

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Joseph's Home
Centre ID:	OSV-0000287
Centre address:	Killorglin, Kerry.
Telephone number:	066 976 1124
Email address:	stjosephskillorglin@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sisters of St. Joseph of Annecy
Provider Nominee:	Margaret Lyne
Lead inspector:	John Greaney
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	37
Number of vacancies on the date of inspection:	3

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 November 2016 09:15	07 November 2016 18:00
08 November 2016 08:30	08 November 2016 17:45

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Substantially Compliant	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate
Outcome 11: Information for residents		Compliant
Outcome 12: Notification of Incidents		Compliant

Summary of findings from this inspection

St. Joseph's Home is a 40 bedded nursing home that was purpose built in the 1970s. It is accessed via a long driveway and situated approximately one kilometre from Killrorglin town. The centre is divided into two sections, St. Bridget's (rooms 1 to 12) and St. Patrick's (rooms 13 to 23). Bedroom accommodation comprises 14 single bedrooms, one twin bedroom and eight triple bedrooms.

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was

to focus on the care and quality of life for residents with dementia living in the centre. The provider had submitted a completed self assessment on dementia care to HIQA with relevant policies and procedures prior to the inspection. The judgements from the self assessment and inspection findings are set out in the table above. According to a self assessment, 14 of the thirty seven residents who were living in the centre on the days of the inspection had a formal diagnosis of dementia and another six residents were suspected of having dementia.

Residents had access to general practitioners (GPs) of their choice, and to allied healthcare services including physiotherapy, dietetics, speech and language therapy, psychiatry, dental, chiropody and occupational therapy. Staff provided end of life care to residents with the support of their GP and the community palliative care team to a good standard.

As part of the inspection the inspector also reviewed actions required from the previous inspection to determine if they were implemented. Some of the required improvements were completed, however, some remained outstanding. For example, the risk management policy was not updated as required and some taps on wash hand basins did not comply with infection prevention and control guidance. While training had been provided to staff on fire safety, some were again overdue refresher training.

Work was at near completion stage in the construction of 20 private bedrooms and it was anticipated that they would be available for occupancy in early 2017. This would contribute to the reduction in the number of residents accommodated in multi-occupancy bedrooms. Renovations were also planned for the existing premises.

Overall, residents' care needs were met to a good standard. Staff were kind to residents and appeared to be knowledgeable of their individual needs. As part of the inspection, the inspector spent a period of time observing staff interactions with residents. The inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in a sitting room and dining room. Overall, the inspector observed staff interacting with residents in a positive and caring manner.

Significant improvements were required in relation to medication management. For example, prescriptions were handwritten and were not always clearly legible. When medicines were discontinued, the prescription was not always signed and dated by the GP to denote that the medicine was discontinued. For PRN (as required) medicines the maximum dosage to be administered in a twenty four hour period was not always indicated. The nursing notes for a resident indicated that a PRN psychotropic medicine had been administered on one occasion, however, a prescription for this was not available.

Addition required improvements included:

- staffing required review as there was a periods of time when staff were not visible in circulation and communal areas
- not all staff had received training in responsive behaviour or recognising and

responding to allegations of abuse

- there were inadequate records of the exploration of alternatives to chemical restraint
- personnel records did not always contain verified reference or a full employment history

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

The person in charge visited prospective residents prior to admission to carry out a pre-admission assessment to ensure that the service could adequately meet the needs of the resident.

Residents had access to general practitioners (GPs) of their choice and out-of-hours GP services were also available. Medical notes indicated that residents were reviewed regularly by their respective GPs. A dietician and a speech and language therapist, both of whom were employed by a nutritional supplement organisation, visited the centre to review residents whenever staff identified concerns in relation to the nutritional status of residents. Physiotherapy services were available through the public health service on a referral basis, however, there was only limited access. This was also the case for occupational therapy. Both of these services were accessible from private organisations for a fee. There was good access to palliative care and a member of the palliative care team visited residents following referral to provide guidance on end of life care. A community mental health nurse visited regularly and a psychiatrist was available on a referral basis.

The inspector viewed a sample of residents' records. Each resident had a comprehensive assessment on admission that included biographical details, medical history, and nursing assessments. Common Summary Assessment Reports (CSAR), which detailed the assessments undertaken by professionals such as public health nurses, geriatricians, and medical social workers, were available in the centre for some residents, but not for all.

The inspector primarily focused on the experience of residents with dementia and tracked the journey of a number of residents with dementia. Aspects of care such as wound care, access to activities and restrictive practices in relation to other residents

was also reviewed.

Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as risk of falling, risk of developing pressure sores and for the risk of malnutrition. Care plans were developed for many of the issues identified on assessment. The inspector noted that there were improvements in the care planning process since the last inspection. Many of the care plans were personalised and provided adequate guidance on the care to be provided. However, some care plans continued to be generic and did not provide specific guidance relating to individual residents. In addition to this, some care plans were cluttered in appearance making it difficult to extract relevant information. For example, as residents' conditions changed over time, some of the care plans were updated, however, historic information remained and it was not always clear if this information continued to be relevant. Some care plans did not address issues relevant to the care of each resident. For example, one resident had a percutaneous endoscopic gastrostomy tube (a tube inserted into a person's stomach through the abdominal wall, which allows nutrition, fluids and/or medications to be put directly into the stomach), however, this was not adequately addressed in the resident's care plan.

There were written policies and procedures in place for end-of-life care. Staff provided end of life care to residents with the support of their GP and the community palliative care team. Records indicated that end-of-life preferences were discussed with residents and/or their relatives and these were documented in residents' records. The inspector reviewed the record of a resident that had been considered active end of life. There was evidence of referral and review by the palliative care team. Narrative nursing notes indicated that the resident's needs were being met to a good standard. The care plan in place, however, was not updated to reflect the resident's current end of life status and there was insufficient detail contained in the plan to guide care.

There was a designated end of life room. This was a single bedroom, which was en suite with shower, toilet and wash hand basin. There was also a relatives' sitting room located close by to support family members to remain overnight should they wish to do so. The room had comfortable seating, including a couch and a television. Residents' religious needs were met and mass was held in the centre each Saturday and Sunday, and intermittently throughout the week.

There was a centre-specific medication policy with procedures for ordering, prescribing, storing and administration of medicines.

Medications were supplied in a monitored dosage system and these were checked against prescriptions when supplied to ensure they were correct. The inspector reviewed a sample of stock medications and found that all were in-date, however, there was no system in place for monitoring levels of stock. For example, there were numerous bottles of paracetamol, each of which were labelled for individual use, however, it was obvious that the amount of paracetamol available in the centre was significantly in excess of what was required.

Significant improvements were required in relation to the management of medication. The inspector reviewed a sample of prescription and administration records. The prescriptions were handwritten and were not always clearly legible. When medicines

were discontinued, the prescription was not always signed and dated by the GP to denote that the medicine was discontinued. For PRN (as required) medicines the maximum dosage to be administered in a twenty four hour period was not always indicated. For one resident, the prescription for regularly administered medicines stated that the resident was to be administered a psychotropic medicine daily. There was no time specified for when the medicine was to be given and the administration record indicated that it was administered at different times each day and was not administered on some days. The inspector was informed that the GP had stated that this medicine was to be given as required, however, this was not indicated on the prescription. This medicine was also prescribed in the PRN prescription sheet and there was no maximum dosage specified. On at least one occasion this medicine was administered twice on the one day and it was not clear if this was within the recommended maximum dosage for this resident. The nursing notes for another resident indicated that a PRN psychotropic medicine had been administered on one occasion, however, a prescription for this was not available. It was also found that for one resident the administration record was not signed for a number of medicines on one day and there was nothing to indicate if the resident had refused the medicine, it had been withheld or if it was given but the nurse omitted to sign the administration record.

The inspector reviewed the management of medications that required special control measures. These medications were stored in a locked cupboard within a locked cupboard as required by legislation, and were counted at the end of each shift by two nurses. Medications requiring refrigeration were store appropriately and the fridge temperature was monitored and recorded.

This outcome was judged to be compliant in the self assessment, and the inspector judged it as non-compliant - major.

Judgment:
Non Compliant - Major

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
Inspectors found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse.

There was an up-to-date policy on responding to allegations of abuse. All staff spoken with knew what action to take if they witnessed, suspected or had abuse disclosed to

them. They also clearly explained what they would do if they were concerned about a colleagues behaviour. The person in charge and the provider were also very clear of their role if there were any investigations. The provider was present in the centre each day, including weekends, and met with each of the residents on a daily basis. Training records indicated that most, but not all, staff had received training on recognising and responding to elder abuse.

There were adequate records in place in relation to the management of residents' finances. All residents spoken with said they felt safe and secure in the centre, and felt the staff were supportive. Relatives of residents spoke highly of the care provided by the staff and their caring attitude.

There were policies in place about meeting the needs of residents with responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. Training records reviewed by inspectors indicated that staff were facilitated attend training related to the care of people with dementia and responsive behaviour, however, a number of staff were yet to attend this training.

The inspector reviewed incident reports in relation to resident's behaviour and records confirmed the information given to the inspector that there were no recent significant behavioural related incidents. There were, however, a small number of residents with responsive behaviour that did not escalate to a level that required an incident report. While staff members spoken with were knowledgeable of individual residents behaviour, including how to avoid the situation escalating, this was not detailed in residents care plans. There were also inadequate records to demonstrate that all alternatives were explored prior to administering chemical restraint. And as already discussed under Outcome 1, one resident was administered a chemical restraint and this was no included on any prescription available to the inspector. There were residents who required the use of bed rails and there were risk assessments completed prior to the use of bedrails. There were also safety checks in place when bedrails were in place.

This outcome was judged to be substantially compliant in the self assessment, and the inspector judged it as moderate non-compliant.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

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

Findings:

Residents were consulted about how the centre was planned and run through residents' meetings. A newsletter was developed and circulated in the days following each meeting detailing what was discussed and what actions would be taken in response to issues raised.

Religious preferences were documented and there was evidence that they were facilitated. The centre had a large church. Religious ceremonies were celebrated in the centre, including mass every Saturday and Sunday and intermittently throughout the week. Residents were facilitated to vote in local and national elections.

Inspectors observed staff interacting with residents in an appropriate and respectful manner. Inspectors observed staff knock on bedroom doors before entering. It was obvious that staff knew each resident and residents were comfortable in the presence of staff. There were adequate facilities to allow residents to meet with visitors in private and there were no restrictions on visits. 26 of the forty beds in the centre were in multi-occupancy rooms and 24 of these were in triple bedrooms. The beds in the triple bedrooms were close together and did not support the privacy and dignity of residents. Staff members respected the privacy and dignity of residents as much as possible during care provision, given the limitations caused by the inadequate size of some bedrooms. At the time of the inspection construction of 20 single bedrooms was well advanced, which will support the elimination of three bedded rooms.

Positive interactions between staff and residents were observed during the inspection. As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). An overview of these observation periods is detailed below

Observations were recorded in the sitting room and also in the dining room. The total observation period was 70 minutes, which comprised one 40 minute period and one 30 minute periods. For rating purposes, there were 14 five minute observation periods. Nine scores of +2 were given predominantly when staff were seen to assist residents to the dining room and assist with meals. Staff were also seen to sit with residents and chat with them while making good eye contact. Four scores of +1 were given when there were minimal staff in the sitting room and care provision was task oriented. One score of 0 was given when residents were seen to be left in the sitting room unattended. Visitors were seen to come and go, and all were made welcome by staff and addressed them by name.

There was an activities coordinator who was present in the centre each day. The coordinator was supported by a number of volunteers to assist residents to participate in the programme of activities. Activities included Sonas, bingo, chair exercises, newspaper reading, hand massage, dog therapy, and music.

This outcome was judged to be moderate non-compliant in the self assessment, and the inspector judged it as moderate non-compliant.

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a system in place to ensure that the complaints of residents or their representative were listened to and acted upon. There was a complaints policy that identified the person responsible for managing complaints and also included an appeals process. The complaints procedure was on prominent display in the centre, and summarised in the residents guide.

Throughout the inspection it was clear that residents were familiar with all members of management including the provider, the person in charge, and clinical nurse manager. It was apparent to inspectors that residents would find staff easy to approach with any concerns or complaints.

Inspectors viewed the complaints log that contained details of complaints, the investigation of each complaint, the outcome of the investigation and whether or not the complainant was satisfied with the outcome of the complaint. While the register indicated that not all complainants were satisfied with the outcome of the complaint, there was evidence of learning from these complaints, such as an enhanced assessment of residents at admission.

This outcome was judged to be compliant in the self assessment, and the inspector judged it as compliant.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors found that staff delivered care in a timely and safe manner. During the inspection, residents were seen to receive attention from staff based on their care requirements, for example, responding to the call bell, and supporting people from the sitting area to the dining room or to their own rooms.

Residents appeared to be familiar with staff. At meal times staff were seen to be speaking to residents, and where support to eat and drink was being provided, it was done in a discreet way. Where residents were able to eat themselves they were supported to do so.

An actual and planned roster was maintained in the centre with any changes clearly indicated. The person in charge was supported by a clinical nurse manager. There was a regular pattern of rostered care staff. The staffing complement included the activities coordinator, catering, housekeeping, administration and maintenance staff.

Some relatives spoken with during the inspection felt there were inadequate levels of staff on duty. A review of the roster indicated that the numbers of staff appeared to be adequate. However, the inspector noted that there were periods of time when staff were not visible in circulation areas or in sitting rooms. The provider and person in charge were requested to review staffing to ensure that staff were in a position to supervise residents at all times.

Training records viewed by the inspector indicated that most, but not all, staff members had completed mandatory training in prevention and response to abuse, and manual handling. A number of staff also required refresher training in fire safety. Additional training facilitated and attended by staff included infection control, food safety and hygiene, and wound care.

Inspectors reviewed a sample of staff files and found that some improvements were required. For example, references were not always verified and a full employment history was not available for all staff with satisfactory explanations for any gaps in employment. Satisfactory records in relation to Garda vetting of staff and volunteers were available in the centre.

This outcome was judged to be substantially compliant in the self assessment, and the inspector judged it as moderate non-compliant.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

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:

St. Joseph's Home is a 40 bedded nursing home that was purpose built in the 1970s. It is accessed via a long driveway and situated approximately one kilometre from Killrorglin town. The centre is divided into two sections, St. Bridget's (rooms 1 to 12) and St. Patrick's (rooms 13 to 23). Bedroom accommodation comprises 14 single bedrooms, one twin bedroom and eight triple bedrooms. Communal space comprises a large sitting room, two small sitting rooms and a seating area in a recessed archway. There was also a kitchen with sufficient cooking facilities and a large dining room.

Sanitary facilities comprises eight toilets, each one containing a wash-hand basin; two shower rooms, each one containing an assisted shower, toilet and wash-hand basin; two bathrooms, each one containing an assisted bath, wash-hand basins and there was a toilet in one; two of the single bedrooms were en suite with shower, toilet and wash-hand basin; and there was also a visitors toilet and staff toilet. There were two sluice rooms containing bedpan washers, a sluice sink, and a large ceramic sink. Hand washing facilities were installed in the sluice rooms since the most recent inspection.

Shared bedrooms had suitable screening between the beds to support privacy and dignity during the provision of personal care. However, the triple bedrooms were inadequate in size and it was not possible to provide personal and intimate care without compromising the privacy and dignity of residents due to the proximity of these beds to each other. For example, in order to assist residents out of bed using a hoist it was necessary to move one of the other beds to make adequate space for staff to manoeuvre equipment to transfer the resident to a chair. Construction was well advanced on 20 single bedrooms that would result in the elimination of all of the triple bedrooms, which would then be converted to either single or twin rooms.

The centre appeared to be clean throughout, however, some work was required in relation to the décor as there was significant amount of chipped paintwork. The inspector was informed that this would be addressed through the premises upgrade works. A number of bedrooms were personalised with residents pictures, furnishings and memorabilia, however, there was limited personalisation in the triple bedrooms.

Residents had access to appropriate equipment such as hoists, wheelchairs and speciality beds and mattresses. Maintenance records were available demonstrating a programme of preventive maintenance. Handrails were provided in bath, shower and toilet areas and handrails were provided on corridors.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

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

Findings:

This outcome was inspected in the context of following up on issues identified for improvement at the last inspection. At the last inspection it was identified that, while there was a risk management policy and risk register in place, they did not address the items required by the regulations. For example, it did not address the measures and controls in place to address the risk of abuse; the unexplained absence of a resident; accidental injury to residents, visitors or staff; aggression and violence; and self harm. This matter was not addressed to the satisfaction of the inspector and remained outstanding. It was also identified at the last inspection that the taps on the wash hand basins and in some other areas did not comply with infection prevention and control guidance. New taps had been installed on the wash hand basins in the sluice rooms, however, there continued to be unsuitable taps in other areas, such as the treatment room.

There was an overall review of accidents and incidents, which contributed to a review of the quality and safety of care in the centre. At the last inspection it was identified that staff required training in fire safety and not all staff were knowledgeable of what to do in the event of a fire. A significant programme of training in fire safety had been undertaken since the then and most staff had received training. However, a small number of these staff were now overdue refresher training as it was in excess of one year since that training was provided. Staff members spoken with by the inspector were knowledgeable of what to do in the event of a fire and of how to safely evacuate residents.

Judgment:

Non Compliant - Moderate

Outcome 11: Information for residents

Theme:

Governance, Leadership and Management

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

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

Findings:

At the last inspection it was identified that contracts of care did not include details of fees for additional services. Based on a sample of contracts reviewed, all fees were now stated in the contract.

Judgment:

Compliant

Outcome 12: Notification of Incidents**Theme:**

Effective care and support

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

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

Findings:

At the last inspection it was identified that not all notifications were submitted as required. Based on records reviewed on this inspection the inspector was satisfied that notifications were submitted as required.

Judgment:

Compliant

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:

John Greaney
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 Home
Centre ID:	OSV-0000287
Date of inspection:	07/11/2016
Date of response:	07/12/2016

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 01: Health and Social Care Needs

Theme:

Safe care and support

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

Improvements were required in the care planning process, for example:

- some care plans continued to be generic and did not provide specific guidance relating to individual residents
- some care plans were cluttered in appearance making it difficult to extract relevant information
- some care plans did not adequately address issues relevant to the care of each

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

resident, such as the care of a percutaneous endoscopic gastrostomy tube (a tube inserted into a person's stomach through the abdominal wall, which allows nutrition, fluids and/or medications to be put directly into the stomach).

- care plans were not always updated to reflect the resident's current end of life status and there was insufficient detail contained in the plan to guide care
- while staff members spoken with were knowledgeable of individual residents behaviour, including how to avoid the situation escalating, this was not detailed in residents care plans.

1. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

- The Director of Nursing who commenced employment on November 5th 2016 has arranged for the purchasing of a new Nurse Documentation System called EPIC CARE and will be introduced by the new Director of Nursing/Person In Charge by February 2017. This will provide for a person centred individualised comprehensive nursing assessment, progress and care planning process in St Josephs for all residents which will address the issues found on inspection related to nurse care planning and record keeping.
- Care plans have been reviewed by the Clinical Nurse Manager immediately after the inspection to ensure that care plans are implemented to meet the needs of residents to include the resident with a PEG, End of Life Care Needs and Challenging Behaviour.

Proposed Timescale: Immediate action taken and new system to be introduced by 28 February 2017.

Proposed Timescale: 28/02/2017

Theme:

Safe care and support

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

Significant improvements were required in relation to the management of medication.

For example:

- prescriptions were handwritten and some were not always clearly legible
- when medicines were discontinued, the prescription was not always signed and dated by the GP to denote that the medicine was discontinued
- for PRN (as required) medicines the maximum dosage to be administered in a twenty four hour period was not always indicated
- a psychotropic medicine was prescribed to be given regularly but was given PRN as this was the advice give verbally by a GP
- the nursing notes for a resident indicated that a PRN psychotropic medicine had been

administered on one occasion, however, a prescription for this was not available

- it was found that for one resident the administration record was not signed for a number of medicines on one day and there was nothing to indicate if the resident had refused the medicine, it had been withheld or if it was given but the nurse omitted to sign the administration record.

2. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

A full review of the Drug Management Procedure was undertaken by the new Director of Nursing/Person in Charge who commenced employment on November 5th 2016. All drug kardex were re transcribed and typed by the new Director of Nursing/Person in Charge. They were additionally reviewed and signed by both the residents General Practitioner and the residents Pharmacist. The administration record form has also been introduced making the recording of administration clearer. Maximum doses for PRN's have been determined and recorded. A Drug Management Policy and Procedure has been agreed and implemented into practice and staff will be undertaking Medication Retraining by end of February 2017. All staff have been introduced to the new drug kardex and administration record and are being monitored closely for compliance and maintenance by both the Clinical Nurse Manager and the Director of Nursing. All staff nurses are aware of their scope of practice and their responsibilities regarding drug policy management and procedures. Recording of Medication Errors were completed and staff counselled in relation to same.

Proposed Timescale: completed and ongoing monitoring in place

Proposed Timescale: 07/12/2016

Outcome 02: 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:

Training records reviewed by inspectors indicated that staff were facilitated attend training related to the care of people with dementia and responsive behaviour, however, a number of staff were yet to attend this training.

3. 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:

A complete re training programme for all mandatory training to include care of people with dementia and responsive behaviour will be undertaken in the first half of 2017 and a the training matrix updated accordingly. The new Director of Nursing has provided those staff that had not had training in 2016 with re training in elder abuse and challenging behaviour and all staff working in the home are now competent and confident in their knowledge and practice of care for people with dementia and challenging behaviour.

Proposed Timescale: All staff to receive re training in Elder Abuse, Dementia Care and Challenging Behaviour by March 2017 with full training programme for all other mandatory training sessions being advertised and scheduled for the first six months of 2017 no later than January 31st 2017.

Proposed Timescale: 31/03/2017

Theme:

Safe care and support

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

There were inadequate records to demonstrate that all alternatives were explored prior to administering chemical restraint.

4. 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:

"Chemical Restraint is the use of medication to control or modify a person's behaviour when no medically identified condition is being treated, or where the treatment is not necessary for the condition or the intended effect of the drug is to sedate the person for convenience or disciplinary purposes." HIQA. We are adamant that at no time has any resident in the home been administered any medication which was not to treat an underlying condition and certainly never to sedate, for our convenience or for disciplinary purposes. Many of our residents have psychosis, depressive disorder, severe chronic anxiety and visual and auditory hallucinations. Any medication administered to these residents are prescribed by their GP's for the treatment and management of their underlying chronic medical condition to relieve their distress associated with the symptoms of their disease. Our new person centred care plans will record more comprehensively the need for such interventions but we can assure you that we do not administer chemical restraint and continue to work towards a restraint free environment. There have been no recorded or reported emergency chemical restraints administered in the home for the treatment of acute psychosis or delirium. All behaviours that challenge have been as a result of chronic ongoing disease. The new Director of Nursing has reviewed and implemented policies related to the Management

of Restraint. All residents that have challenging behaviour and require medication to manage the symptoms of same have a care plan in place. These will be further improved upon and enhanced by the new epic care nurse documentation system being introduced by February 2017 by the new Director of Nursing

Proposed Timescale: immediate and ongoing monitoring of same by the CNM and DON

Proposed Timescale: 07/12/2016

Theme:

Safe care and support

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

Training records indicated that most, but not all, staff had received training on recognising and responding to elder abuse.

5. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Those staff that had not yet received training at the time of inspection have received training from the new Director of Nursing in the Detection Prevention and Management of Abuse and all staff have been advised to read the reviewed and updated policy and procedures related to Elder Abuse and Restraint Management. Additionally policies related to Protection of residents rights and Quality of Life have also been introduced and circulated to all staff by the new Director of Nursing.

Proposed Timescale: Completed and re training for all staff by March 2017

Proposed Timescale: 31/03/2017

Outcome 03: 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:

The beds in the triple bedrooms were close together and did not support the privacy and dignity of residents.

6. 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:

The new building will be ready for residents of the triple rooms to move into by February 2017. In doing so there will be no triple bedrooms in St Joseph's thereafter. Maximum occupancy after this date will be double rooms. The New building comprises of 20 single private rooms en suite.

Proposed Timescale: 28/02/2017

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Some relatives spoken with during the inspection felt there were inadequate levels of staff on duty. A review of the roster indicated that the numbers of staff appeared to be adequate. However, the inspector noted that there were periods of time when staff were not visible in circulation areas or in sitting rooms.

7. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

Staff levels of care staff will be increased by January 9th 2017 at both the weekends and the evenings. We have recruited additional care staff and are in the process of them having them Garda Vetted. Once Vetted we hope they will commence work by January 9th. We are placing an additionally two care assistants on from 4-7pm daily seven days a week to assist with the suppers and returning residents to bed. Additionally there will be an additional carer rostered from 8-2pm daily on Saturday and Sundays. The Clinical Nurse Manager and RGN's will ensure that on any given shift staff are managed to ensure there is always a presence of a member of staff circulating in public areas, sitting and dining rooms to ensure that those needing attention can obtain same easily.

Proposed Timescale: 09/01/2017

Theme:

Workforce

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

Training records viewed by the inspector indicated that most, but not all, staff members had completed mandatory training in prevention and response to abuse, and manual handling.

8. 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 staff will receive retraining in all mandatory training sessions in the first half of 2017 but abuse and manual handling will be completed by March 2017.

Proposed Timescale: 31/03/2017

Theme:

Workforce

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

Inspectors reviewed a sample of staff files and found that some improvements were required. For example, references were not always verified and a full employment history was not available for all staff with satisfactory explanations for any gaps in employment.

9. Action Required:

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.

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

A full review of personnel files was undertaken by the new Director of Nursing and Administrator. All files are now complete and in keeping with regulations.

Proposed Timescale: Completed

Proposed Timescale: 07/12/2016

Outcome 06: 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 triple bedrooms were inadequate in size and it was not possible to provide personal and intimate care without compromising the privacy and dignity of residents due to the proximity of these beds to each other.

10. 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:

The new building will be completed and residents will be moved from triple bedrooms by 28 February 2017. This will address the compromised privacy and dignity issues highlighted by the current triple room occupancies. There will be no further triple rooms in St Joseph's Nursing home by 28th February 2017.

Proposed Timescale: 28/02/2017

Theme:

Effective care and support

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

Some work was required in relation to the décor as there was significant amount of chipped paintwork.

11. Action Required:

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

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

A refurbishment plan is in place for the old building and will commence after the move to the new building in March 2017.

Proposed Timescale: March 2017 and ongoing

Proposed Timescale: 31/03/2017

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

The risk management policy did not address the measures and controls in place to address the risk of abuse; the unexplained absence of a resident; accidental injury to residents, visitors or staff; aggression and violence; and self harm.

12. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

The new Director of Nursing in keeping with Regulation 26 (1) has completed a Risk Management Policy, Health and Safety Policy and Health and Safety Statement. She has also completed risk assessments on the Risk of Abuse, Unexplained absence of a resident, accidental injury to residents visitors or staff, aggression and violence and self- harm.

Proposed Timescale: Completed

Proposed Timescale: 07/12/2016

Theme:

Safe care and support

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

New taps had been installed on the wash hand basins in the sluice rooms, however, there continued to be unsuitable taps in other areas, such as the treatment room.

13. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

New taps will be installed on all wash hand basins that are not in keeping with Regulation 27 by 31 January 2017.

Proposed Timescale: 31/01/2017

Theme:

Safe care and support

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

A small number of staff were now overdue refresher fire safety training as it was in excess of one year since that training was provided.

14. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Re training on fire safety management has been undertaken with staff that had not

received training in 2016 by our homes Fire Safety Officer and re training will take place again in the first half of 2017.

Proposed Timescale: Completed and retraining by April 2017

Proposed Timescale: 30/04/2017