<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Carthage’s House Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000687</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Lismore, Waterford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>058 54309</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:stcarthageshouse@gmail.com">stcarthageshouse@gmail.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>St. Carthage's House Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Mary Fenton Morrissey</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mairead Harrington</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Ide Batan;</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>37</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>14</td>
</tr>
</tbody>
</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.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times

From: 27 January 2015 10:30  27 January 2015 17:00  
28 January 2015 09:30  28 January 2015 16:00

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

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

Summary of findings from this inspection

This was an announced inspection following an application by St Carthage's House, in accordance with statutory requirements, for re-registration of a designated centre. St Carthage's House is a community service run on a voluntary basis and managed by a board of directors through a nominated provider with care directed via the person in charge. On the day of inspection there were 35 residents in the centre with two more in hospital. As part of the process inspectors met with residents, the nominated provider, the person in charge, members of the board of management and other staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Residents spoken with expressed a good level of
satisfaction with the service they experienced at the centre. Other documents reviewed included training records, residents' care plans and minutes of meetings.

The last inspection, on 27 August 2014, was a thematic that focused on the outcomes of food and nutrition and end-of-life care. The inspection findings were satisfactory and, where required, the provider and person in charge had taken action accordingly. A copy of that report, including the provider's response and action plan, can be found on www.hiqa.ie.

The findings of this re-registration inspection are set out under 18 outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of 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.

Areas for improvement were identified in relation to governance and management, risk management and safety, premises, staffing and documentation. These issues are covered in more detail in the body of the report. Also, the application for registration did not include all the documentation as prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspector reviewed the statement of purpose which declared the aims, objectives and ethos of the centre and summarised the admission criteria, facilities available and services provided. The person in charge confirmed that the statement of purpose was kept under review though it required amendment in order to correctly reflect the capacity of the centre and the dependency range of residents. This information was revised and incorporated in the course of the inspection.

**Judgment:**
Substantially Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The designated centre was operated on a voluntary basis with a well established system of governance in place via a board of management. Care was directed through the person in charge who reported to the provider with both answerable to the board of
Management systems to ensure the service provided was safe, appropriate, consistent and effectively monitored were limited with no evidence of any audits having been completed in the previous 12 months in areas such as medication management, health and safety or infection control. As a consequence minimal action had been taken on any related review of quality of care and the production of the annual report in this respect had not been progressed. Both the provider and person in charge explained that this had been a time of significant change to membership on the board of management; this upheaval in leadership combined with what they stated were both shortages and inefficiencies in the use of resources, had meant action on these functions had lapsed. It was also explained to the inspector that the services of a quality management consultancy had been retained to address these issues and that a review of the service, particularly in relation to documentation around policies, procedures and audits, was being undertaken. The inspector impressed on management, and those board members present, the necessity to prioritise action in this area as the existing systems did not effectively ensure management methods were adequate to the provision of a safe, appropriate, consistent and effectively monitored service.

In general the governance structure was supportive of both staff and the person in charge who reported effective on-going communication. Staff were aware of the requirements in relation to the regulations and a copy of the national standards was available and accessible at the centre. Members of staff spoken with were found to be committed to providing quality, person-centred care to their residents. Evidence was also available in relation to forum meetings where residents had the opportunity to have input to issues pertaining to the delivery of service at the centre.

The application for registration did not include all the documentation as prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009.

Judgment:
Non Compliant - Major

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
A guide outlining the services and facilities of the centre was available to residents. The inspector reviewed a sample of resident contracts which included details of the overall
fees to be paid and services to be provided in relation to care and welfare. The contracts reviewed were dated and had been signed by the resident.

**Judgment:**
Compliant

---

### Outcome 04: Suitable Person in Charge

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge was a long standing member of staff who held the post full-time and was a registered nurse with experience appropriate to the role. A clear reporting system was in place with the person in charge reporting to both the provider and also a board of management. Residents and staff spoken with could identify the person in charge and understood that the role carried responsibility and accountability for the service and that issues and concerns could be addressed to the person in charge for action if necessary. In the course of the inspection the person in charge demonstrated a satisfactory knowledge and understanding of 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 person in charge also understood the regulatory responsibilities associated with the role and demonstrated an on-going commitment to compliance with the statutory requirements.

**Judgment:**
Compliant

---

### Outcome 05: Documentation to be kept at a designated centre

*The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.*

**Theme:**
Governance, Leadership and Management
**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
A substantial amount of work had been undertaken since the previous inspection around the development of documentation; to this end the centre had also retained the services of a consultancy firm. There were some issues around documentation in relation to staff files as required in accordance with schedules 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013; these findings are detailed in the associated outcome 18 on staffing. As described at outcome 9 on medication management, records in relation to the monitoring of controlled drugs were incomplete.

Documentation as required by schedule 4 of the regulations was appropriately maintained. Policies and procedures in respect of schedule 5 were site-specific and had been reviewed within the last twelve months.

**Judgment:**
Non Compliant - Moderate

---

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

**Theme:**
Governance, Leadership and Management

---

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

**Findings:**
Both the provider and person in charge understood the statutory requirements in relation to the timely notification of any instances of absence by the person in charge that exceed 28 days; and also the appropriate arrangements for management of the designated centre during such an absence. There had been no such period of absence by the person in charge since the last inspection.

**Judgment:**
Compliant

---

**Outcome 07: Safeguarding and Safety**
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

---
Theme: Safe care and support

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

Findings:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse dated July 2014 which was comprehensive and included directions where allegations were made against residents or visitors. Staff spoken with understood what constituted abuse and, in the event of such an allegation or incident, were clear on the procedure for reporting the information. The training matrix indicated training in this area was on-going and all staff had received updated training accordingly.

Residents spoken with stated they felt safe in the centre and were clear on who was in charge and who they could go to should they have any concerns they wished to raise. There was no record of any allegations of abuse having been reported. A policy dated July 2014 was in place on managing challenging behaviour which also referenced the use of restraint. The person in charge explained that the profile of residents was one of low dependency and that the centre's policy was one of no restraint.

A policy was in place for the management of residents' personal property, finances and possessions dated July 2014. Policy was in keeping with the independent resident profile and residents retained responsibility for the management of their own finances. Inspectors reviewed a sample of finance records and found that they reconciled with the related account balances. However, the procedures in place to safeguard these processes required further development as there was a lack of transparency and control around receipts and documentation in particular.

Judgment:
Substantially Compliant

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:
A comprehensive risk management policy was in place dated July 2014 covering the required areas in relation to unauthorised absence, assault, accidental injury, aggression, violence and self-harm. A centre-specific safety statement was also in place. However, there had been no audits or reviews in relation to risk or health and safety in
the past 12 months and action in this respect is recorded against outcome 2 on governance and monitoring safe care.

Staff training in relation to fire prevention and precaution had been delivered in May 2014 with the exception of two staff - action in this respect is recorded against outcome 18 on staffing.

An inventory of equipment, and its location, was in place and fire equipment had been inspected in December 2014. A daily check of both the fire panel and fire escapes was recorded. Weekly checks of first aid and fire equipment, including the fire alarm test, were in place. Evacuation drills were documented for December 2014. Emergency lighting had been tested on 8 August 2014. Corridors were kept clear and exits were unobstructed although the inspector observed a practice of holding open bedroom fire doors with wedges.

An emergency policy was in place dated December 2014 and emergency and evacuation plans were on display. A list of emergency phone numbers was readily accessible by staff with provisions in place to support night staff. The inspectors spoke with housekeeping staff and saw evidence of a regular cleaning routine and practices that protected against cross contamination, including the use of a colour coded cleaning system. An infection control policy was in place dated July 2014 and staff had received training in hand hygiene. Good infection control practices were observed with staff utilising personal protective equipment appropriately. Sanitising hand-gel was readily accessible and regular use by staff was evident. The premises, overall, was clean and well maintained though issues were identified in relation to the laundry/sluice facilities and action in this respect is recorded against outcome 12 on premises. There was a system in place to record data around accidents and incidents and those which did occur, such as falls, were responded to appropriately.

Judgment:
Non Compliant - Major

**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:**
There were written, operational policies and procedures, dated July 2014, which covered requirements in relation to the safe ordering, prescribing, storing and administration of medicines to residents. The policy also referenced procedures around the safe handling and disposal of out of date or unused medicines.
Practices observed in relation to the storage of medication were in keeping with policy, current guidelines and legislation and included suitably secure storage in the case of controlled drugs. However, the controlled drug register was checked and signed off only once a day and not at the changeover of each shift as required by professional guidelines. Action in this respect is recorded against outcome 5 on documentation.

The inspectors noted that medications were prescribed and administered in accordance with best practice and that medication administration sheets contained the signature of the nurse administering the medication and prescription sheets contained the necessary biographical information including a photograph, name, dosage and route of administration. There was adequate space to include comments in instances where residents refused medication or it was withheld. There were no instances of medications being crushed or prescriptions being transcribed. No non-nursing staff administered medications. Where a resident was self-administering medications an appropriate assessment had been completed and effective systems were in place for staff to provide support if required, including direct input by the pharmacist. Residents could retain the services of their pharmacist if they wished.

Although both pharmacist and GP reviews of medication were undertaken regularly with staff, overall there were inadequate systems in place for reviewing and monitoring medication practices with no medication audits having been undertaken in the previous 12 months. Action on this finding is recorded against outcome 2 in relation to systems of governance.

**Judgment:**
Compliant

---

**Outcome 10: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**
Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

A system for recording all incidents at the designated centre was in place and the person in charge was aware of the requirements to notify the Chief Inspector accordingly. Quarterly reports or nil returns were also provided to the authority as required.

**Judgment:**
Compliant
Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The centre had current and site-specific policies and procedures dated July 2014 in relation to the care and welfare of residents. On the day of inspection there were 35 residents living in the centre and two further residents in hospital. The inspectors found that the welfare and well-being of the residents was prioritised and suitable and sufficient care was provided. The care provided was based on a social model with the independence of residents actively promoted through choice in daily routines in keeping with the low dependency profile of residents. Residents enjoyed a significant level of independence and freedom and used their own personal transport in a number of cases. Residents spoken with also explained how they were supported in accessing public transport or alternatives when attending community services outside the area.

The care plans reviewed by the inspectors contained evidence of pre-assessments undertaken by the person in charge prior to admission. On admission residents were regularly assessed using appropriate evidence based tools. Residents’ weights were monitored and the services of allied healthcare professionals were available. A sample of care plans reviewed indicated that residents were provided with timely access to medical assessment and care with regular attendance by the local GP services. Residents also had the option of retaining the services of their own GP whilst at the centre. Appropriate arrangements were in place to access services out-of-hours also. The care plans reviewed reflected a solid base of care that included effective use of the broader health services such as chiropody, occupational therapy and speech and language therapy. Community mental health services were also available as required. The person in charge explained that the services of a community dietician had also recently become available to the centre. Where transfer to acute services was recommended admissions were arranged in a timely manner although documentation around discharge and transfer activities on some care plans was incomplete. Care plans were reviewed regularly on a four monthly basis.

Staff and management at the centre demonstrated an active commitment to person-centred care. Both the resident and staff population came mainly from the local area and as a consequence there was a strong sense of a connected community. Care plans were individualised and staff spoken with had a well developed knowledge and
understanding of the personal circumstances around individual residents. Residents spoken with felt very well cared for and supported in their choices; they were consulted with, and participated in, communication and decisions around their daily living choices including social contact, transport arrangements and activities. There were however, some gaps in relation to documentation with limited evidence of consultation with residents in the development and review of care plans, for example in relation to spirituality and dying. Also documentation around transfers and discharge was not always complete. Overall there was a lack of assessment of the care planning and its delivery, against the regulatory standards, which would serve to inform the centre’s annual review of the quality and safety of care delivered – this finding is recorded for action against outcome 2 on governance and management.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
The location, design and layout of the centre were suitable to meet the individual and collective needs of the resident profile in keeping with the centre’s statement of purpose. The single storey building had been purpose built in the 1990’s and comprised a main building with 31 single rooms and two doubles. A further eight en-suite residential units were conjoined by a glass corridor at the rear of the building. The centre had capacity for 51 residents with a total of 35 in residence; at the time of inspection all accommodation at the centre was single occupancy.

The building was well constructed and maintained. Provisions were in place to address health and safety hazards including call-bell systems and grab rails where necessary. There was ample parking to the front of the premises which was located in an attractive, landscaped setting.

There was a large communal sitting room in the main building along with a dining room and a small oratory. There were two further lounges available for use where residents could also receive visitors in private should they so wish. The dimensions of all accommodation were in keeping with statutory requirements. Residents' rooms were comfortable and provided the necessary space and storage for furniture and individual
belongings. Appropriate heating, lighting and ventilation were in place throughout the premises. Separate facilities were also available for staff. Facilities available for catering purposes were appropriately maintained and equipped.

The laundry facilities referenced in outcome 17 were not fit for purpose. The laundry space was cramped and inadequate for effective segregation of soiled/clean clothing which raised issues in relation to appropriate infection control. Also, there were no appropriate sluice facilities. These findings had been identified on previous inspections. On the day of inspection one of the two washing machines in use was out of order.

**Judgment:**
Non Compliant - Moderate

**Outcome 13: Complaints procedures**

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

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

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

**Findings:**
A site specific complaints policy and procedure was in place dated July 2014 which covered both written and verbal complaints. The policy cited relevant legislation and included a clear outline of the procedure to follow in making a complaint, such as who to approach and the expected time frames for resolution. Details of the nominated person responsible for dealing with complaints were provided along with a summary of the appeals process. Information about advocacy services and the relevant contact details were also provided. A summary of the complaints procedure was on display in the centre. Residents spoken with were aware of how to make a complaint should they so wish though residents reported that communication with staff and management was very good with opportunities to raise issues at residents’ meetings also. In general any requests or issues were usually addressed on an on-going basis without the need to escalate matters via the complaints process. Where complaints had been received they were recorded and responded to in a prompt and timely manner with outcomes recorded. The complaints log was reviewed by the inspector and contained a record of complaints along with investigations undertaken and communication of the outcome to complainants.

**Judgment:**
Compliant
### Outcome 14: End of Life Care

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

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

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

#### Findings:
The centre had been the subject of an inspection focused on end of life care in August 2014 and was found to be substantially compliant with action around training for staff implemented and scheduled as on-going.

The person in charge confirmed that there had been no death at the centre since it had been registered and that there had been no instances where end of life care had been provided. The policy and procedure in place indicated that where the needs of a resident changed and end of life care provision became necessary, residents requiring such care would be referred for assessment and transferred to an appropriate service provider accordingly.

The policy summarised the protocol in the event of a sudden or unexpected death and outlined a process whereby the relatives of residents were provided with advice and practical information on what to do in the event of a death. A policy on residents’ personal property and a protocol for the return of personal possessions was also in place. Religious and cultural practices were facilitated and residents also had access to ministers of other religious denominations. Care plans reviewed contained provision for the assessment of needs around spirituality and dying although, of the sample reviewed, not all of these had been completed. Action in relation to this finding is recorded against outcome 11.

#### Judgment:
Compliant

### Outcome 15: Food and Nutrition

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

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

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

Findings:
St Carthage’s House provides supportive care for those who have been assessed as not requiring full time nursing care. As such the care provided was appropriate to the assessed needs of a resident profile with low dependency levels. Independent dining was encouraged and on the day of inspection there was no resident requiring direct assistance at mealtimes. The centre had been the subject of an inspection focused on food and nutrition in August 2014 where action had been identified in relation to the development of an associated policy and also the provision of choice around menu. The person in charge confirmed that these actions had been addressed. The inspector reviewed the policy dated July 2014 which had been revised to reflect good practices at the centre accordingly.

A sample of care plans reviewed by the inspector contained relevant records of monitoring with regard to nutrition and weight. Access to allied healthcare services such as a speech and language therapist or a dietician was available via GP referral. Members of staff spoken with demonstrated an understanding of the residents and their requirements and were seen to accommodate individual preferences where requested. Residents assessed as requiring a modified diet had individualised diet plans and, where necessary, an appropriate swallow care plan was in place which was also available in the kitchen for reference by staff. Kitchen staff were appropriately trained and kitchen facilities were in keeping with the design and layout of the premises.

The dining area was clean and bright with tables laid for small groups. Residents spoken with were very satisfied with both the quality and quantities of food provided. The inspector saw that food was well prepared and presented with staff also giving appropriate attention to the fluid intake of residents. The inspector noted however that there had been no menu audits or reviews of menus around nutritional content; the person in charge explained that the services of a community dietician had recently become available and that it was her intention to establish contact and seek input accordingly.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

**Findings:**
Residents spoken with reported positively on the experience of living at the centre stating that they were comfortable and felt safe and secure. The inspectors saw evidence that residents adopted a relatively independent daily routine and were fully supported in doing so by both staff and management. The ethos of the centre as described in the statement of purpose referenced "a vision of resident centred care ... in a homely setting where each person's uniqueness and right of choice is valued." The inspectors found that the intention of this statement was actively promoted by both staff and management in the day to day care at the centre.

The inspector observed a regular attendance of visitors and there was an open visiting policy in place with no restricted visiting times. The inspectors observed communication and interactions between residents and staff which were helpful and assistive whilst being courteous and respectful. Staff knew and understood the individual needs and preferences of residents and responded accordingly.

The quality of care and experience of the residents was monitored and inspectors noted that satisfaction surveys completed by residents recorded positive returns on issues such as quality of food, care, hygiene, comfort and complaints. Input by residents in relation to the running of the centre was further facilitated by a resident forum. The inspector spoke to a resident who regularly acted as spokesperson and who reported that issues were often resolved satisfactorily once raised and recommendations were implemented where possible. All residents were registered to vote on the electoral roll with the returning officer attending for elections and referenda. Residents also had access to an independent advocacy officer with provisions in place for the support of an external advocacy organisation if necessary.

Facilities at the centre were adequate for recreation and occupation with a schedule of weekly activities available including musical therapy, reminiscing conversations and pongo. Live music was being performed on one day of inspection and there was access to other recreational resources such as TV, radio, newspapers, magazines and books.

**Judgment:**
Compliant

**Outcome 17: Residents’ clothing and personal property and possessions**
Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

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

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
A policy was in place in relation to residents’ personal property and possessions dated July 2014. The person in charge confirmed that residents had access to, and retained possession of, personal belongings and finances. The inspector noted that residents' rooms were personalised with belongings and photographs and adequately furnished with clothing stored in individual wardrobes.

Arrangements were in place for the regular laundering of linen and clothing and a formalised system of clothing identification was in place to ensure the safe return of items to residents. Laundry staff spoken with understood the requirements in relation to segregation of garments and explained the infection control procedures that were in place. However, the laundry facilities available were inadequate and the finding and action in this regard are detailed at outcome 12 on premises.

Judgment:  
Compliant

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):
No actions were required from the previous inspection.

Findings:
Based on a review of the actual and planned rota, and the observation of staff operational levels, the inspector was satisfied that the staff numbers and skill-mix were appropriate to meet both the assessed needs of the residents and the effective operational management of the service. Staff spoken with were aware of the statutory requirements and standards in relation to the delivery of care and copies of relevant guidance were available at the centre. Staff training records reflected mandatory requirements and training was in keeping with the profiled needs of residents. Training in relation to manual handling and elder abuse was up to date though two staff had not received updated fire training and the person in charge confirmed that this was currently being scheduled for delivery.

There were written, site specific policies in relation to the recruitment, selection and vetting of staff dated July 2014. However, a sample of personnel files reviewed did not
contain all the documents required under Schedule 2 of the regulations - in some instances employment histories were incomplete, references were incomplete and volunteers did not have their roles and responsibilities set out in writing. Also, several garda vetting forms were not available; though the provider was able to demonstrate action to address this had been taken and the inspector reviewed copies of correspondence with the relevant authority to this effect. Action in respect of this finding is recorded against outcome 5 on documentation.

Staff spoken with felt supported by both the person in charge and management in relation to their professional training, development and supervision. However, the procedures in place around supervision and appraisals, for both staff and volunteers, were not being implemented. The person in charge explained that an additional 12 nursing hours per week had recently been agreed by the board to support improvement in this area.

**Judgment:**
Non Compliant - Moderate

---

**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Carthage's House Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000687</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>27/01/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>27/03/2015</td>
</tr>
</tbody>
</table>

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The application for registration did not include all the documentation as prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009.

Action Required:
Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for...
Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015

Please state the actions you have taken or are planning to take:
All outstanding documentation will be forwarded

Proposed Timescale: 30/04/2015
Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The governance board were not implementing management systems that were sufficiently robust, or adequately resourced, to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
• Medication Audit will be completed by pharmacist
• Kitchen Audit will be carried out by out by Kitchen Staff
• All further audits will be initiated and activated on advice and under guidance of consultant after meeting on 2nd April 2015 which will also include identifying ongoing training for staff members.
Where actions are identified, they will be reviewed by Board of Management at Quality Management Review Meetings.

Proposed Timescale: 02/04/2015
Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review of service measured against the standards set by the Authority had not been progressed.

Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
A Quality Management System has been put in place. This system will gather information both positive and negative and in particular, analyse all adverse data, information and practises with a view to developing a system and culture of continuous improvement and learning. The Board of Management, P.I.C and consultant advisor will operate as a team to achieve this goal. The chairman of the Board of Management will nominate selected members for producing the annual review document.

**Proposed Timescale:** On Going

<table>
<thead>
<tr>
<th>Outcome 05: Documentation to be kept at a designated centre</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Documentation in respect of staff records as required at paragraphs 2, 5 and 8 of schedule 2 of the regulations were incomplete.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>All staff records have now been completed with the exception of Garda Clearance for three members of staff whose clearance forms have yet to return from Garda Vetting section. Staff files are being audited and will be fully completed in the near future. Main priorities are vetting of staff, suitability of staff and keeping records complete and up to date. This is the responsibility of the provider.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 30/05/2015</td>
</tr>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Controlled drugs were not signed off at the start of each shift as specified by the relevant professional guidelines.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>Policy in place to ensure that all controlled drugs are counted at the commencement of each tour of duty</td>
</tr>
</tbody>
</table>
**Proposed Timescale:** 22/04/2015

### Outcome 07: Safeguarding and Safety

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Recording procedures in place to safeguard systems of financial control from potential abuse required further development.

**Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Safe guard systems of financial control from potential abuse are in place for all residents.
- Where resident receives money it is signed by the recipient and witnessed
- Monies will no longer be kept by management for safe keeping
- Where monies were held for a sole resident at their request, such monies is now being lodged in their reactivated bank account by the resident concerned
- Where small amounts of pocket money is being held for residents in the office safe, receipts and expenditure will be forwarded to the next of kin who will be requested to sign for such documentation and return a copy to the provider.

**Proposed Timescale:** 30/04/2015

### 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:
Ensure adequate precautions against the risk of fire are in place such as the appropriate use of fire doors.

**Action Required:**
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
We have obtained a number of quotations in relation to the purchase and installation of a Fire Door System for St Carthages House. Fire Consultant has now carried out an
inspection and his report and recommendations are expected within the next number of days. Work will be carried out when finance is made available. In the interim period, despite the objections of some residents, all doors will be closed at night which will be implemented and supervised by person in charge, staff and overseen by Board of Management. Residents and next of kin have been advised in writing of the new safety arrangements.

**Proposed Timescale:** 30/04/2015

---

**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:**
The needs of residents are not always fully recorded in relation to spirituality and dying.

**Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
End of life care policy reflects best practise in the case of unexpected deaths. All residents at St Carthages House are low to medium dependency level. Some residents have been with us 15 years. We have experienced difficult situations which has caused undue stress to new residents, when endeavouring to discuss spirituality and end of life at time of admission when such resident expect a normal life span in their new home. End of life and spirituality is discussed at the behest of the resident and or when the person in charge deems it appropriate to do so. There is a record kept of such conversations in the care plan and reviewed by the PIC when deemed necessary. New residents are made aware of the relevant religious clergy in the area who visit the house on a regular basis to assist in their spiritual needs.

**Proposed Timescale:** 27/03/2015

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Copies of documentation relating to the transfer and discharge of residents were not always in place on care plans.

**Action Required:**
Under Regulation 25(1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre for treatment at another
designated centre, hospital or elsewhere, to the receiving designated centre, hospital or place.

**Please state the actions you have taken or are planning to take:**
Completed - Copies of documentation relating to transfer and discharge of all residents are being recorded and in place in care plans.

**Proposed Timescale:** 27/03/2015

<table>
<thead>
<tr>
<th>Outcome 12: Safe and Suitable Premises</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong></td>
</tr>
<tr>
<td>Effective care and support</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Regulations in relation to Schedule 6 were not met as per 3, (e) requiring appropriate sluicing facilities.

**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:**
Designs and costing for new Utility area to include Sluicing facilities have commenced. Application for capital funding will also be necessary and being explored by B.O.M

**Proposed Timescale:** 30/07/2015

<table>
<thead>
<tr>
<th>Theme:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective care and support</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Regulations in relation to Schedule 6 were not met as per part 3 (f) requiring adequate laundry facilities.

**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:**
Designs and costing for new utility area to include laundry facilities have commenced. Application for capital funding will also be necessary and being explored by B.O.M. Local architect employed.

**Proposed Timescale:** 30/07/2015
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 centre currently has no input from a dietician to ensure the nutritional value of resident’s meals.

Action Required:
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:
Consultation with dietician has taken place

Proposed Timescale: 22/04/2015

Outcome 18: Suitable Staffing

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received up to date fire training.

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:
All Fire Training for staff completed on 12th February 2015.

Proposed Timescale: 12/02/2015

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Appropriate procedures for the supervision and appraisal of staff, including volunteers, were not in place.

Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately
supervised.

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

All Fire Training for staff completed
The following areas of staff training has been completed:-
  - Elder Abuse in February 2015
  - Lecture – HIQA standards and schedule, policies and procedures – February 2015
  - Cross Infection - March 2015
  - First Aid and CPR Training for all staff commenced on 23rd March and will be completed
  - Training chemical use and handing completed on 25th February 2015
  - Hand Hygiene - completed in February
  - Staff appraisals are now being conducted and updated by person in charge and will be reviewed on an annual basis. There are currently no volunteers working in the centre.

**Proposed Timescale:** 07/05/2015