<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Joseph's Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000175</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Lurgan Glebe, Virginia, Cavan.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>049 854 7012</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:stjohnsstjosephs@eircom.net">stjohnsstjosephs@eircom.net</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Masonic Havens Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Richard Graves</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Stephaine Dawn McLean</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>PJ Wynne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Marie Matthews</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>49</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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</table>
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.
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 1 day(s).

The inspection took place over the following dates and times
From: 24 February 2014 09:30
To: 24 February 2014 18:15

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<tr>
<td>Outcome 02: Contract for the Provision of Services</td>
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<tr>
<td>Outcome 03: Suitable Person in Charge</td>
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<td>Outcome 04: Records and documentation to be kept at a designated centre</td>
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<tr>
<td>Outcome 05: Absence of the person in charge</td>
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<td>Outcome 06: Safeguarding and Safety</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Medication Management</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10: Reviewing and improving the quality and safety of care</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<td>Outcome 16: Residents Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents clothing and personal property and possessions</td>
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<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection
This report set out the findings of an announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (the Authority) Regulation Directorate, to renew registration of the designated centre.

The inspectors met with the provider, person in charge and members of the management team who all displayed a good knowledge of the Authority’s Standards and regulatory requirements and were found to be committed to providing quality person-centred care to the residents. They were proactive in response to the actions required from the previous inspection and the inspectors viewed a number of improvements from the last inspection which are discussed throughout the report.
A number of questionnaires from residents and relatives were received prior to the inspection and the inspectors spoke to residents during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

The inspectors were satisfied that the residents were well cared for and that their nursing and care needs were being met. Residents had good access to general practitioners (GP). The person in charge was fully involved in the management of the centre and was found to be easily accessible to residents, relatives and staff. There was evidence of individual residents’ needs being met and the staff supported residents to maintain their independence where possible. There was a wide variety of social and recreational activities led by a full time activities coordinator. The inspectors found the premises, fittings and equipment were very clean and well maintained.

Some improvements were identified to further enhance the service provided. The required improvements include a review of aspects of restraint practice in the use of bed rails to further promote a restraint free environment. The involvement of residents or their next of kin in agreeing and reviewing care plans was not personalised to each resident’s plan of care to reflect the individual care being delivered. The quality assurance program required further expansion to review additional areas which impact on resident’s well being. Structural work is required in one bedroom occupied by three residents to ensure their comfort and encourage and aid their independence.

**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.**

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**Theme:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
The inspector was satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided.
The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider.

**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:**
The inspector found that each resident had an agreed written contract which included details of the services to be provided for that resident and the fees to be charged in the sample examined. Contracts of care were agreed within the time frame required by the regulations.

The contracts of care viewed included the terms and conditions and an undertaking to pay an extra charge in respect of any additional service not included in the overall fee. These services were outlined in the contracts of care and included for example, hair dressing and chiropody and transport costs.

**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:**
The person in charge has not changed since the last inspection. She is a registered nurse and holds a full-time post. She was well known by residents. She had good
knowledge of residents care needs and could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

She maintained her professional development and attended mandatory training required by the regulations in fire evacuation, safe moving and handling of residents and adult protection. She had attended courses in nutrition in the elderly and dementia care. The person in charge confirmed she assists in the delivery of clinical care at intervals to ensure she is appraised of each resident’s care needs.

There was an organisational structure in place to support the person in charge. The provider attends the centre routinely. There is an assistant director nominated to deputise in the absence of the person in charge and a clinical nurse manager appointed to support the nursing team. The arrangements and reporting systems were known to staff and were described in the statement of purpose.

**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:**
Compliant

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

**Findings:**
The inspector found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

The inspector found that medical records and other records, relating to residents and staff, were maintained in a secure manner. Appropriate insurance cover was in place with regard to accidents and incidents, outsourced providers and residents’ personal property.

The directory of residents contained all the information required by schedule three of
the regulations and was maintained up to date.

**Outcome 05: 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:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
The person in charge was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge. This had not been necessary to date.

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**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:**
Non Compliant - Minor

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

**Findings:**
The inspector was provided with a copy of the centre’s policy on prevention, detection and response to elder abuse which was revised since the last inspection. The policy was specific to the centre and defined the various types and signs of abuse and the reporting arrangements. However, the policy did not outline an overall person with responsibility to investigate any allegation of abuse as it stated, 'refer to the unit manager or the staff nurse on duty'. Details of how to protect a vulnerable resident while the matter was being investigated were not outlined and the policy did not consider other possible abuse scenarios such as:

- resident to resident,
- a relative, visitor or other such person
- a potential allegation against a member of management

Protected disclosure/whistle blowing procedures to guide staff in their reporting of a suspicion of abuse were not documented.

Residents spoken with and questionnaires completed by residents stated that they felt safe in the centre. There was a visitors log in place and entrance and exit doors were monitored by CCTV. No incidents, allegations or suspicions of abuse have been recorded or notified to the Authority in the preceding 12 months at this centre.

Staff were educated in adult protection and an ongoing program of refresher training was in place. Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse.

The financial controls in place to ensure the safeguarding of residents’ finances were examined by the inspector. A petty cash system was in place to manage small amounts of personal money for residents. Each resident’s petty cash was held in a separate envelope and secured in a locked safe. A record of the handling of money was maintained for each transaction. Two signatures were recorded in all instances and receipts were issued to residents.

### 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 - Minor

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

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

**Findings:**

The inspector was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. The actions in the previous inspection which related to the risk management policy had been completed. The policy contained procedures to guide staff in the event of a resident going missing, assault, accidental injury to residents or staff, aggression and violence, and self-harm.

A maintenance log was maintained to report any faults noted on a day-to-day basis such as call-bells, lighting or problems with residents furniture and were promptly attended to by a maintenance person employed. The centre was inspected by an authorised officer from the health and safety authority in June 2013. The outcome of the visit report indicated satisfactory compliance with relevant health and safety legal requirements.
The Authority was provided with written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for dependent older people in advance of this inspection.

The person in charge had sufficiently prioritised the safety of residents in the event of fire. The inspector read the records which showed that daily inspections of fire exits were undertaken. The fire alarm was sounded weekly and automatic door closers were checked to ensure they were operational. The fire extinguishers were checked to ensure equipment was in place and intact. The inspector viewed contracts which indicated the fire alarms; smoke and heat detectors were checked and serviced routinely and fire extinguisher serviced annually. Evacuation sheets were fitted to the beds of all residents and the escape route plans were provided on the back of all doors to indicate the direction to the nearest fire exit. Fire training for staff was completed annually by an accredited trainer. Records indicated staff participated in fire drill practices routinely to reinforce their theoretical knowledge from annual fire training. Staff interviewed could explain to inspectors, how they would evacuate residents safely in the event of a fire.

Access to stairways, sluice and cleaning rooms were secured in the interest of safety to residents and visitors. Infection control practices in relation to hand hygiene were robust. Hand sanitising dispensing units were located at the front entrance and throughout the building. Staff were observed to be vigilant with hand hygiene and had been trained on best practice in this regard.

A risk assessment was completed for residents who smoke to ensure they were safe to smoke independently or outline the level of assistance and supervision these residents might require in a plan of care. This was an area identified for improvement on the last inspection.

The training records showed that staff had up-to-date training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents needs. Each residents' moving and handling needs were identified and available to staff at the point of care delivery in bedrooms, outlining whether a resident required the assistance of a hoist or one or two staff members. A validated moving and handling risk assessment tool was sourced to determine each resident's moving and handling needs in an evidenced based manner since the last inspection. However, the risk assessment tool was not completed for each resident and in completed cases where a resident requires a hoist, the type of hoist was not specified. Details of the sling type and size were not outlined in assessments.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. In the sample of accident report forms reviewed vital signs for all residents were checked and recorded consistently. New records sheets were provided to neurological observations where a resident sustained an unwitnessed fall or a head injury. While these records were maintained they were not completed in line with best practice for a defined period of time at regular intervals post fall.
**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:**
There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets were revised since the last inspection and were now coloured coded and distinguished separately between PRN (as needed), regular and short term medication. The maximum amount for PRN medication was indicated on all prescription sheets viewed by the inspector. The prescription sheets were also revised to specify the time the prescribed medication was to be administered.

Medication was not being crushed for any residents prior to administration due to swallowing difficulty by the residents at the time of this visit. Improved links were evident with the pharmacy and where possible a liquid or dispersible form of the medication was obtained. There was space to record when medication was discontinued and these were signed on the sample reviewed.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medicines were being stored safely and securely in the clinic room which was secured with a coded keypad. The temperature ranges of the medicine refrigerator was being appropriately monitored and recorded. A separate fridge was available to store specimens.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked at the change
of each shift and signed by two nurses. The inspector checked a selection of the balances and found them to be correct.

**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:**
The inspector reviewed a record of incidents/accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required. On this visit the inspectors identified one resident with a wound which was not reported to the Authority as required by the regulations. This notification was submitted on the day of inspection.

**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:**
Non Compliant - Minor

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

**Findings:**
There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge.

The person in charge continued to review the quality and safety of care and quality of life of residents living in the centre. A system of audits for 2014 was planned. Clinical data was collected and reviewed by the person in charge with the staff on a regular basis. This included clinical information on falls management, accidents/incidents and medication management, the number of residents on night sedation or psychotropic
medication

The inspectors found that this information was used to improve the safety of care in relation to the management of falls. The number and times of falls were identified. Residents who had repeat falls were identified and individual strategies implemented to minimise the risk of repeat occurrence. Two residents were provided with sensor alarms and another had a medication review to determine underlying factors.

However, improvement plans to ensure enhanced outcomes for residents were not developed in a similar manner for other areas audited. The type of information collected for example, in medication management and the procedure to review the clinical data collected required further development to assist in identifying observation of trends to lead to enhanced outcomes for residents.

The quality assurance program required further expansion to review additional areas which impact on residents’ well being. While practice in relation to physical restraint management had significantly improved since the last inspection there remains a high percentage of bed rails in use by residents as discussed under outcome eleven.

While the findings from audits and quality improvement strategies were discussed by the management team with nursing staff the audit findings were not collated into reports with copies made available to the resident or their representative for their information as required by the Regulations.

**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 - Minor

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

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

**Findings:**

The arrangements to meet residents’ assessed needs were set out in individual care plans. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. There was a record of each resident’s health
condition and treatment given completed daily. Care staff documented their interventions and these were discussed and signed by the nurse at the change of each shift.

Recognised assessment tools were used to evaluate residents’ progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, tissue viability and cognitive functioning.

The inspector reviewed four resident’s care plans in detail and certain aspects within other plans of care. The inspector found that all files reviewed were comprehensive. In the sample of care plans reviewed there was evidence care plans were updated at the required three monthly intervals or in a timely manner in response to a change in a resident’s health condition. Risk assessments were regularly revised. Staff demonstrated good knowledge and understanding of each resident’s background in conversation with the inspectors. While care plans were bring reviewed they were mainly rewritten and frequently an evaluation was not documented to highlight changes or a professional judgement to its effectiveness in many cases. An overall conclusion or professional judgement of the care pathway being followed was not indicated in the evaluation column of care plan documentation at three monthly intervals or more frequently if there is a change in residents' care needs.

There was evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan when reviewed or updated. However, this was a standard form outlining the same information for each resident and was not personalised to each resident’s plan of care to reflect the individual care being delivered. This was identified as an area for improvement on the last visit and while the form was revised it remains general in nature and repeats the same information for all residents.

On the last visit the inspector identified in one case file a resident had a history of seizures. At the time there was no plan of care in place to guide and inform staff of the procedures to follow for this problem. This file was reviewed and a detail plan of care was in place.

Residents had access to GP services and there was evidence of medical reviews at least three monthly and more frequently when required. A review of residents’ medical notes showed that GP’s visited the centre regularly. The GP’s reviewed and re-issued each resident’s prescriptions every three months. This was evidenced on reviewing medical files and drug cards. There was evidence of referral to allied services such as speech and language and occupational therapy.

There were two residents with wounds on the day of inspection. There was a wound care plan in place reviewed by the inspector. Advice in relation to the type and frequency of dressing was being adhered to by nursing staff. Documentation reviewed indicated improvement. Access to a wound specialist was available.

Where residents had specialist care needs such as mental health problems there was evidence in care plans of good links with community mental health services. The consultant psychiatrist and their team visit the centre as required to review residents. Medication is reviewed to ensure optimum therapeutic values.
The policy on restraint was based on the national policy on promoting a restraint free environment. Aspects of physical restraint management, in the use of bed rails have improved since the last inspection. A restraint register is now maintained to record the times the restraint measure is applied and released. Signed consent was obtained by the resident or their representative and the GP was involved in the decision process. The risk assessment documentation was revised and now takes account of a more detailed range of issues to include risks from challenging behaviour or intermittent confusion. However, further progress is required in achieving a restraint free environment.

Approximately 50% of the residents have two bed rails in place. There was limited evidence of exploring alternative options prior to using a restraint measure in the documentation reviewed such as ultra low beds, perimeter mattresses or additional Mattress by the bed or increased safety checks.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by the activities coordinator, employed seven days each week. The inspector spoke with the activity coordinator who outlined the range of physical and sensory activities provided. Residents’ likes were ascertained and an activity plan was developed to meet their individual needs. Records were maintained of each resident’s participation during the week. Activities forming part of the weekly program included seat based exercises, quizzes; storytelling, newspaper review, hand massage and pet therapy to ensure meaningful engagement for residents. The activity schedule provided for both cognitive and physical stimulation. There was a live music session each week.

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

**Findings:**
The building is adapted to meet the needs of dependent older people. Communal rooms were home-like by way of décor and furnishings. There is a large sitting room where the majority of residents sit together or residents can chose to sit in a number of smaller quieter sitting rooms.

The environment was clean and satisfactorily maintained throughout both internally and
externally. The inspector noted the building was comfortably warm. Hand testing indicated the temperature of radiators and dispensing hot water did not pose a risk of burns or scalds.

There were a sufficient number of toilets, baths and showers provided for use by residents. Toilets were located close to day rooms for residents’ convenience. Each resident had sufficient space to store their clothing and personal belongings in single and twin bedrooms.

Staff facilitates were provided with space for the storage of personal belongings. Separate toilets and showering facilities were provided for care and kitchen staff in the interest of infection control. A separate cleaning room, sluice areas and laundry were available.

On the last inspection it was identified the location of cameras in the dining room and day sitting rooms compromised the privacy of residents to undertake activities in private within a communal space. These cameras were removed and CCTV only focused on exit doors and corridors in the interest of resident safety and security of the building.

There is one ensuite bedroom with toilet, shower and wash hand basin accommodating three residents. This bedroom was examined by inspectors. The layout and configuration of beds did not ensure residents safety and comfort and did not encourage and aid their independence. Each resident did not have a wardrobe to store their own clothing. There was not adequate space in the bedroom to provide a chair by each bed to facilitate residents sit by their bed during the day if they wished. There was inadequate space around each bed to facilitate the safe use of a hoist without encroaching on other residents’ personal space and privacy. The television was not visible to all three residents. The provider had scaled drawings of proposed structural works he intended to implement to provide suitable accommodation for residents in accordance with the premises and physical environment regulatory notice and the National Quality Standards for Residential Care settings for Older People in Ireland.

A patio garden space was available to residents provided with seating. However, the gateway was not secured at the time of inspection. While there was a metal barrier located adjacently this was not suitable as a permanent measure to secure the gateway. The patio area had a pleasant aspect overlooking the lake. However, it was not capable of being adequately secured to minimise the risk of mobile residents with dementia leaving the area unescorted. This was discussed with the person in charge who explained an alternative area was identified for development to ensure a safe enclosed space with unrestricted access for residents.

**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:
Compliant

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

Findings:
The inspector was satisfied that complaints were listened to and there was a policy and procedure in place to ensure complaints were monitored and could be appealed if necessary. There was a comprehensive complaints policy in place. The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise. This ethos was underpinned in the complaints policy.

The inspector reviewed the complaints log which contained the facility to record all relevant information about the complaints, investigation made and the complainant’s satisfaction with the outcome. All complaints were recorded in the complaints log ensuring they are separate and distinct from a resident’s individual care plan. No complaints were being investigated at the time of inspection.

The inspector reviewed the complaints procedure displayed inside the main entrance. A designated individual was nominated with overall responsibility to investigate complaints. The independent appeals process if the complainant was not satisfied with the outcome of their complaint was clear.

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:
Non Compliant - Minor

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

Findings:
At the time of inspection there was one resident receiving end-of-life care.

There was a policy in place regarding end-of-life care. The person in charge told the inspector that care practices and facilities were in place to ensure that residents received end-of-life care in a way that met their individual needs and wishes and respected their dignity and autonomy.
The person in charge explained that they accessed the services of the local palliative care team who provided support and advice when required. The person in charge confirmed the palliative care team will attend the centre outside of core hours if required. This was evidenced on reviewing medical files.

The inspector was satisfied that caring for a resident at end-of-life was regarded as an integral part of the care service provided in centre. Resident’s personal choices and spiritual wishes were documented in the file reviewed. The end of life plan included discussions in relation to life sustaining treatments. A multi disciplinary approach was undertaken to include the residents’ family and the medical practitioner. This was further evidenced by a review of medical files where the GP had documented a consensus judgement. However, end of life wishes were not documented consistently in all case files examined to take account of personal choices and spiritual wishes in an early and planned manner to facilitate residents choice in absence of a terminal/ acute medical condition.

Religious and spiritual practices were facilitated in accordance with the wishes of the resident. Family were supported to be with the residents and facilitated to stay overnight and refreshments were provided.

**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

**Judgement:**
Compliant

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

**Findings:**
The inspector was satisfied that residents received a nutritious and varied diet that offered choice. Mealtimes were unhurried occasions that provided opportunities for residents to interact with each other and staff.

Residents’ dietary requirements were met to a high standard. The chef discussed with the inspector the special dietary requirements of individual residents and information on residents’ dietary needs and preferences. The catering staff received this information from the nursing staff and from speaking directly to residents. The chef was knowledgeable regarding the dietary needs, preferences and nutritional value of food and providing appropriate meals for residents with specific conditions such as diabetes and those with swallowing difficulties.
Residents’ weights and body mass index (BMI) were monitored routinely and those identified at risk had their weight reviewed on a more frequent basis. There was specialist equipment available to record the weights of those residents unable to stand on a weigh scales. Medication records showed that supplements were prescribed by a doctor and administered appropriately.

The inspector visited the kitchen and noticed that it was well organised and suitable in size to cater for the maximum number of residents accommodated. There was a wide range of choice at mealtimes. There was a four week rolling menu to ensure a variety of choice at meal times. Nutritious snack were provided between meals to ensure optimum calorie intake with appropriate fortified snacks available to include yoghurts and milk puddings as part of the evening meal.

Food intake and fluid balance charts were available to record residents at risk of dehydration or unintentional weight loss.

**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 of a good communication culture amongst residents, the staff team and person in charge.

Residents were dressed well and according to their individual choice. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents’ civil and religious rights were respected. Residents and staff confirmed that they had been offered the opportunity to vote at each election either in house or their own locality. Residents could practice their religious beliefs. Mass took place on a weekly basis.

Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move
around the centre freely. They had a choice of sitting rooms and could move to a smaller quieter room if they wished.

Residents had access to a variety of national and local newspapers and magazines to reflect their cultural interests and heritage. These were located in easily accessible areas and available to residents daily.

A residents’ forum was in place and minutes of meetings circulated. The person in charge responded in writing to the issues raised by residents and outlined how she proposed to address any concerns they had. This was confirmed by reviewing the minutes of the previous meetings

**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:**
Compliant

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

**Findings:**
There was a policy for the managing of residents’ monies, valuables and personal belongings; it provided guidance to staff on the storage and care of residents’ belongings.

A staff member was assigned to the laundry each day of the week. A system was in place to ensure all clothes were identifiable to each resident. There were no complaints recorded of clothes going missing. Property lists were completed on admission for each resident. A member of staff was assigned for two days each month to review all residents' clothing and update their property list.

Residents’ were encouraged to personalize their bedrooms. Many residents had framed photographs and ornaments located within the vicinity of their beds.
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 - Minor

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

Findings:
The provider employs a whole-time equivalent of 8 registered nurses and 24 care assistants. In addition, there is catering, cleaning and laundry staff and an activity coordinator employed. The inspector viewed the staff duty rota for a four week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched the staffing levels on duty.

There was an adequate number and skill mix of nursing, care assistants, catering and cleaning staff rostered on the day of inspection to meet the assessed care needs of residents. Direct care staff were divided into two teams. The roster allowed for an overlap of up to 30 minutes between shifts to facilitate handover communications between staff. Each team included one nurse and four care attendants excluding the person in charge and the assistant director of care. Call bells were answered promptly and there was a visible presence of staff in the day rooms and around the building during the inspection.

There is a minimum of four nurses rostered each day and two until 22:00 hrs. The rostering arrangements ensured care staff shifts during the day did not exceed seven hours. The time allocated to shift handover ensured the minimum disruption to residents’ routines. The care staff that came on duty in the late afternoon assisted residents with their evening meal and supper. They helped the majority of residents who wished to retire to their bedrooms for the night, before night staff came on duty at 22:00 hrs. These rostering arrangements ensured continuity of care and provided reassurance for residents during the busy evening period.

There was a training matrix available which conveyed that staff had access to on-going education and a range of training was provided. In addition to mandatory training
required by the regulations staff were facilitated to engage in continuous professional development. Staff had attended training on hand hygiene and nutritional care of the elderly. Staff had completed training on cardio pulmonary resuscitation techniques and AED training.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. This was evidenced by a review of staff files. Recently recruited staff confirmed to the inspector they undertook an interview and were requested to submit names of referees. All the information required by Schedule 2 of the regulations was available in the staff files reviewed with the exception of evidence of physical and mental fitness. Some files examined had a self declaration and this was not sufficient evidence of physical and mental fitness. This was identified as an area for improvement on the last visit and work was in progress to achieve full compliance with the regulations.

**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:**

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

<table>
<thead>
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<th>Centre name:</th>
<th>St. Joseph's Nursing Home</th>
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<tbody>
<tr>
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<td>ORG-0000175</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>24/02/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>07/04/2014</td>
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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 06: Safeguarding and Safety

Theme: Safe Care and Support

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

The policy did not outline an overall person with responsibility to investigate any allegation of abuse as it stated refer to the unit manager or the staff nurse on duty. Details of how to protect a vulnerable resident while the matter was being investigated were not outlined and the policy did not consider other possible abuse scenarios such as:

- resident to resident
- a relative, visitor or other such person
- potential allegation against a member of management.

Protected disclosure/whistle blowing procedures to guide staff in their reporting of a suspicion of abuse were not documented.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
**Action Required:**
Under Regulation 6 (1) (b) you are required to: Put in place a policy on and procedures for the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**
A new Policy is being introduced.

**Proposed Timescale:** 26/03/2014

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**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:
A moving and handling risk assessment was not completed for each resident and in completed cases where a resident requires a hoist; the type of hoist was not specified. Details of the sling type and size were not outlined in assessments.

**Action Required:**
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

**Please state the actions you have taken or are planning to take:**
A new Moving and Handling Risk Assessment tool has been sourced and is being implemented. In addition a Manual Handling communication sheet for staff will be located in each resident’s bedroom.

**Proposed Timescale:** 01/04/2014

**Theme:** Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Neurological observations where a resident sustained an unwitnessed fall or a head injury were documented. While these records were maintained they were not completed in line with best practice for a defined period of time at regular intervals post fall.

**Action Required:**
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

**Please state the actions you have taken or are planning to take:**
The Neurological and Vital Observation Chart has been revised to provide for more frequent Neurological observations.
**Proposed Timescale:** 25/02/2014

**Outcome 10: Reviewing and improving the quality and safety of care**

**Theme:** Effective Care and Support

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

Improvement plans to ensure enhanced outcomes for residents were not developed for all areas audited. The type of information collected for example, in medication management and the procedure to review the clinical data collected required further development to assist in identifying observation of trends to lead to enhanced outcomes for residents.

The quality assurance program required further expansion to review additional areas which impact on resident’s well being.

**Action Required:**
Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

**Please state the actions you have taken or are planning to take:**
We have commenced a review of all areas audited, and implemented a new audit tool that will identify trends and improvements to enhance outcomes for residents.

**Proposed Timescale:** 07/04/2014

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While the findings from audits and quality improvement strategies were discussed by the management team with nursing staff the audit findings were not collated into reports with copies made available to the resident or their representative for their information.

**Action Required:**
Under Regulation 35 (2) you are required to: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

**Please state the actions you have taken or are planning to take:**
Outcomes reports will be made available to residents.

**Proposed Timescale:** 07/04/2014
**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:

Approximately 50% of the residents have two bed rails in place. There was limited evidence of exploring alternative options prior to using a restraint measures in the documentation reviewed such as ultra low beds, perimeter mattresses or additional mattress by the bed or increased safety checks.

**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:**
With the use of low beds, crash mats, and alarm mats, the use of bed rails, other than as enabling, will be reduced. Reduction to 30% of residents by 31 December 2014.

**Proposed Timescale:** 31/12/2014

**Theme:** Effective Care and Support

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

While care plans were bring reviewed they were mainly rewritten and frequently an evaluation was not documented to highlight changes or a professional judgement to its effectiveness in many cases. An overall conclusion or professional judgement of the care pathway being followed was not indicated in the evaluation column of care plan documentation.

**Action Required:**
Under Regulation 8 (2) (b) you are required to: Keep each resident's care plan under formal review as required by the resident’s changing needs or circumstances and no less frequent than at 3-monthly intervals.

**Please state the actions you have taken or are planning to take:**
Care Pathways will be evaluated and the evaluation documented.

**Proposed Timescale:** 26/05/2014

**Theme:** Effective Care and Support

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

There was evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan when reviewed or updated. However, this was a standard form outlining the same information for each resident and was not...
personalised to each resident’s plan of care to reflect the individual care being delivered.

**Action Required:**
Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

**Please state the actions you have taken or are planning to take:**
Residents’ Care Plans will be planned and implemented without using a standard form.

**Proposed Timescale:** 26/05/2014

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**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:**
There is one ensuite bedroom with toilet, shower and wash hand basin accommodating three residents. The layout and configuration of beds did not ensure residents safety and comfort and did not encourage and aid their independence. Each resident did not have a wardrobe to store their own clothing. There was not adequate space in the bedroom to provide a chair by each bed to facilitate residents sit by their bed during the day if they wished. There was inadequate space around each bed to facilitate the safe use of a hoist without encroaching on other residents’ personal space and privacy. The television was not visible to all three residents.

**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 room presently accommodating three residents will become a two bed room as and from the expiry of the Nursing Home’s present registration period, thus reducing the number of beds to 51; alterations are being considered to create a new double bedroom with en suite to bring the number of beds to 53. Present registration period ends 21 July 2014.

**Proposed Timescale:** 21/07/2014

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A patio garden space was available to residents provided with seating. However, the gateway was not secured at the time of inspection. While there was a metal barrier located adjacent this was not suitable as a permanent measure to secure the gateway. The patio area had a pleasant aspect overlooking the lake. However, it was
not capable of being adequately secured to minimise the risk of mobile residents with dementia leaving the area unescorted.

**Action Required:**
Under Regulation 19 (3) (o) you are required to: Provide and maintain external grounds which are suitable for, and safe for use by residents.

**Please state the actions you have taken or are planning to take:**
Following the repair of the pathway from the east side of the Nursing Home, the patio area at the south of the Nursing Home is to be re-secured for residents using that area, including the installation of a fit for purpose gateway.

**Proposed Timescale:** 20/04/2014

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**Outcome 14: End of Life Care**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
End-of-life wishes were not documented consistently in all case files examined to take account of personal choices and spiritual wishes in an early and planned manner to facilitate residents choice in absence of a terminal/ acute medical condition.

**Action Required:**
Under Regulation 14 (2) (a) you are required to: Provide appropriate care and comfort to each resident approaching end of life to address his/her physical, emotional, psychological and spiritual needs.

**Please state the actions you have taken or are planning to take:**
End of life wishes are being discussed, and documented in the Care Plans during the three monthly reviews.

**Proposed Timescale:** 26/05/2014

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**Outcome 18: Suitable Staffing**

**Theme:** Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All the information required by Schedule 2 of the Regulations was available in the staff files reviewed with the exception of evidence of physical and mental fitness.

**Action Required:**
Under Regulation 18 (3) (c) you are required to: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.
Please state the actions you have taken or are planning to take:
Certification of physical and mental fitness to work is required from new employees.

**Proposed Timescale:** 25/02/2014