## Compliance Monitoring Inspection Report

**Designated Centres under Health Act 2007, as amended**

### Centre Information

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Joseph's Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000176</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Mountsackville, Chapelizod, Dublin 20.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 821 3134</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:clunymg@gmail.com">clunymg@gmail.com</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Sisters of St. Joseph of Cluny</td>
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<tr>
<td>Provider Nominee:</td>
<td>Maeve Guinan</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Sophie Prad</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Nuala Rafferty</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>32</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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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 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 15 January 2014 11:00
To: 15 January 2014 17:30
16 January 2014 09:30
16 January 2014 18:00

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

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<td>Outcome 13: Complaints procedures</td>
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Summary of findings from this inspection
This was an announced inspection and is part of the assessment of the application for renewal of registration by the provider. The inspection took place over two days and as part of the visit, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents and staff members of the centre were also sought.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider, for the purposes of application
to register were found to be satisfactory. The nominated person on behalf of the provider and person in charge demonstrated some knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland throughout the inspection process.

The fitness of the nominated person on behalf of the provider was determined by interview during the previous registration inspection process and through ongoing regulatory work such as inspections. However, as the person in charge is a recent appointee she will be required to undertake the fit person interview as part of the Authority’s process to determine fitness for registration purposes.

A small number of residents' questionnaires were received by the Authority prior to the inspection. The opinions expressed through both the questionnaires and conversations with the inspector on site were broadly satisfactory with services and facilities provided. In particular, residents were very complimentary on the manner in which staff delivered care to them commenting on their good humour and respectful attitude. However, some expressed dissatisfaction with the variety and availability of activities for all residents. Residents spoken with were also very complimentary about the food provided and the staff team.

Overall, evidence was found that residents’ healthcare needs were met. Residents had access to general practitioner (GP) services and to community health services.

The inspector found there were aspects of the service that needed improvement such as activity provision care planning and recruitment processes.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority’s Standards.
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 2009 (as amended) 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:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
A written statement of purpose was available that accurately described the service provided in the centre. On review it was found that the document contained all of the information required by Schedule 1 of the Regulations.

Assurances were given by the provider that the statement of purpose would be kept under review and any changes which would affect the purpose and function of the designated centre would be communicated to the Chief Inspector in writing prior to being implemented.

### Outcome 02: Contract for the Provision of Services

*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:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
On review of a sample number it was found that of those reviewed, each resident had a written contract agreed with the provider, and signed by the provider, resident or their
next of kin or nominated advocate. The contract included details of the services to be provided and the fees to be charged. Details of any additional charges were also included.

### Outcome 03: Suitable Person in Charge

*The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
A full-time nurse was in charge of the designated centre on the day of inspection. The inspector was informed that the appointed person in charge was on an extended period of study leave which had commenced only recently. The provider had informed the Authority as soon as possible further to the leave being granted. The provider confirmed that the recently appointed assistant director of nursing had agreed to take over as person in charge in an interim capacity effective from the start of January 2014. The provider was also endeavouring to maintain a strong clear management structure by appointing an experienced clinical nurse manager to replace the assistant director of nursing post and support the recently appointed person in charge.

The person in charge in place during this inspection had worked as a registered nurse in the centre for up to two years prior to her appointment as assistant director of nursing some months previously. She was found to be aware of her role and responsibilities and was involved in the day-to-day operational management and governance of the centre. She was observed during interactions with staff and residents and was found to have a very good knowledge of residents’ needs and preferences on both a personal and clinical level. Residents responded warmly to her and in conversation said they could bring any issues they may have to her attention.

Both the provider and the person in charge are aware of the requirement for a fit person interview to be conducted as part of the determination of fitness under the Health Act 2007 Registration Regulations 2009.

### Outcome 04: Records and documentation to be kept at a designated centre

*The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

**Theme:**
Leadership, Governance and Management

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The records listed in the Regulations were found to be maintained in a manner so as to ensure confidentiality and ease of retrieval. A copy of the insurance cover in place was provided which meets the requirements of the Regulations.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations.

All records required under Schedule 3 were maintained in the centre and were found to be substantially compliant.

The directory of residents was reviewed and was found to meet the requirements of the Regulations and was up to date with records of admissions, discharges and transfers maintained.

Although not all records were reviewed on this visit it was found that general records as required under Schedule 4 of the Regulations were maintained including key records such as appropriate staff rosters, accident and incidents, nursing and medical records and operational policies and procedures as required by Schedule 5.

A sample of residents general records including the documentation of medical and nursing delivered were reviewed and it was found that, the recording of residents’ health conditions and the treatment given required to be improved to ensure completeness accuracy and adequacy. These findings are discussed in detail under Outcome 11 further in this report.

**Outcome 05: Absence of the person in charge**
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Leadership, Governance and Management
Judgement:
Compliant

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

Findings:
As previously indicated under Outcome 3 The Authority had been notified of the expected absence of the person in charge in a timely manner and there were suitable arrangements made for the absence and these arrangements were notified to the Authority.

Outcome 06: 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.

Theme:
Safe Care and Support

Judgement:
Compliant

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

Findings:
Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to manage incidents of elder abuse. In conversation with some staff members, the inspector found they were competent in their knowledge regarding reporting mechanisms within the centre and what to do in the event of a disclosure about actual, alleged or suspected abuse. Residents spoken to expressed feeling safe and knew to whom they would go if they had any concerns.

The inspector was informed by the provider that the centre does not manage finances on behalf of any resident currently and do not envisage doing so in the future.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe Care and Support

Judgement:
Non Compliant - Moderate
Outstanding requirement(s) from previous inspection:
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Actions required from the previous inspection were found to be addressed. The fire procedure had been revised to reference the responsibility of staff in the event of a fire alarm activation in the adjoining building and the emergency plan was updated to include the resources available for the evacuation of residents overnight if required. Adequate precautions against the risk of fire, including the provision of suitable fire equipment were found. Arrangements were in place for the maintenance of the fire alarm system and equipment within this centre. Staff were knowledgeable in relation to fire evacuation procedures and staff training was provided on an ongoing basis and at induction.

Smoke detectors were located in all bedrooms and general purpose areas. Emergency lighting and fire exit signage was provided throughout the building. The inspector reviewed service records which showed that fire equipment, the fire alarm system, and emergency lighting were regularly serviced. Fire escape routes were unobstructed. Fire alert action notices and building layout plans showing evacuation routes were displayed throughout the centre.

Written confirmation from the provider and a competent person that all the requirements of the statutory fire authority have been complied with was received prior to registration of this centre.

Risk management policies and procedures were in place and reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre were found. Policies and procedures relating to the health and safety of residents were also in place as were health and safety statements which were reviewed as required by the Regulations.

Training for staff in the moving and handling of residents was provided and practices observed were in line with evidence-based practice.

On review of a sample number of accident and incident records it was noted that the recording of incidents were completed in a detailed manner and where required, neurological observations were monitored and recorded. The person in charge reviewed the incident forms and actioned additional preventative measures such as medication reviews or ‘crash’ mats to reduce the risk of recurrence. These risk management processes were noted to be effective and the levels of falls within the centre was found to be quite low.

The entrance to the centre was secure and a visitors’ log was in use to monitor the movement of persons in and out of the building. Inspectors observed this record to be in use. Residents confirmed to inspectors in conversations that they felt safe in their day-to-day life at the centre.
The environment was noted to be clean and clutter free and there were measures in place to control and prevent infection. Staff had received training in infection control and could explain the procedures in place to control infection. A member of the housekeeping staff was able to describe the cleaning systems in place and how it worked in practice. However, in conversations with a number of staff it was found that the understanding and interpretation of their responsibility and processes for the cleaning of blood spillages were not clear or consistent.

A designated cleaning room to store equipment was available in the centre and was located in the basement floor behind the laundry and staff canteen. The inspector was told and viewed the layout of the basement and the availability of sluicing facilities to empty and wash/disinfect mops and mop buckets. Although there were sluice sinks available on each floor of the centre these were not dedicated cleaning rooms and not suitable for use by the household team. It was found that the current system involves the used equipment being brought through either the staff room or the laundry area to access the dedicated cleaning room, this poses a high risk of cross contamination of the environments where either clean laundry is located and/or where food is being prepared or eaten in the staff room. This was brought to the attention of the provider person in charge and household manager prior to the end of inspection who acknowledged that a review of the risk management systems in place were required.

Records were maintained regarding the servicing of fire equipment, the fire alarm system and fire officer’s visits. Checklists were also maintained to ensure fire exits remained clear and fire equipment and alarms were tested. Maintenance of equipment was verified through invoices viewed for equipment such as regular servicing of beds, wheelchairs pressure relieving equipment water heating and call bell system.

**Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Safe Care and Support

**Judgement:**
Compliant

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

**Findings:**
Written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents were in place and were revised following the last inspection to reflect improved guidance on prescribing and administration processes.

Overall, the inspector found evidence of safe medication management practices. Nursing staff were knowledgeable about medication and administration practices. It was found
that each resident’s medication was reviewed regularly by the medical team.

The medication trolley was stored securely in the treatment room. Inspectors observed a staff nurse during a medication round and observed safe practice in line with An Bord Altranais agus Cnáimhseachais na hÉireann guidance to nurses and midwives.

**Outcome 09: 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

**Judgement:**
Compliant

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

**Findings:**
A record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector. Quarterly notifications had been submitted to the Authority as required and within the appropriate timeframe.

**Outcome 10: Reviewing and improving the quality and safety of care**
*The quality of care and experience of the residents are monitored and developed on an ongoing basis.*

**Theme:**
Effective Care and Support

**Judgement:**
Compliant

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

**Findings:**
The quality and safety of some aspects of care was monitored and reviewed on an ongoing basis by the person in charge. A system for reviewing care practices was established, including areas such as falls management and medication management. Audits were carried out on aspects of care such as food and nutrition and continence care and identified key areas for improvement. These were then discussed with the nursing team at regular staff meetings. However, it was noted that the findings of the audits and the improvements identified had not yet been implemented. This was
discussed with the recently appointed person in charge who was aware of the need to implement the findings however, as she has only very recently commenced in the post has not had an opportunity to do so. The Inspector was assured of the person in charges commitment to implement the improvements identified in the audits and therefore an action plan has not been included in this report.

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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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

Judgement:
Non Compliant - Moderate

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

Findings:
Residents had good access to general practitioner (GP) services. A GP visited the centre during the inspection to review residents. Access to specialist and allied health care services was reported as available and in place to meet the diverse care needs of residents such as opticians, dentists and chiropody services. Evidence of the availability of these services were found. However, there was limited evidence of access to other allied health professionals such as occupational therapy, physiotherapy speech and language or dieticians. This was discussed with the provider and acting person in charge who stated that all of these specialists were accessed via the community geriatrician service delivered through Connolly Hospital in Blanchardstown and that residents were regularly and routinely reviewed there. This was confirmed by residents who told the inspector they were going out for appointments and in meeting a member of the congregation who drove the residents and attended the appointments with them as required or requested to ensure safety and timely update of information to the nursing team.

The arrangements to meet residents’ assessed needs were set out in individual care plans and each resident had a care plan completed. Risk assessment tools to evaluate levels of risk for deterioration were also completed. However, care plans and risk assessments were not always linked, did not reference if referral to allied health professionals was required or had occurred and where residents were seen by external specialists or consultants did not include their recommended interventions. Although in general, residents healthcare needs were met, significant areas for improvement were
identified in the documentation of care given and there was a need to develop a system to ensure that care plans reflected the care delivered and were reviewed in response to changes in residents’ health and that care plans, evaluations of those plans and nurses daily notes were appropriately linked to give a clear and accurate picture of residents’ overall health. It was also found that most although not all care plans were generic in nature and were not person centred.

Efforts to focus on more person-centred care elements were noted, but aspects of documentation which in totality provide an overview of the resident’s condition and the care interventions required and delivered to ensure safe, sufficient and high quality care were not linked or sufficiently specific to make an informed determination of the quality of care delivered. For example, care plans in place to manage identified hygiene needs did not include reference to the frequency of showers or baths preferred or required by the resident. Nurses daily care records did not give consideration to changes in residents mental, or psychosocial well being in that they did not indicate variance in mood, participation in activities, interactions with staff visitors or other residents.

Although inspectors found that staff knew residents well and could describe all aspects of the care required by and given to residents, care plans were not specific enough to manage the identified needs. For example, residents assessed as being at risk of weight loss were not reviewed by relevant specialists such as dieticians, care plans for residents experiencing arthritic pain recommended use of exercise but did not specify the type frequency or amount of exercise recommended or whether these had been recommended by a qualified physiotherapist.

Although monitoring of intake was in place for some residents assessed as being at risk of weight loss, records were not sufficiently detailed to determine the actual amount of intake.

Restraints such as bedrails were found to be in use for a number of residents. The documentation referencing the need for restraint did not always identify whether the restraint used was suitable for the resident's needs without restricting the resident unnecessarily. Evidence that residents’ personal care needs were maintained, for example, regular release schedules from the restraint, were not in place. Risk assessments that determined that the intervention was in the best interests of the resident, was the least restrictive solution and was being put in place as previous less restrictive interventions had failed had not been completed.

Activity provision required to be improved for high dependency residents, particularly those who spend long periods of time in bed or those with cognitively impaired who the inspector noted to be sitting in chairs or in bed with little or no stimulation for significant periods of time. Although a weekly activity programme was in place and some activities were observed to take place, these were generally limited to morning and early afternoon. Those activities which did occur such as sonas, bingo and general knowledge quizzes were delivered in the communal areas i.e. front sitting rooms and therefore confined to a small group of residents.

All activities were delivered in a group session such as arts and crafts, aromatherapy or exercises and alternative or individual activities for residents who did not have capacity
to participate in these or were not interested were not available.

Meaningful activities which reflected residents past interests or hobbies were not available and in conversation with the activity coordinator it was acknowledged that there were gaps in the programme for more frail residents.

Feedback from residents' questionnaires was discussed and although the majority of residents and relatives were happy with the activity provision some requested an improvement in the type of activity provided, for example more outings and also more activities in the evening and at weekends.

**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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Major

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

**Findings:**
St Joseph’s Nursing Home is a three-story centre with one basement floor. It overlooks the Liffey Valley and the Phoenix Park. The building is not purpose-built, but was adapted from what was previously accommodation for a boarding school. The design has encompassed the use of lifts and ramps to promote mobility and access to all areas. This adjoins a convent and also the Mount Sackville school.

Residents live on the ground, first and second floors. The basement floor is used for laundry, storage and staff facilities. The high dependency unit known as Sacred Heart is on the ground floor and consists of seven single rooms, five of which have en suite shower and toilet facilities, with a large assisted bathroom and a nurse’s station and reception area. A secure reception area is attended during the day and the receptionist controls access to the centre. Shalom is a shared room for dependent residents with dementia on the second floor. Shalom ward has its own assisted shower room, sluice, and kitchenette. The remainder of the residents live in single rooms on the first, second and third floors. There are two lifts servicing all floors.

The ground floor has two communal day spaces, one of which acts as a day dining area for residents who require assistance at meal times. This area has a small kitchenette attached. A further day room is located near the Sacred Heart unit.
The main kitchen is located on the ground floor adjacent to a large dining room. The reception, parlour/visitors’ room, administration offices and large chapel are also located on the ground floor. There are three assisted shower rooms and two sluice rooms. There are additional toilets, three of which are wheelchair accessible.

Car parking is available at the centre, with controlled access and an easily accessible landscaped garden. Residents from Sacred Heart have easy access to the garden from the ground floor with seating areas provided.

The premises were found to be clean well maintained and clutter free fire doors were not obstructed and could be accessed freely in the event of an emergency. The design, layout and decor of the centre provided a tranquil environment for residents with appropriate furnishings and areas of diversion and interest. A spacious and well stocked library including three computers with access to email and wifi was available for residents use.

There was a cleaning schedule in place and staff undertaking cleaning duties were observed to be thorough in their approach to cleaning residents’ rooms and communal areas.

There was appropriate equipment for use by residents and staff which was in good working order. The service records were up to date and equipment was noted to be well maintained and clean.

As stated above the centre adjoins a convent and secondary school. Access to the school is controlled via a door linked to a coded intruder alarm system. However, access to the convent is not controlled and a linked door was noted to be unlocked and allowed free access to anyone passing through either the centre or the convent.

Although the premises were found to be well maintained and in general meets the needs of residents some improvements were found to be required to ensure it fully meets the requirements of the Regulations and the Authority’s Standards.

Improvements required to aspects of the environment are outlined below.

The multi-occupancy bedroom called Shalom Unit consists of a seven bedded unit which does not meet the needs of residents in terms of privacy and dignity, with limited space between beds. There is inadequate space for free movement around all of the beds and space is limited to store personal possessions, furnishings and assistive equipment. The profile of residents currently in this unit are at the high to maximum level of dependency. However, in discussions with the provider the inspector was told that there are no plans to deliver high support nursing care as part of the centre's purpose and function and plans are currently being devised to renovate the room to meet the Regulations and the Authority's Standards by June 2015.

Aspects of the communal areas within the centre were adapted to improve accessibility for residents with limited mobility and included ramping on corridors. However, the inspector noted that some of these ramps posed a difficulty for staff and residents, particularly for wheelchair users, in particular ramps located on the corridor at the office...
of the person in charge and he ramp going to St Martha's day room. The gradient of the ramps appeared quite steep and staff were noted to struggle when pushing residents in transit wheelchairs up the ramps.

The shower on the second floor did not have a lock to maintain residents privacy and dignity and although the shower area was accessible via a ramp the cubicle toilets were not easily accessible for residents with limited mobility with steps leading down to them. The cubicle toilets were not wheelchair accessible.

Signage in relation to the function and purpose of each room in the centre requires to be reviewed in terms of its appropriateness and should reflect the availability of communal rooms, bathrooms or toilets to all residents. Clear signage indicating private or non accessible areas in particular where doors lead into aspects of the building that are not part of the registered centre is required.

As previously stated above, review of access to buildings adjoining the centre requires review to maintain residents' safety and review of the location and/or access to the dedicated cleaning store behind the laundry to mitigate the risk of cross contamination when returning used/soiled cleaning equipment full details under Outcome 7 in this report.

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

Judgement:
Non Compliant - Minor

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

Findings:
There was a written operational policy and procedure relating to the making, handling and investigation of written complaints. The procedure identified the nominated person to investigate a complaint and the appeals process. There is also a nominated person who holds a monitoring role to ensure that all complaints are appropriately responded to, and records are kept. The inspector examined the complaints record and this showed that both verbal written complaints were promptly investigated, detailed the outcome for the complainant and indicated discussions to ascertain the satisfaction or otherwise of the complainant.

In conversation with a number of residents all identified the nominated person on behalf of the provider as the person they would go to if they had a complaint. Some also said they would tell the person in charge if it was a health related issue. Similarly most of the
staff spoken to also identified the nominated person on behalf of the provider as the person to whom complaints were made. Although all staff were aware of the complaints policy not all were clear on the process as set out in the policy. It was also noted that the policy was not displayed in a prominent position as required by the Regulations.

**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

**Judgement:**
Compliant

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

**Findings:**
There were no residents receiving end-of-life care at the time of this inspection. However, there was evidence that arrangements were in place to meet the needs of residents at the end of life and respect their dignity and autonomy as far as practicable. It was noted that residents' family and friends could be facilitated and religious and cultural preferences respected. There is access to specialist palliative care services, if appropriate.

**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 discreet and sensitive manner.*

**Theme:**
Person-centred care and support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Residents were provided with food and drink at times and in quantities adequate for their needs. Food was properly served and was hot and well presented. The inspector observed that assistance was offered to residents in a discreet and sensitive manner.
Menus showed a variety of choices for starters and main courses and there was a large selection of dessert choices on offer. The three week rolling menu in place provided a variety of meals to residents. However, the nutritional status of the menu in place to ensure it was wholesome nutritious and met residents' individual nutritional needs could not be determined. The menu had not been reviewed by a dietician to assess its nutritional status.

Drinks such as juices, milk, tea and coffee were available and staff were attentive to the needs of all residents. Meals were served in a pleasant and helpful manner. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate.

All residents were effusive in their praise for the excellence of the food provided to them by the catering team. They welcomed and were very appreciative of the high level of efforts the team make on a daily basis to provide them with tasty, well cooked and presented food. They were also keen to commend all staff on their efforts to facilitate changes to residents' choice and meet personal preferences and taste. However, improvements were found to be required. A robust communication process such as a daily diet sheet to ensure catering staff were aware of the changing dietary needs of all residents was not in place. Although staff were familiar with residents' usual choices, clarity on the specific types of specialised diets required by residents such as, high calorie or fortified diets was not available, although the head chef was familiar with residents who were identified as requiring improved nutrition and stated that they were receiving fortified diets.

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.

Theme:
Person-centred care and support

Judgement:
Compliant

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

Findings:
There was evidence that a residents' consultation process was in place and they could receive visitors in private. Staff were observed to respect residents' privacy and dignity through ensuring the appropriate use of screening in communal bedrooms and closing doors when providing assistance with personal care.

The inspector observed that residents were addressed by staff in an appropriate and
respectful way and that there were mutually warm interactions between residents and staff.

It was noted that residents' choice and independence was promoted and enabled and this was confirmed in conversations with residents.

**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

**Judgement:**
Non Compliant - Minor

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

**Findings:**
The inspector saw that there was adequate space provided for residents’ personal possessions and clothing was noted to be neatly and appropriately stored. Residents had a locked facility in their bedrooms. There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents. In a sample of those reviewed a record of residents’ personal possessions was not in place or had not been updated.

**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.

**Theme:**
Workforce

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The inspector found that at the time of this inspection, the levels and skill mix of staff were sufficient to meet the needs of residents. Inspectors checked the staff rota and found that it was maintained with all staff that work in the centre rostered and identified. Annual leave and other planned/unplanned staff absences were covered from within the existing staffing complement. Staffing deployment strategies involved teams of staff on each floor consisting of nurses, and care staff allocated to a specific number of residents on a daily basis.

The inspector observed staff and residents' interactions and found that staff were respectful, patient and attentive to residents' needs. It was noted that staff provided reassurance to residents by delivering care to them in a quiet confident manner. In conversation with residents, inspectors were told they felt safe in the centre staff were respectful of their choices and very good to them.

Training for all staff in areas of practice which require mandatory training such as fire safety, moving and handling and prevention of elder abuse were found to be delivered, further training was noted to be provided in areas of clinical practice such as medication management, infection prevention and control continence promotion and first aid. A training plan for 2014 was also in place.

A sample of staff files were reviewed to determine whether the requirements of Schedule 2 have been met. It was found that although most of the requirements were met, aspects of documentation such as three references, qualifications and evidence of medical/physical fitness were not available on all records reviewed.

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

**Report Compiled by:**

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

Centre name: St. Joseph's Nursing Home
Centre ID: ORG-0000176
Date of inspection: 15/01/2014
Date of response: 12/02/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 04: Records and documentation to be kept at a designated centre

Theme: Leadership, Governance and Management

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

On review of the documentation of medical and nursing care delivered it was found that the recording of residents health condition and the treatment given required to be improved to ensure completeness accuracy and adequacy.

Nurses’ daily progress records and evaluations were not detailed, linked to the care plans or give an accurate reflection of the residents overall health condition.

Action Required:
Under Regulation 25 (1) (b) you are required to: Complete, and maintain in a safe and accessible place, an adequate nursing record of each residents health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The PIC and the CNM attended a study day on Care Planning and its implementation. They met formally with the Nurses to share HIQA Inspection comments on the Daily Reports as well as the outcome of the training day. It was decided to change the way the daily progress records are done, to make them more personalised, ensuring they reflect the overall health condition and daily routine of each Resident. The PIC and CNM are also monitoring the Reports to ensure the new reporting methodology continues to evaluate and reflect accurately each residents’ overall condition.

Proposed Timescale: 30/04/2014

Outcome 07: 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 systems in place to manage and prevent risks of cross contamination were not sufficiently robust in that the systems in place to transport used cleaning equipment from all areas in the centre to the dedicated cleaning room for decontamination involves bringing the used equipment through the laundry or the staff canteen and poses a high risk of cross infection.

Staff understanding and knowledge of the processes in place and equipment available to manage potential blood spillages were inconsistent and unclear leading to risk of inappropriate management which poses a risk to both residents and staff.

Action Required:
Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
A Policy for dealing with Spillages is in place but the PIC and the CNM have reviewed and updated the policy as required. A Cleaning Manual is being devised to accompany the Policy. This is a joint project of the Care and Cleaning Staff- strengthening the implementation of the policy it in a safe and effective way. It will also ensure that all grades of staff are fully cogniscant of the management of all manner of spillages.

Another room has been renovated as a Staff Canteen and should be ready for use on 19th February 2014.
This ensures a dedicated passage to the designated cleaning room

Proposed Timescale: 31/03/2014
Outcome 11: Health and Social Care Needs

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Activity provision required to be improved for high dependency residents, particularly those who spend long periods of time in bed or those with cognitively impaired who were noted to be sitting in chairs or in bed with little or no stimulation for significant periods of time.

Meaningful activities which reflected residents past interests or hobbies were not available.

Action Required:
Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Please state the actions you have taken or are planning to take:
The Activity Programme has been reassessed and reviewed by the PIC and the Activity Coordinator with input from Residents, Nurses and Care assistants. The Activity Coordinator’s roster has been changed in order to facilitate continuity of the Programme throughout the day.
An updated schedule of activities is in the planning stage. The Activity Coordinator and PIC will meet the Residents every month to review the Activities with them and involve them in the choice and organisation of Activities. The outcome of these meetings will inform the programme. The Activity Coordinator will work closely with Staff Nurses and Care assistants a programme that is varied and attractive. Individual sessions are also planned.
Documentation has been reviewed to record the activities that Residents attend and their level of participation so that the most successful and interesting can be included in each ones Care Plan.
The PIC and Activity Coordinator will meet formally on a monthly basis to evaluate the work done and plan the outings and Celebrations.

Proposed Timescale: 30/06/2014

Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents care plans did not reflect practice, adequately guide care, were not linked or sufficiently specific to make an informed determination of the quality of care delivered and were not person centred.

Action Required:
Under Regulation 6 (3) (b) you are required to: Provide a high standard of evidence based nursing practice.
Please state the actions you have taken or are planning to take:
The PIC and the CNM attended a course about “Care Planning in the Residential Care Setting” They plan to share what they learned with the Nurses at a formal meeting so that it can inform practice in the Nursing Home.
We are in the process of implementing the Minimum Data Set as an instrument to ensure that the care Plans reflect practice, adequately guided care, are sufficiently specific to the individual Residents and thus person-centred.
Residents Charts will be reviewed at each monthly Nurses Meeting to share information about each Resident and ensure a more personalised Care Plan.
Residents’ charts will be audited to make sure this is actioned correctly. The results of such audits will be shared with the Staff Nurses to promote continued improvement and an even greater compliance with HIQA Standards.

**Proposed Timescale:** 30/09/2014

**Theme:** Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Systems in place to ensure residents are facilitated to receive all appropriate health care as required in order to achieve and enjoy the best possible health required review as evidenced by:
- use of restraint that did not evidence whether the restraint used was suitable for the residents needs without restricting the resident unnecessarily
- regular release schedules were not in place
- limited evidence of access to other allied health professionals such as occupational therapy, physiotherapy speech and language or dieticians.

**Action Required:**
Under Regulation 9 (1) you are required to: Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

**Please state the actions you have taken or are planning to take:**
The Restraint Policy is being reviewed and a “Use of Physical Restraint in Residential Care Unit” course is planned for the 4th of March this year for all Care Staff.
Documentation will also be reviewed during this course and will be amended to cover the use of the Release Form. The use of Restraints has already been reviewed and the two Residents who used bedrails have had their beds changed to “low-low” beds and this has proved a very successful alternative to bedrails.

The residents are frequently referred to the local hospital and benefit from the great array of services available there. Feedback to Nursing Home and GP can be a challenge as residents are not able of themselves to give a comprehensive report.
A meeting has been arranged between PIC, the CNM and the Manager responsible for the “Care of the Elderly” unit at the hospital to address these issues. All Residents’ Appointments whether in or out with the Home are recorded in the Residents’ Directory.
The Nursing Home now has access to a Consultant Dietician, a Consultant Speech and Language Therapist and an Occupational Therapist who are available when needed and in fact the process has begun already. All appointments and sessions are recorded in the Residents’ files

**Proposed Timescale:** 30/03/2014

**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 design and layout of the centre was not entirely suitable for the stated purpose and function. Inspectors found that there were a number of aspects of the premises which did not comply with the Regulations and the Authority's Standards. These aspects are outlined in the body of this report and a management plan is required to address these deficiencies by July 2015.

**Action Required:**
Under Regulation 19 (1) you are required to: Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.

**Please state the actions you have taken or are planning to take:**
Consultants are at present devising plans to turn multi-occupancy room ‘Shalom’ into single and twin bedded rooms that will comply the Regulations and the Authority Standards

**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:**
Some improvements were found to be required to ensure it fully meets the requirements of the Regulations and the Authority's Standards. Specifically in relation to multi-occupancy rooms, maintaining residents safety in relation to accessibility of the centre from adjoining buildings; safe accessibility to all toilet and bathroom/shower areas; appropriate gradient on ramps; review of location and/or access to the dedicated cleaning store to mitigate the risk of cross contamination.

**Action Required:**
Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.
Please state the actions you have taken or are planning to take:
• The door in question accessing the convent has now been locked and appropriate signage used.
• Toilets and washrooms adjacent to the Assisted Shower on Level 2 have now been physically separated and appropriately signed
• The contractor plans to commence working on the Ramps on March 10th to ensure appropriate gradients.
• The Occupational Therapist is to instruct the staff on the safe managing of wheelchairs.

Proposed Timescale: 30/03/2014

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 complaints policy was not displayed in a prominent position as required by the Regulations.

Action Required:
Under Regulation 39 (4) you are required to: Display the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
All complaints and comments policies have been updated and placed on each Floor in a prominent place.

Proposed Timescale: 12/02/2014
Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All residents or staff were not fully aware of the complaints process as laid down in the policy specific to the centre.

Action Required:
Under Regulation 39 (3) you are required to: Make each resident aware of the complaints procedure as soon as is practicable after admission.

Please state the actions you have taken or are planning to take:
All complaints and comments policies have been updated and placed on each Floor in a prominent place. Each Residents Meeting will be used as a means to ensure the residents are fully aware of the Complaints process.
**Proposed Timescale: 12/02/2014**

### Outcome 15: Food and Nutrition

**Theme:** Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The nutritional status of the menu in place to ensure it was wholesome nutritious and met residents individual nutritional needs could not be determined. The menu had not been reviewed by a dietician to assess its nutritional status.

**Action Required:**

Under Regulation 20 (2) part 1 you are required to: Provide each resident with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each residents individual needs.

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

The Nursing Home has now a Consultant Dietician and a programme to address nutrition issues; Her schedule for the year is:

- **March:** review Menus, liaise with Chef Manager an Care Staff
- assess Residents’ needs on an ongoing basis
- give workshop to the Residents on “Healthy Eating”.

- **Summer:** Workshop for Staff on “Nutritional needs of Older Persons”.
- The Chef and the Director of Nursing Menu review on a three weekly basis to ensure the Residents nutritional and dietary needs are met and choices are available for all courses.

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**Proposed Timescale: 31/07/2014**

**Theme:** Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

A robust communication process such as a daily diet sheet to ensure catering staff were aware of the changing dietary needs of all residents was not in place.

**Action Required:**

Under Regulation 20 (3) you are required to: Facilitate any dietary restriction on medical or religious grounds.

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

Each Resident is now audited for a week, their exact diet recorded and reviewed. This is kept in a file in the Kitchen and gives an overview of their eating habits and
preferences. Any Resident on dietary restrictions due to religious or medical grounds is facilitated by the Chef.
Residents requiring a special diet will have their diet reviewed regularly by the Dietician. The names of these Residents are listed both in the Nurses’ Station and Chef’s office. Any subsequent changes are submitted in writing immediately to the Director of Nursing and Chef and the lists are amended accordingly. Residents who are on Food and Fluid Charts have their food weighted before their meal and uneaten food remaining is weighed also. In this way the exact amount of food/ fluid taken is recorded accurately.

**Proposed Timescale:** 31/03/2014

### Outcome 17: Residents clothing and personal property and possessions

**Theme:** Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A record of residents personal possessions was not in place or had not been updated for all residents.

**Action Required:**
Under Regulation 7 (2) you are required to: Maintain an up to date record of each residents personal property that is signed by the resident.

**Please state the actions you have taken or are planning to take:**
The policy about Personal Belonging has been reviewed. Each Resident now has his/her personal belonging reviewed and recorded. They have been asked to inform Staff when they receive new belongings so that these can be added to their inventory. Each Resident has been asked to sign their Property list.

**Proposed Timescale:** 21/02/2014

### Outcome 18: Suitable Staffing

**Theme:** Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All of the requirements of Schedule 2 were not available such as three references, qualifications and evidence of medical/physical fitness on all records reviewed.

**Action Required:**
Under Regulation 18 (2) (a) and (b) you are required to: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.
Please state the actions you have taken or are planning to take:
All Staff are in the process of supplying 3 references; details of their qualifications and evidence of medical and physical fitness.

**Proposed Timescale:** 31/03/2014