00

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

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

Summary of findings from this inspection

This announced inspection was the fourth inspection of this centre and took place over two days. The purpose of the inspection was to inform the decision of the Authority in relation to the application by the provider to renew the registration of the centre which was granted registration in 2011.

There were six actions identified following the previous inspection in 2012. Of these four were satisfactorily resolved. The unresolved actions include the suitability of the premises and the implementation of adequate care plans for supporting residents with behaviour that challenges.

The findings of the inspection demonstrated that resident's health care was prioritised and met to a good standard with ease of access to a range of multidisciplinary services. There was evidence of good governance, systems in place to review the quality and safety of care. Staffing levels and skill mix was very satisfactory and staff were knowledgeable on care needs and evidenced based nursing practices. Mandatory training was satisfactory and other training relevant to the residents needs was provided. Complaints were managed appropriately and there were appropriate protective mechanisms in place.

Some improvements were required in training for staff in care of residents with dementia, activities and stimulation for the residents, management of challenging behaviours and restraint practices.

The premises in its current configuration poses significant challenges to the provision of person-centred care on a long term basis. Wards contain between three and seven people and there are insufficient toilet facilities and lack of adequate dining and day-room space. The provider has indicated that there is a firm plan to remedy this within an agreed timeframe.

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

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose had been forwarded to the Authority as part of the application for registration. It was found to be in compliance with the regulatory requirements. Admissions to the centre and care practices implemented were congruent with the statement.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The provider was in compliance with this regulation. A number of systems are in place to support governance arrangements and to ensure that residents care and safety is prioritised within the care of the elderly section of which Hospital Four is an integral part. There are effective supportive structures in place for the person in charge including risk management and quality assurance systems. The board of management meets circa six weekly and reports available demonstrate a comprehensive reporting structure. The governance is further supported by the quality and safety risk review committee which

reports quarterly and provides a due-diligence report annually.

A number of systems are used including audits and reporting structures to monitor the quality and safety of care. These include audits of incidents and risks, prescribing practices, nutrition, falls and pressure incidents or other adverse events. A quality improvement plan is also implemented and regularly reviewed. A review of these procedures indicates that the information was used to implement changes to structures and systems where any deficits are identified. Examples of such issues identified include end of life procedures, systems for monitoring the function of volunteers and the ultimate plan for the relocation of the centre. There were agreed timeframes for the changes identified. Resources available including staffing, management and equipment were seen to be well utilised.

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 is a detailed resident's guide available and each resident is provided with a contract of care. The inspector noted that the fees were not identified on the contract and the contract did not fully detail the accommodation or care and welfare systems to be provided to residents. The provider informed the inspector that they were fully aware of this deficit. The funding and fees are arranged directly between the HSE and the resident but is administered and managed by the provider. It is for this reason that the fees are not outlined in the contract. The provider agreed to remedy the contract. No fees outside of the cost of care are levied.

Judgment:
Non Compliant - Moderate

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 full-time person in charge was on statutory leave at the time of this inspection. She is expected to return to duty. She has previously been deemed suitably qualified and experienced for the post. The provider has nominated two suitably qualified people to act in management functions. One of the nominated people was in post as acting person in charge at the time of this inspection. As this appointment was relatively new, a fit person interview was held with this post holder. She demonstrated a good knowledge of the regulations and standards and her responsibilities. She is suitably qualified and experienced and has continued her professional development with post graduate qualification in gerontology and person-centred dementia care, leadership and management. The post holder also has responsibility for the rehabilitation unit and the day hospital. There was no evidence that these additional responsibilities impacted in any negative way on the governance in the designated centre. She is engaged full time in post. She is supported by a team consisting of clinical nurse managers in each ward and quality control and clinical governance systems.

The person nominated to act on behalf of the provider was intrinsically involved in the governance of the centre as the Chief Executive Officer of St James Hospital. Governance arrangements, including monitoring of practices and reporting systems were clearly outlined and satisfactory and responsibilities were understood.

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:
The inspector found that the records required by regulation in relation to residents, including medical records, nursing and general records were up to date, easily retrieved

and maintained in a manner so as to ensure completeness. All of the required policies were in place and had been revised. Documents such as the residents guide and directory of residents were also available. The inspector saw that insurance was current and included the liability for resident's personal property as required by the regulations. Reports of other statutory bodies were also available. Written evidence of compliance with the statutory fire authority had been forwarded to the Chief Inspector as part of the application for registration.

Judgment:
Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
The provider has made suitable arrangements for periods of absence of the person in charge. Both persons are suitably qualified and experienced. The provider has also complied with his responsibilities to notify the Authority of any periods of absence over and above normal annual leave periods. All relevant documentation has been forwarded to the Authority. Arrangements were suitable and consistency of management was evident.

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

Findings:
The inspector reviewed the policy and procedures on the prevention, detection and reporting of abuse and found that it was satisfactory and in line with all guidelines. Records demonstrated that all staff had received updated training in the prevention, detection and response to abuse which is facilitated by the medical social worker and this is available for staff monthly on a rotating basis. Staff spoken with demonstrated an understanding of their own responsibilities in relation to this and signs and symptoms which would indicate concern. They also expressed their confidence in the provider and person in charge to act on any concerns raised. Residents informed the inspector that they felt safe and well cared for in the centre. They were familiar with the person in charge and expressed their confidence in being able to address any issue with her or the clinical nurse managers. The inspector was informed that no allegations of this nature had been made since the previous inspection.

A review of a sample of records of fee payments and transactions for residents for whom the provider acts as agent and a resident who was a ward of court and found that the records were transparent, adequately recorded and residents could at any time be given a detailed statement of their finances including fee payments. Arrangements for the management of monies for residents at ward level were recorded and signed by two nurses.

There was a detailed policy on the management of challenging behaviours and on the use of methods of restraint which were in accordance with national policy and guidelines. Care plans were available for a number of residents which outlined very person-centred and specific guidelines for residents who demonstrated such behaviours including systems of communication, possible triggers and the most effective way to support the residents. In addition, staffing had been increased to provide individual supervision where this was required. This increased supervision provided support for the individual residents and also helped to filter interactions with other residents who may have been at risk. However, these care plans were not consistent across the wards and in some instances the guidelines did not demonstrate good knowledge of the individual resident, triggers and supportive strategies. This may in part be explained by the use of pro-forma document. These consist of a number of standard interventions which staff can choose to implement and they can then include specific guidelines based on each residents assessed need. However, the review of these plans indicated that additional training for staff in making these plans person-centred and specific is required in some instances. Staff included the pro-forma document but failed to include the elements specific to each resident. The multidisciplinary team reviews, which are held circa six to eight weeks for each resident, review the incidents and make recommendations. Where necessary psychiatric care review was evident and medication was altered to support symptoms.

Policy on the use of methods of restraint and enablers was also detailed and in the main practices were found to be in line with the policy. Enablers such as supportive belts for seating were only used on the recommendation of the occupational therapist and reviewed at the multidisciplinary meetings. An assessment tool for the use of bed rails was also used. In some instances the assessment indicated that the use of the bed rail was contra-indicated and they were not used. However, there was no evidence in the

assessment or reviews that exploration of alternatives such as low beds or censor alarms had been adequately considered. Some residents informed the inspector that they preferred the bedrail up as they feared falling and the inspector observed that bumpers were used in some instances to prevent injury form the rails. Two hourly checks were also documented on residents who were using these rails. Only two low beds were currently in use.

Examination of incidents and adverse events records available indicated that in exceptional circumstances the use of physical restraint was allowed and had been implemented. According to the policy exceptional circumstances apply where there is an immediate risk to a resident or to other residents. The information available to the inspector did not suggest that the actions used were contrary to the policy. A full review of such incidents took place immediately following such events by the risk management team. However, there was an ambiguity in the policy as to the actions staff are permitted to take in such circumstances. Training in an agreed and approved method of such actions was not available for staff. The records used to detail this intervention were not sufficiently discreet and descriptive. This practice places residents at risk of injury and the potential for misuse of this exception in the policy.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
There was a current and signed health and safety statement available. Systems for review of safety and risk were evident. Quality and safety assurance systems were evident. The risk management policy was in compliance with the regulations including the process for learning from and review of untoward events. This was further supported by relevant policies including an emergency plan and a detailed missing persons policy. The emergency plan was detailed and it contained all of the required information including arrangements for the interim accommodation of residents should this be required. An integrated generator was available for use and emergency phone numbers were readily available to staff. However, the wards did not have a current and easily accessible mobility profile of the residents for use by the emergency services.

A risk register was available and found to be centre-specific and pertinent to the resident population. The risk management committee reviewed significant incidents and made recommendation as to remedial actions. Risk management was supported by individual risk assessments for residents and a review of incidents was implemented to

assist in the prevention of re-occurrences and thereby learning from untoward events. A review of accidents and incidents indicated that actions were agreed upon and incidents which had occurred were managed appropriately. For example, a resident had been absent from the ward and was located safely. The alarm system had not in fact activated. The incident was fully reviewed and actions taken to prevent a re-occurrence. Core safety features including non–slip flooring, hand-rails and call-bells were installed. Training records demonstrated that staff had undergone specific training in moving and transporting residents and in the safe use of the hoist. Staff were able to articulate this to the inspector and good practice was observed during the inspection. Censor alarms were used to alert staff for some residents who were assessed to be at risk of falls or of wandering.

Residents who smoked were assessed for safety and supervised. The designated smoking room contained fire retardant aprons, extinguishers were available and the room was ventilated. Residents could either be observed via the viewing panel or directly supervised as indicated by their assessment.

Fire safety procedures were satisfactory with the fire alarm and emergency lighting serviced quarterly and other equipment serviced annually as required. Daily checks on the exit doors and fire panel were recorded. The fire procedure was displayed and all staff spoken with were able to demonstrate a good knowledge of the procedure to be used in such an event. Fire safety training had taken place annually for all staff and this training included the use of the fire compartments, movement of residents and the use of ski sheets where these were indicated. Fire drills were held circa twice yearly.
The inspector was satisfied that the safety of residents was prioritised with the exception of the regular review of the condition and safety of the bedrails some of which were observed to be loose and a regular check of the censor door alarm system.

Judgment:
Non Compliant - Minor

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

Findings:
The action in relation to the medication management policy, namely the Prescriber signature on PRN (as required) and other medication had been satisfactorily addressed. Current policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for controlled drugs were satisfactory. There are appropriate

documented procedures for the handling, disposal of and return of medication. Medication is dispensed via the hospital pharmacy.

There was evidence that resident's medication was regularly reviewed by the medical officers or mental health clinicians where this was required. Records also demonstrated that staff observed residents response to medication. An audit of medication documentation storage and administration was undertaken regularly and any discrepancies were identified and acted upon. There was evidence that any errors or incidents were reported and addressed with appropriate actions taken promptly. Medication errors or incidents were also included in the internal audits undertaken quarterly. At the time of this inspection no residents were deemed to have the capacity to self-administer medication.

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:
Examination of accident and incident records and notifications forwarded to the authority demonstrated that the person in charge was aware of and complied with her responsibility to maintain records of all incidents and forward the relevant records to the Authority. Incidents were reviewed as they occurred.

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):
No actions were required from the previous inspection.

Findings:
Hospital 4 is part of the Medicine for the Elderly Directorate known as 'MedEl' in St James' Hospital and provides long term and respite care for 48 people over 65 years of age, including older people with dementia. Residents have access to the acute hospital services if they require them, including specialized clinics for falls, osteoporosis, memory difficulties and psychiatry of old age.

There were 48 residents present in the centre at the time of this inspection. The dependency level of residents on the day of inspection was assessed as 38 maximum dependency, 7 as high dependency and 3 at medium dependency. Admission processes were robust with full multidisciplinary assessment being undertaken. Admissions are routed via the acute care section of the hospital. From a review of 10 care plans and medical records the inspector was satisfied that the healthcare requirements of residents were met to a good standard. All residents had updated evidenced based assessment tools completed for pressure area care, falls prevention, nutrition and other needs specific to the residents. These assessment tools were reviewed either monthly or three monthly. All medical care is provided within the "MedEl" directorate ensuring that residents have access to physicians who have knowledge and expertise in the care of older persons. Ward rounds by the registrars take place weekly, and access is as required with medication reviewed regularly. On-call is available within the hospital cohort of clinicians. The inspector noted that staff were vigilant and responsive to residents changing healthcare needs. There was evidence of access to psychiatry of old age as required.

Care plans were formally reviewed and rewritten at six monthly intervals. The inspector observed however, that where a residents needs changed the care plan was duly updated on daily basis if required. The plans demonstrated a good knowledge of the individual residents and this was confirmed by speaking with staff. There was evidence of good access to multidisciplinary services including physiotherapy, occupational therapy, dietician, speech and language, optician and dentistry available to residents. Nursing notes, maintained on a daily basis were reviewed by the inspector. These were detailed, correlated with the care plans, and clearly outlined the care provided to residents and any changes observed by staff.

Supportive aids were evident including walking frames and residents were individually supported to maintain their independence as their capacity allowed. Residents who could communicate with the inspector stated that they were very satisfied with the healthcare they received and that staff were prompt and attentive to them. Relatives also indicated via questionnaire and interview that they were kept fully informed of the care plans and any changes were quickly communicated to them. There was evidence of residents and or relatives being informed of the care plan details. There was a very low incident of either accidents or pressure area risk despite the significant dependency level of the residents. Weights, food and fluid intake were monitored in accordance with the resident's condition and under the direction of the dieticians.

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

Findings:
The three units which comprise Hospital Four are laid out over two floors: Unit One on the ground floor provides care for 15 male residents; Units Three and Four on the first floor provide care for 32 female residents. There is lift access between floors.
All bedrooms are multi-occupancy with between four and six people sharing. Two of the wards in the female unit are subdivided into two three bedded sections with interconnecting doors. Unit four contains three toilets but units one and three contain only two toilets which is not sufficient for the number of residents accommodated. There is a bathroom and assisted shower room on each ward. The male ward has a small dining room and conservatory which services as the day room. This day room was seen to be used primarily to store specialised chairs not in current use and was not observed to be used by the residents. Both female wards on the first floor share a large sitting room although again this was not used except for organised activities. No visitor rooms are available although a relatives room is available on the ground floor for use by all three wards in the event that relatives need to remain on the premises. The dining space in the units does not accommodate the number of residents. A significant number of residents have or are supported to have, their meals by the beds. There was evidence that staff had attempted to ascertain the wishes of the residents in relation to this although in some instances this was difficult to do as many resident were unable to communicate their preferences. The long term plans for the re-location of hospital four will alleviate this issue.

Despite the age and lay out of the building the provider and staff had sought to make the environment as homely as possible. There was additional seating and ornaments on the corridors. The premises was brightly painted and decorated with age appropriate pictures and ornaments. The wards were spacious and there was room for chairs and furnishings beside beds. There was sufficient room for ease of movement and the use of any specialised equipment necessary. There is an adequately equipped sluice facility on each ward. Staff toilets and storage areas are available. There is a lift and internal stairway to the first floor and each ward has a suitably equipped kitchen area for storage of food which is delivered from a central kitchen. As the provider is in the

process of a significant building programme on the site of St James Hospital access to the garden has been removed and residents now access the garden outside the day hospital which is located in the same building as Hospital Four. Records reviewed by the inspector demonstrated that all equipment for resident use and comfort was serviced annually or more frequently including specialist's beds, chairs call-bells and heating systems. Safe flooring and grab rails were available in suitable areas of the wards. Each ward is entered via a secure swipe to prevent unauthorised entry. Policies and procedures for the control of infection were satisfactory and good practise was observed and articulated by staff. A maintenance log is maintained on each ward and issues appeared to be dealt with in a timely manner.

The environment clearly impacts on the experience of residents, ease of movement and access to the outside. These issues were referenced in the relatives and residents questionnaires returned to the authority. The provider informed the inspector that as part of the capital programme it is expected that Hospital Four will be re-located in its entirety to a suitable facility adjacent to the current location within a twelve month period.

Judgment:
Non Compliant - Moderate

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
There are written operational policies and procedures for the making and management of complaints. This included the function of the designated person who is responsible for overseeing and monitoring the implementation of the complaints procedures in accordance with Regulation 34 (3).The policy included external appeals via the office of the ombudsman and the Health Service Executive (HSE) and encouraged local resolution. The CNMs responsible for each ward undertakes the process of local resolution of complaints and there the sample viewed by the inspector indicated that they were resolved satisfactorily at that point. The details were forwarded to the person in charge who reviewed the outcome. There was evidence that the views of the complainant on the outcome of complaints was elicited. Residents and relatives spoken with indicated that they were aware of how to make a complaint and felt confident in doing so. They were familiar with the ward managers, staff and the person in charge. The inspector was informed that no formal complaints had been made since the previous inspection.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
There was a written operational policy on end of life care. Records reviewed indicated that there was advanced planning with consultation processes between the medical team, families and the resident where this was appropriate. There was documentary evidence of this and it was also reviewed six monthly. Decisions regarding resuscitation were appropriately documented. Where residents were deemed to be at the terminal stage amended care plans were implemented and symptom management including pain relief was prioritised. As all of the wards are shared the option of a single room is not currently available within Hospital four.The provider stated that residents may, if they and their family wish avail of a single room in the main hospital. Staff outlined procedures where they might increase the immediate space in the bays by requesting a resident to temporarily move to another bay with their consent and agreement. This allowed more space and privacy to the dying resident and family members. A relatives room is available on the ground floor which contains reclining chairs should relatives wish to remain in close proximity. Religious affiliations are supported and there are appropriate religious symbols and hospice friendly signage available. Resident can be laid out on the wards if that is their own or the family's wishes.

A multidisciplinary review of the process and care given was held in some instances to identify any matters which could be managed more appropriately. A memorial service is also held 6 monthly to which relatives are invited. Legal requirements following a death were adhered to. There was evidence of good access liaison and support from palliative care services and staff have training in cardio pulmonary resuscitation.

Two of the staff, a nurse and a care assistant have undertaken practice development training in end of life care and it is expected that this will further inform practice in the centre as a whole.

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:
There was evidence that the provider was in substantial compliance with this regulation. Relevant policies and guidelines were in place to support nutritional intake and hydration. There was evidence on records available of the consistent monitoring of residents nutritional status and there were effective systems in place for monitoring resident's nutritional needs. The malnutrition universal screening tool (MUST) was undertaken within twenty four hours of admission and repeated to identify any resident at risk. Dietician and speech and language services were integral and dietary needs were discussed at each three monthly multidisciplinary review. Weights are monitored monthly or weekly for some residents.

The inspector observed that communication tools were utilised to ensure all interventions were transferred to the catering nursing and care assistant staff. The staff were able to provide details of these interventions to the inspector. Where deemed necessary by virtue of illness food and fluid charts were maintained and the information was collated and used to inform care needs. Subcutaneous fluids were also utilised. Resident's had care plans for the management of specific regimes such as enteral feeds, or diabetes and again staff were knowledgeable on the protocols to be used.
Residents, including those on modified foods were offered a choice at all meals and the menu was seen to be varied and regularly reviewed by the dieticians. Meals observed including modified meals, were presented in an appetising manner. There was sufficient staff to ensure residents were supported in an unhurried manner with staff communicating and encouraging them. The inspector observed that fluids were encouraged during the day and at evening time.
As the dining rooms are small in all wards a significant number of residents had their meals by their beds which may have been dictated somewhat by the size of the dining spaces. Snacks and hot and cold drinks including juices and fresh drinking water were readily available throughout the day. Residents and relatives all spoke positively about the food in terms of its nutritional value and the fact that it was very tasty. Although the meals come from a central location there was a kitchen on each ward which was equipped with the necessary heating and refrigeration systems and food safety control measures .Food such as sandwiches,fruit, yoghurt and and rice pudding were available for snacks at different times of the day. Residents were provided with additional supplements as deemed necessary and prescribed by the medical officer.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Residents who could communicate with the inspector were able to articulate their medical and care needs and indicated that they were consulted in regard to their care. Written feedback from relatives also indicated that they were consulted regarding care plans and care needs. It was apparent that there was choice in regard to their daily routines such as getting up or attending activities. However, these choices could be seen to be limited by the premises and ease of access to the day room or garden. Feedback processes in use included the resident's forum and day-to-day conversations with staff. There was evidence that residents were supported with information and encouragement regarding their healthcare in order to maximise their continued health. Newspaper and other media such as television were evident and voting arrangements were made.

The resident's forum meets circa 6 monthly. A review of the minutes indicated that the views of those residents who could attend were elicited and acted upon. Surveys had been undertaken in 2013 and overall the outcome was positive with reference to clothing storage being the main issue raised.

While mealtimes are protected visiting times are flexible outside of this and residents were free to leave with their relatives for visits should they wish to. The main hospital grounds and coffee shop was used for this purpose. The inspector observed that staff were careful in regard to fully drawing curtains and placing do not enter signs on the ward door to indicate that personal care was being carried out.

Communication as observed was respectful and staff were knowledgeable on the residents preferences for food, clothing and manner of being addressed. Staff also demonstrated knowledge of the individual resident's means of expression and were able to interpret the meaning. Residents stated that staff was respectful and that their privacy was maintained.

Despite the excellent clinical care the inspector found from observation, review of records and interviews that the social and psychosocial needs of residents in particular those residents with dementia required a review. At the time of this inspection there was no designated activities coordinator available although a activities committee is in place. A range of events were organised regularly including music twice weekly, slideshows, Sonas ,undertaken by the occupational therapist , and celebratory events such as a

valentines evenings were organised. The wards were decorated for the world cup at the time of the inspection. Staff presence was visible and there was good interaction and communication evident. There was significant time spent by residents sitting beside beds in the wards. A significant number of the residents had dementia and the interaction and stimulation available for these residents was limited.The design and lay out of the premises may also be a contributing factor in this finding.

Judgment:
Non Compliant - Moderate

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 is a policy on the management of residents clothing and possessions. Residents clothing is laundered in a central location and while records including the residents and relatives survey indicated that on occasion there has been problems with clothing not being returned in the past there was no current evidence that this was continuing. Clothing was labelled and each resident's laundry was sent to the laundry in individually labelled storage returned in the same manner.

The storage space is limited on the wards but each resident has a wardrobe and a bedside locker. In some wards shelving had been erected which contained colourful baskets for personal toiletries or other sundries. However, while records of monies held for residents on the wards are recorded their personal possessions are not and the provider agreed to remedy this.

Judgment:
Non Compliant - Minor

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
The inspector reviewed the actual and planned staff roster and from observation was satisfied that there was a sufficient number and suitable skill mix of staff on duty day and night to meet the needs of residents and take account of the size and layout of the premises. There were three nurses and between two and three care assistants one each ward until 16:00hrs each day. This was then reduced to two nurses and two care assistants. The clinical nurse managers are supernumery to that ratio. Overnight there are two nurses and one heath care assistant on each ward. A night manager and site night manger is available overnight and at weekends. The inspector observed that where a residents healthcare or behaviour indicated that additional supervision and staffing was required this was made available on an individual basis. There were sufficient catering and household staff available who were knowledgeable on their respective responsibilities and duties.

A sample audit of four personnel files demonstrated that improvements had been made in recent recruitment procedures and efforts continued to address deficits from historical appointments prior to the implementation of the 2009 regulations. This process is ongoing. All documentation including evidence of registration with professional bodies for staff required was present. There was also Garda Síochána vetting and references available for volunteers. Examination of the training records demonstrated that mandatory training in moving and transporting of residents had taken place and was current for all staff as was fire safety training with 67 staff having undergone this training annually.

Other training of relevance included falls prevention, dysphagia and end of life care. Training in non violent crisis intervention is mandatory every two years. Care assistant staff with the exception of nine had undertaken Further Education and Training Awards Council (FETAC) level five and there is a plan to support the remainder of the staff to complete this training.

However a significant number of residents have cognitive impairment or dementia. The person in charge and one of the clinical nurse managers has undergone formal training in dementia care. The impact of this finding is outlined under Outcome 7 Safeguarding and Safety and in Outcome 16 Rights Dignity and Consultation which indicates that this training should inform practice across the units more thoroughly.

Training in the prevention of infection was also undertaken and relevant staff had undertaken food safety training. The ward managers were responsible for identifying staff training needs as part of professional development planning which was undertaken annually although this was not consistent across the wards. Staff were supervised on a daily basis, responsibilities were clearly defined and accountability was evident. Ward

meetings took place monthly and handover records seen by the inspector indicated that these were comprehensive. The inspector found that staff were aware of the policies and procedures and articulated their various roles competently.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	St James's Hospital Residential Unit, Hospital 4
Centre ID:	OSV-0000473
Date of inspection:	02/07/2014
Date of response:	22/08/2014

Requirements

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

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

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans did not demonstrate that staff had sufficient training and knowledge to consistently respond appropriately to behaviour that is challenging.

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

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

that is challenging.

Please state the actions you have taken or are planning to take:
• Participate in the current review, update and dissemination of the Hospital's Challenging Behaviour: Patient Management Policy (SJH:NA(P)012) & Restraint Policy (SJH:N(P)003)

• Encourage and support the Centre's nursing staff to undertake the Hospital's or externally provided education/ training programmes in Challenging Behaviour Management appropriate to their role and responsibilities

• Include additional information / training on managing challenging behaviour in the Centre's Staff Development Programme

• Provide Nursing staff with additional training and support in developing and updating Resident's care plans so that they apply their information and learning in creating care plans that are person-centred

• Amend Centre's Care Plan audit-tool and process to include evaluation and of care-plan completeness and effectiveness. Use audit findings to identify staff training and/or support needs

Proposed Timescale: 31/03/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Practice in the use of methods of restraint were not sufficiently guided by national policy and adequate training for staff.

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

Please state the actions you have taken or are planning to take:
☐Participate in the current review, update and dissemination of the Hospital's Challenging Behaviour: Patient Management Policy (SJH:NA(P)012) & Restraint Policy (SJH:N(P)003) in order to ensure there is clarity for all staff regarding the following practices:
- The exceptional circumstances where the use of physical restraint is allowed i.e. where there is an immediate risk to a resident or to other residents
- The type of action / restraint that is permissible in the circumstances
- The training provided for staff in the safe deployment of the agreed restraint method

☐Provide staff with access to the information and training appropriate to their roles and responsibility.

Proposed Timescale: 31/03/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some measures to prevent accidents and incidents to residents were not routinely identified including the safety of bed rails and systems to check the censor door alarms.

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

Please state the actions you have taken or are planning to take:
☐Reiterate to nursing staff the requirements for monitoring appropriateness and safety of in-use bed-rails directed in the Centre's existing Bed-Rails Policy (SJH:N (Pt) 30).
☐Update the existing Bed-Rail Monitoring Record and audit tool to include requirement to check appropriateness and safety of in-use bed-rails
☐Use audit findings to further identify staff training and/or support needs
☐Develop & document designated responsibility and the process for daily monitoring of the censor door alarm system

Proposed Timescale: 30/09/2014

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises does not meet the needs oft he residents and the care as set out in the statement of purpose.

Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
☐Ensure the planned new Residential facility is designed, constructed and commissioned to meet the number and needs of the residents and are in accordance

with all legislative, regulatory and best-practice.

Proposed Timescale: 30/06/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an Insufficient numbers of toilets, insufficient dining and day room space and inadequate private space due the number of resident accommodated in the shared wards.

Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
Ensure the planned new Residential facility is designed, constructed and commissioned to meet the number and needs of the residents and are in accordance with all legislative, regulatory and best-practice.

Proposed Timescale: 30/06/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A sufficient number of staff did not have training specific to the needs of residents with dementia or cognitive impairment.

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

Please state the actions you have taken or are planning to take:
☐Encourage and support the Centre’s nursing staff to undertake the Hospital’s or externally provided education/ training programmes in Challenging Behaviour Management appropriate to their role and responsibilities

☐Include additional information / training on managing challenging behaviour in the Centre’s Staff Development

Proposed Timescale: On-going
Proposed Timescale: