

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Joseph's Centre
Centre ID:	OSV-0000102
Centre address:	Crinken Lane, Shankill, Co. Dublin.
Telephone number:	01 282 3000
Email address:	stjosephs@sjog.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Saint John of God Hospital Limited
Provider Nominee:	Emma Balmaine
Lead inspector:	Deirdre Byrne
Support inspector(s):	Noelene Dowling
Type of inspection	Unannounced
Number of residents on the date of inspection:	57
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 30 September 2014 10:00 To: 30 September 2014 21:00

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

Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 18: Suitable Staffing

Summary of findings from this inspection

Inspectors followed up on the previous inspection on 19 August 2014, in which a number of areas of non compliances were identified with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The provider had also been required to take immediate action for a number of significant risks identified at that time. Responses to the immediate action plan were submitted on 25 and 27 August 2014 which were satisfactory.

At this inspection, the inspectors met the person in charge. The person nominated on behalf of the provider was on leave on the day of the inspection.

Inspectors found significant evidence of improvement in relation to the development and documentation of care plans to address for residents identified needs. There was evidence of improved practices in the management of falls, wound care, nutrition, epilepsy management, which appeared to be in line with best practices. Overall, the mealtime experience for residents had improved, with an area of improvement identified.

There was good access to general practitioner (G.P.) services, and allied health professionals. There were fifty seven residents on the day of the inspection. The majority of residents had a dementia or a cognitive impairment diagnoses. Inspectors found residents appeared well cared for, and by staff who were patient, respectful and knowledgeable of their health care needs. There was evidence that a good standard of evidence based nursing care was provided to residents.

While there was evidence of compliance with the Regulations at this inspection, a number of non-compliances were identified. These included the management of risk and the maintenance of the centre to a good standard of repair. An eight bedded unit will not meet the requirements of the Standards. There were improvements also identified in relation to the management of restraint.

Inspectors reviewed the actions to address the non compliances identified at the inspection in August 2014. There was evidence of appropriate actions taken and a number of actions were in the process of being completed. A small number were not completed. For example, of the nine actions from August 2014, six had been completed, and three were in the process of being completed:

The six actions completed were in relation to:

- the documentation of care plans,
- residents health care needs,
- the mealtime experience of residents,
- supervision of residents.

The three actions partially completed included:

- training for staff
- key operational policies.

These issues are further discussed in the body of the report and the Action Plan at the end of the report.

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

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that the centre was managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

At this inspection, the inspectors found the person in charge demonstrated improved clinical governance as per her responsibilities under the Regulations. This had been a concern at the previous inspection. There was evidence that the person in charge had taken appropriate and timely action to ensure residents received adequate health care and care plans were developed (see Outcome 11: Health Care). Additionally, the supervision of staff (see Outcome 18: Workforce) and the supervision of the mealtimes (see Outcome 15: Food and Nutrition) had improved, with an area of improvement identified.

The person in charge was a registered general nurse and had the relevant length of experience required by the Regulations. Since the last inspection she attended training days in topics such as falls prevention and the management of nutrition. Previously, she had attended seminars in care of the elderly. She had completed a diploma in management and industrial relations and a master's degree in health services management.

The person in charge was supported in her role by the director of services who also deputised in her absence. She was not available on the inspection day.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

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

5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

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

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

Findings:

Inspectors reviewed the policies required to be kept by the Regulations under this outcome. There were policies in place as required by Schedule 5 of the Regulations, with some improvement identified in relation to policies guiding practice.

Overall policies in place were centre specific and generally guided practice. An action from the last inspection was partially completed, with work currently under way by the person in charge to review and revise policies. Although the nutrition management policy had been revised by the person in charge, staff practices were not fully reflected in the policy (see Outcome 11).

The person in charge had a system in place to ensure staff had read key policies. Staff were sufficiently knowledgeable of key operational policies.

Inspectors found resident, staff and general records were maintained in the centre, were up-to-date, secure, and easily retrievable.

Judgment:

Non Compliant - Minor

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found systems were in place to protect residents from being harmed or suffering abuse. However, some improvements were identified in relation to the management of challenging behaviours and restrictive practices.

Inspectors found suitable arrangements in place for management of behaviours that challenged. However, improvements were identified. There was the policy in place,

although it was not fully implemented in practice. For example, there was no record of the evidence based tools as referred to in the policy having been completed for incidents of challenging behaviours. Furthermore, from reading the incident reports there were issues with the management of the incidents and the residents' behaviors that were impacting on other residents in the centre. Staff were familiar with residents' needs, and training was planned however, not all had received training in this area. This could lead to different responses in the future. This was discussed with the person in charge who advised that four staff were to attend a year long course in behaviors that challenge in October. In addition, a psychologist was to attend the centre once a month to meet staff and discuss behaviour issues amongst residents. A high number of residents presented with behaviours that challenged. Staff were observed to interact in a patient, kind manner with residents. Inspectors read care plans developed for residents that outlined their behaviour, the triggers and the strategies in place to mitigate the impact of or a behaviour occurring.

Inspectors found good practices were in place for the management of restrictive practices. However, improvements were identified in relation to the assessment process. For example, while two assessment tools were used to assess the residents, one form was not fully completed, and where a risk was identified, a decision was made to use bedrails. This was discussed with the person in charge who informed inspectors she would address the matter. Approximately 40 percent of residents with bedrails in place and two residents used lap belts. There was availability of alternatives to bedrails, with low low beds provided. The person in charge said they were striving for a restraint free environment. There was evidence of consultation and discussion with residents or families on the decision to use restraint. There was regular review and monitoring checks carried out. Care plans were in place for residents.

Inspectors were satisfied systems were in place to protect vulnerable residents. There was a centre specific policy on the protection of vulnerable adults that provided sufficient detail to staff on the steps to follow in the event of an allegation of abuse. Records read confirmed all staff had received training with the person in charge facilitating same. Staff spoken with were knowledgeable of the types of abuse and the reporting arrangements in place.

The person in charge was aware of the requirement to the notify the Chief Inspector of allegations or suspicions of abuse. Previous to the inspection, allegations of abuse had been notified to the Authority. The person in charge was familiar with the process of completing an investigation into incidents, taking appropriate and timely action when required.

Inspectors found suitable arrangements were in place to safeguard residents' finances. There was a procedure in place to guide staff that was implemented in practice. There were systems in place to ensure residents' money was managed robustly and in line with best practice.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

While inspectors found there were systems in place to protect and promote the health and safety of residents, visitors and staff, improvements were required in relation to the ongoing management of risk in the centre.

Inspectors reviewed the centres risk management policy that met the requirements of the Regulations. A risk register was read that contained non clinical risk assessments along with control measures to manage them. Individually, risk assessments were completed for a range of residents clinical needs. However, where individual risks were identified, the care plans in place did not comprehensively address the controls to manage them. For example, where residents were at risk of absconsion, the care plans did not outline the control measures in place to prevent the risk occurring.

In addition, a number of risks were identified by inspectors and not documented in the risk register. For example:

- storage of clean linen stored in a communal bathroom,
- assistive equipment stored in communal bathroom,
- the smoking hut and surrounds in an internal garden.

The person in charge assured the inspector these issues would be addressed.

Inspectors found there were arrangements in place to manage adverse events involving residents however, an area of improvement was identified. There were records completed for incidents and those reviewed included the action taken to address each incident. However, there was inconsistent documentation of the learning or improvement to prevent these incidents from happening again. For example, preventative measures were not clearly outlined for residents who experienced falls or unexpected bruising. This was discussed with the person in charge who outlined an action plan to address this. Inspectors were shown a draft of an adverse incident report form to be completed where incidents were escalated for further investigation. The report would include the corrective action, improvement and learning from each incident investigated. Furthermore, an adverse incident database was in the development. Each incident would be recorded on the system. It would include details of the action taken, recommendations made and any other information relevant to the incident. It was anticipated this would be addressed by the end of October 2014.

Inspectors saw residents were encouraged to be actively mobile and were seen being escorted around the centre. Staff were observed following best practice in the

movement of residents. Inspectors read records of training provided to staff in the movement and handling of residents. There was safe floor covering and handrails throughout the centre.

A comprehensive emergency plan was in place which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency.

Inspectors found that there were measures and policies in place to control and prevent infection. Staff had received training in infection and appeared to follow best practice. There was access to supplies of gloves and disposable aprons and staff were observed using the alcohol hand gels which were available throughout the centre.

Inspectors were satisfied suitable fire precautions were in place. Fire procedures and maps of escape routes were prominently displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. It was noted that the fire panels were in order and fire exits, which had daily checks, were unobstructed.

Inspectors read training records which confirmed that all staff had attended training within the last year, with a schedule of training for staff due for refresher training. Regular fire drills were conducted including evacuation procedures. Staff spoken with were knowledgeable of the procedure to follow in the event of a fire.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that each resident was protected by policies and procedures for medication management.

There was a comprehensive policy relating to the prescribing, storing and administration of medicines for residents. There were policies in place on out of date and the disposal of medication. Inspectors reviewed a sample of residents' medication prescription and administration sheets and overall good practice was observed. Nursing staff spoken with were knowledgeable of the best practices to follow.

Inspectors read procedures and observed good practice on the management and storage of medications that required strict controls (MDAs). A register of controlled medications was held, and two nurses checked the balance of the medications at the

end of every shift. At the time of inspection no resident was self medicating however, procedures were in place to guide practice if required.

There was regular review of residents medication by a GP. There was a system in place for monitoring safe medication practices. Inspectors read audits carried out by the pharmacy, with recommendations made acted on by the person in charge. Inspectors saw records of medication errors that had occurred in the centre. The person in charge had investigated each, and there was evidence appropriate action was taken.

Inspectors saw evidence of medication management training being completed by nursing staff.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

Overall, care was provided by staff who had a good understanding of residents' health care needs. There was a significant improvement in the documentation of care plans in line with residents' identified needs. Inspectors found residents had regular assessment of their health care needs. There was good access to GP services, and to a range of allied health professionals. The actions from the previous inspection were followed up and all apart from one action were completed, which related to gaps in care plan documentation.

Inspectors found suitable arrangements were in place for wound care. There was a policy in place to guide staff. The files of a number of residents with a wound were reviewed. There were care plans developed that outlined the frequency and dressing type. A wound assessment chart was completed to track healing and photos were also taken. Residents were regularly assessed for the risk of developing pressures sores however, care plans were not consistently developed where a risk was identified. Furthermore, the settings for pressure relieving mattresses were not clearly outlined in residents care plans. These matters had been an action at the previous inspection and not fully addressed.

Inspectors found good practices in the prevention of falls. This had been an action at

the previous inspection and was completed. There was a policy in place, which was due to be updated by the end of October 2014. Inspectors reviewed the care plans for residents at risk of falls and they guided practice. Where residents experienced falls, post falls procedures were completed. Additionally, there was evidence that neurological observations were completed following an unwitnessed fall or suspected head injury. Inspectors read care plans for residents who had experienced injuries from falls. There were appropriate controls measures to protect residents such as increased staff supervision along with hip protectors, alarm and crash mats.

There were good practices in relation to the management of nutritional needs. A revised policy was in place, although further detail was required to reflect staff practice. For example, the triggers to staff when to take action when a resident loses weight. This is actioned under Outcome 5 (Documentation). There were systems in place to ensure residents did not experience poor nutrition with monthly weights and regular assessments of residents using a malnutrition universal score test (MUST) assessment tool. Care plans were developed which guided practice. Where residents were at risk the person in charge carried out increased monitoring, with weekly weights, food balance sheets and referral to the dietician. Inspectors read that recommendations were followed up by staff. For example, supplements were prescribed by the GP when required.

There were good practices in the management of residents with dysphagia (swallowing problems). A detailed policy was read which guided practice. There was evidence of regular review by speech and language therapy, with recommendations incorporated into residents' care plans and seen to be carried out in practice by staff.

There were improved practices noted in the management of residents with percutaneous endoscopic gastrostomy (PEG) feeding tubes. A procedure had been put in place since the last inspection that guided practice. The file of one resident with a PEG tube was reviewed. A care plan was developed that outlined the feeding regime, cleaning and care procedure. There was evidence the resident had been seen by a dietician and speech and language therapist, whose recommendations were incorporated into the care plan. Additionally, a fluid intake chart was completed, which included the times of each prescribed feed, flush and medications.

There were improved practices in the management of residents with epilepsy. A protocol was developed and care plans were in place that outlined residents care needs. One resident's care plan was reviewed, and it clearly outlined the care to be provided in the event of a seizure. A seizure diary was in place to record and to monitor a seizure episode.

There were improved practices identified in the investigation of residents with unusual bruising. Records were maintained where unusual or repeated bruising was identified. However, there no evidence of what action had been taken or the outcome of an investigation if carried out, this is outlined under Outcome 8.

The residents' care plans were in hard copy. A sample was reviewed by inspectors during the inspection. Since the last inspections, actions had been taken to address non-compliances identified in the overall completion of care plans. Each resident had a key

worker who took responsibility for the development of their care plan. There was evidence that residents were regularly assessed using evidence based tools for a range of health care needs. Overall, care plans were developed where a need was identified, with the exception of residents at risk of developing pressure sores (as outlined in the paragraph above). Care plans were reviewed and updated, with an area of improvement identified in relation to falls, outlined above. There was evidence residents were consulted with regarding their care. Inspectors met families who confirmed the nursing staff discussed care plans with them.

Inspectors found residents had a choice of retaining their own GP and there was evidence of regular review of residents' medical needs. An on call GP arrangement was in place for out of hours and at weekends. There was access to a range of allied health professionals. Inspectors saw records of referrals and appointments with services including dietician, occupational therapist, speech and language therapy, chiropody and physiotherapy. Where recommendations were made, these were recorded and residents' care plans were updated. This had been an action at the previous inspection and addressed.

Judgment:

Non Compliant - Minor

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that aspects of the physical environment in St. Joseph's Centre did not meet fully residents' needs and the requirements of the Regulations. Furthermore, significant improvements are required to the premises in order to comply with the Regulations and the Authority's Standards by 1 July 2015.

The person in charge advised inspectors that there were definite costed plans in place to address the deficits in the premises in order to meet residents' needs. Planning permission had been obtained for building and reconfiguration works and these were expected to commence once a fire certificate was received. Inspectors were informed the project consisted of dividing the centre into six units, and the deficits in the building would be addressed. The deficits are outlined below:

The eight bed room in the Kilcrony unit did not meet the needs of the residents in this unit. Inspectors visited the room, which was divided up into three bays. There were

eight residents accommodated in the room at the time of inspection, who were highly dependent with varying degrees of cognitive impairment. They found the design and layout of the room was unacceptable and did not meet residents' needs. One of the rooms was mixed gender, and posed issues in terms of privacy and dignity for the residents. There appeared to be sufficient space for residents to personalise the area around their bed, and room for residents to store their clothes. The person in charge informed inspectors that the planned works would address these issues. The rooms would be decommissioned in the reconfiguration plans for the centre.

All other bedrooms in the centre were either single or two person occupancy. They were suitable and met the residents needs and were located within easy reach of a communal bathroom.

Although the centre was in a clean condition, inspectors found it was not well maintained throughout to a good standard of repair. For example, paint on walls was worn in areas and door architraves were chipped. Inspectors were informed a painting programme was due to commence this year.

There was a large, landscaped, garden around the perimeter of the centre that was directly accessible to residents. In addition, there were a number of internal, secure garden for more vulnerable residents. However, a number of internal courtyard gardens were not maintained to a good standard for example, hose pipes and old furniture was stored in a number of gardens.

Inspectors saw a number of storage rooms and areas were provided for assistive equipment however, it was not sufficient for the quantity of equipment in use. For example, hoists were stored in communal bathrooms, reclining chairs and wheelchairs were stored in residents communal areas.

There were adequate number of bathrooms, showers and toilets available to residents. Each bedroom had a wash hand basin provided. However, there was no lock on the inter-connecting doors joining two communal bathrooms. This is discussed under Outcome 16.

Adequate dining space was provided. There were two dining rooms in the centre. There was adequate communal accommodation provided, with an oratory, a number of sitting areas and smaller rooms available for residents to sit in during the day.

All beds had an emergency call facility, and inspectors read records that confirmed these were regularly serviced.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found policies and procedures were in place for end-of-life care. However, improvements were identified to ensure residents preferences and wishes were gathered and recorded.

While the end-of-life policy guided practice, it was not fully implemented in practice. For example, there was no evidence that residents end-of-life wishes and care needs were routinely assessed on a regular basis. There were no arrangements in place to illicit residents end-of-life preferences and care plans were not developed that outlined their wishes.

Where residents approached end-of-life, there was access to palliative care services. A room was available to families if they wished to stay over with their relative when required. A resident had passed away the day before the inspection, and there were discreet signs displayed advising staff, residents and visitors to this. Staff were facilitated to attend residents funerals. There were suitable arrangements in place for the removal of remains in consultation with deceased families wishes.

Judgment:

Non Compliant - Moderate

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

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

Findings:

Inspectors found resident's were provided with meals that were wholesome and in accordance with their assessed needs. Areas of non-compliance identified at the previous inspection were completed. However, a review of the mealtime experience for residents that took account of the dependency levels and needs of residents was required.

Inspectors spent time in both dining rooms at the lunchtime and evening meal. Overall, the mealtime experience had significantly improved since the previous inspection, and actions were completed. A designated nurse and health care assistant were assigned at mealtimes to ensure residents received the correct consistency diet, and received

appropriate supervision. Inspectors found residents were discreetly and respectfully assisted with their meals by staff. Inspectors read a list of that outlined each residents' special dietary requirements.

As reported before, many residents had a maximum or high dependency and many required assistance at mealtimes. Furthermore, some residents who remained in bed also required assistance. While there were adequate staff available and residents were supervised, it was noted that the mealtime was a slow experience overall. For example, some residents waited up to 45 minutes after they finished their meal to be offered a dessert or tea, or to be escorted from the dining room. This was discussed with the person in charge, and inspectors were assured the matter would be reviewed.

A menu was displayed on the dining room wall that outlined the choice of meal for the day. Tables were pleasantly set and residents were served as they sat. Staff showed residents meals to see in order to make a choice.

There was evidence of choice for residents on a modified consistency diet. The staff were familiar with the special dietary requirements, the preferences of residents' and were knowledgeable of the residents' assessed needs.

Inspectors saw residents being offered a variety of snacks and fresh water, fruit juices and hot drinks during the day.

Judgment:

Non Compliant - Minor

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

This outcome was reviewed in terms of routines, practices and facilities maximising residents independence.

Inspectors found sanitary accommodation was generally provided with locks. However, as outlined in Outcome 12: Premises, a number of communal bathrooms with interconnecting doors were not provided with locks. This was discussed with the person in charge who confirmed the matter would be addressed.

Inspectors observed routines and care practices carried out by staff that appeared to be

carried out in a manner that respected residents privacy and dignity. While staff were courteous to residents, some practice observed may have compromised residents' privacy. This were brought to the attention of the person in charge who assured inspectors they would be addressed.

Judgment:

Non Compliant - Minor

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

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

Findings:

Inspectors found that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents' on the day of inspection. However, staff required additional support and training to enhance their skill to manage residents with behaviours that challenge.

Actions from the previous inspection in relation to the supervision of staff were followed up and found to be addressed. Inspectors found the system of supervision of residents had improved. The person in charge had delegated staff to oversee the supervision at mealtimes and other times of the day. Inspectors also observed residents appropriately supervised in communal areas, and in smaller quieter areas.

There was education and training available to staff in a broad range of areas. All staff had completed up to date training in mandatory areas. Inspectors saw a detailed training programme in place. This had been an action at the previous inspection, and was partially completed. Since then, staff had attended nutrition training. Furthermore, there were plans to train up four staff in the area of behaviours that challenge however, additional training was required to ensure all staff had the skills to manage residents and document reports of incidents of behaviours that challenge (see Outcome 7: Safeguarding and Safety).

There were adequate staffing levels and skill mix on the days of inspection. There were three nurses on duty at all times, over a 24 hour period. A two week roster was read that accurately outlined the staff on duty.

There was a recruitment policy that met the requirement of the Regulations. Inspectors reviewed a sample of staff files and found recruitment practices were in line with the Regulations. A number of agency staff worked in the centre. There were service level agreements in place, that outlined staff documentation was in line with the requirements of the Regulations.

Inspectors reviewed a sample of files and found that nursing staff had up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2014. The person in charge informed inspectors that there were a small number of volunteers and external service providers working in the centre. Files reviewed confirmed An Garda Síochána vetting and a written agreement of their role was in place.

Judgment:

Non Compliant - Minor

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St. Joseph's Centre
Centre ID:	OSV-0000102
Date of inspection:	30/09/2014
Date of response:	31/10/2014

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The policy on the management of nutrition required revision.

Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them

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

in accordance with best practice.

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

The nutrition policy is under re review and will be completed by November 30th 2014.

Proposed Timescale: 30/11/2014

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

The management of behaviours that challenge required improvement.

Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

2 staff are fully trained and 4 staff are currently receiving training in Multi-Element Behaviour Support for Needs Driven Behaviours here in St. Joseph's Centre. All Nursing and Healthcare Assistant staff will have received education in managing behaviour that is needs driven in a manner that is not restrictive, including education relating to the policy and the tools being used, by January 31st 2015.

Proposed Timescale: 31/01/2015

Theme:

Safe care and support

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

The practices in relation to the management of restraint required improvement.

Action Required:

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

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

We will identify one risk assessment tool, and all nursing staff will be educated on its use to improve our assessment process. We will continue to reduce the use of bedrails as we strive towards a restraint free environment.

Proposed Timescale: 31/01/2015

Theme:

Safe care and support

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

Not all staff had received training in the management of behaviours that challenge.

Action Required:

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

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

2 staff are fully trained and 4 staff are currently receiving training in Multi-Element Behaviour Support (MEBS) for Needs Driven Behaviours here in St. Joseph's Centre. All Nursing and Healthcare Assistant staff will have received education in managing behaviour that is needs driven in a manner that is not restrictive, including education relating to the policy and the tools being used, by January 31st 2015.

Proposed Timescale: 31/01/2015

Outcome 08: Health and Safety and Risk Management**Theme:**

Safe care and support

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

A number of areas of risk were identified during the inspection as outlined in the inspection report.

Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

For every risk identified for every resident, a care plan is being created which will address the controls required to manage the risk. When an incident has occurred involving a resident the care plan will be reviewed to reflect any new actions to be taken.

The risk register will be kept under constant review to reflect all existing risks and the control measures in place to manage each risk including storage of clean linen, storage of assistive equipment and the smoking hut and surrounds in the internal garden.

Fire extinguisher and fire blanket have been installed in the smoking hut and are easily accessible.

A call system for this area is currently being explored.

All clean linen is stored in the linen room.
All assistive equipment is stored in its designated storage space.

Proposed Timescale: 31/12/2014

Theme:

Safe care and support

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

There was inconsistent evidence of learning and improvement from adverse events involving residents.

Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The draft adverse incident report form seen by the inspectors will be completed by October 31st 2014, as planned. Education to staff regarding the documentation of the learning and the communication of the learning will be completed by January 31st 2015.

Proposed Timescale: 31/01/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Care plans were not consistently developed where a need was identified e.g. risk of pressure sores

Some care plans did not contain sufficient guidance e.g. skin integrity

Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Any resident at risk of developing a pressure sore, or where skin integrity may present as a concern, will have a detailed care plan in place to guide practice.

Wherever there is a need identified, a comprehensive care plan will be developed to guide practice. The care plan will include the pressure relieving setting required for the

mattress, where applicable.

Proposed Timescale: 31/12/2014

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 multi-occupancy bedrooms were institutional in nature and did not provide adequate privacy and dignity.

Parts of the premises are poorly maintained and in need of repair.

There was inadequate storage for assistive equipment.

Action Required:

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

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

Detailed costed plans are in place to address the deficits in the premises. Planning permission and fire certification has been received and we have now progressed to the tendering stage of the development. The refurbishment of St. Joseph's Centre will address the documented deficits, and the privacy and dignity issues outlined in the body of the report.

A number of resident's rooms have already been decorated since the inspection on September 30th 2014. Outstanding issues of immediate repair are being addressed. We will continue to address maintenance issues and décor as they arise. The Centre will receive a full redecoration between now and the end of the refurbishment.

All hoists are stored in their hoist bay.

Any equipment, e.g. special chairs, not in current use are being removed from the Centre.

Proposed Timescale: 31/12/2015

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:

There were no arrangements in place to illicit residents end-of-life preferences, wishes

and care needs.

Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

A new Enriched Care Plan has been introduced in St. Joseph's Centre. This care plan addresses all areas of End of Life Care planning, including a plan to elicit end of life preferences, wishes and care needs. Care plans are being developed to reflect these needs.

Proposed Timescale: 31/12/2014

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 mealtime experience required revision with regard to provision of meals in a timely manner.

Action Required:

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

We have already commenced a pilot project which addresses the mealtime experience in relation to dependency needs, we are monitoring it's effectiveness. A group of staff from nursing and catering are developing this project in the best interests of all of our residents. (November 30th 2014).

We await the planned refurbishment to be completed which will further improve the mealtime experience. (December 2015)

Proposed Timescale: 31/12/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

There were no locks provided on a number of communal toilets.

Action Required:

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

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

Locks are now in place on the interconnecting doors in the bathing areas as identified in the inspection on September 30th 2014. All other toilets already had and continue to have locks provided.

Proposed Timescale: 31/10/2014

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Staff required further training in the management of behaviours that challenge

Action Required:

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

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

2 staff are fully trained and 4 staff are currently receiving training in Multi-Element Behaviour Support (MEBS) for Needs Driven Behaviours here in St. Joseph's Centre. All Nursing and Healthcare Assistant staff will have received education in managing behaviour that is needs driven in a manner that is not restrictive, including education relating to the policy and the tools being used, by January 31st 2015.

Proposed Timescale: 31/01/2015