Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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:	Helena (Margaret) Lyne
Lead inspector:	John Greaney
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	1

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.

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 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:	To:
30 August 2017 10:00	30 August 2017 18:00
31 August 2017 09:00	31 August 2017 17:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

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 Killorglin town. The centre is divided into three sections, St. Bridget's, St. Patrick's and the recently constructed new wing, St. Mary's.

At the time of the inspection St. Mary's wing had only recently been occupied and accommodated 20 residents in 20 single en suite bedrooms. There were 12 residents in St. Bridget's in four twin and four single bedrooms; and eight residents in St. Patrick's in four twin bedrooms. Due to the transfer of residents to St. Mary's wing, a number of bedrooms in St. Bridget's and St. Patrick's wings were vacant and would remain so until renovations were complete.

Overall, residents' care needs were met to a good standard. Staff were kind to residents and appeared to be knowledgeable of their individual needs. The inspector met with a number of relatives and residents during the inspection and all commented positively on their experience of care at the centre. Numerous visitors were seen to visit the centre throughout the two day inspection and a many of them commented positively on the care provided to residents.

The bedrooms in St. Mary's wing were large, bright and spacious and were furnished to a high standard. The en suites were also large and contained a shower, toilet and wash hand basin. In addition to the bedrooms, there was a large, bright reception area with seating for residents with a view to the outside through large windows and glass paned doors. There was also a large, secure outdoor space that was accessible from different parts of the centre. Plans were in place for the renovation of St. Bridget's and St. Patrick's but this had not yet commenced. Bedrooms in these wings that had previously been used to accommodate three residents, now accommodated two residents allowing more space between beds. St. Patrick's and St. Bridget's appeared to be clean throughout, however, some work was required in relation to the décor as there was significant amount of chipped paintwork. The corridors were narrow and there was limited natural light in comparison to St. Mary's wing.

Improvements were required in relation to governance and management. The programme of audits was not sufficiently comprehensive to provide assurance that the service provided was at the desired standard and was at all times safe. While there were regular medication management audits, there were no audits completed in high risk areas such as infection prevention and control, accidents and incidents, or the environment. Governance and management meetings that had commenced in November 2016 had lapsed. Improvements were also required in relation to training. A number of staff were overdue mandatory training, such as in fire safety, manual handling, safeguarding, and responsive behaviour.

Additional required improvements included:
- the contract of care
- personnel records
- the use of restraint
- fire safety
- care planning.

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 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:
There was a written statement of purpose that contained all of the information required by the regulations.

Judgment:
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:
There were adequate resources to support the effective delivery of care. There was a clearly defined management structure. The provider was based in the centre and was present in the centre on a daily basis, including weekends.

The person in charge reported to the provider and was supported in her role by a clinical nurse manager. There was an annual review of the quality and safety of care,

completed in December 2016. The review contained a detailed action plan and many of the actions had been addressed or were in the process of being addressed.

Significant improvements were required in relation to governance and management. There were deficits in staff training and this is addressed under relevant outcomes of this report. There were regular audits of medication management and required improvements were addressed. There was also a weekly collection of indicators such as admissions, discharges, deaths, hospitalisations, pressure ulcer development and incidents of violence or aggression. However, there was no evidence of this data being used for performance improvement purposes. While it had been identified that improvements were required in care planning and nutritional assessment, this was not documented. These issues, however, were in the process of being addressed. There were no other audits completed in high risk areas such as accidents and incidents, infection prevention and control, the environment, or clinical care.

A governance and management meeting had been held in November that had representation from nursing, care staff, catering, housekeeping and maintenance, however, these meetings had lapsed. The provider person in charge met informally each morning after report, but minutes were not recorded. There were records of staff meetings and meetings with residents and there families to keep them informed of progress in constructing new bedrooms and renovating other parts of the premises.

Judgment:
Non Compliant - Moderate

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:
There was a guide to the centre available to residents. The guide included a summary of the services and facilities available, the terms and conditions of residency, the procedure respecting complaints and the arrangements for visits.

Each resident had a contract of care. The contract set out the services to be provided and the fees charged to residents, including fees for additional services, such as chiropody, hairdressing, and pharmacy. The contract included a small monthly fee for activities, however, it did not clearly specify what the fee covered. Additionally, the contract did not include terms relating to the bedroom to be provided to the resident and the number of other occupants, if any, of that bedroom.

Judgment:
Substantially 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:
There was a person in charge of the centre. The person in charge was a registered nurse and had the required experience in nursing older persons. During the days of the inspection the inspector observed the person in charge interacting with residents and it was evident that residents knew the person in charge. The inspector was satisfied that the person in charge was engaged in the day-to-day governance, operational management and administration of the centre.

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:
Inspectors found that the designated centre had 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.

Other records listed in Schedules 3 and 4 were also maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The residents' directory was available, was continuously updated by staff and contained all of the information required under Regulation 19.

Inspectors saw evidence that the centre was adequately insured in respect of buildings, contents and stock. Injury to residents and loss or damage to residents' property were also covered.

Improvements were required in relation to the maintenance of Schedule 2 documents. For example, there were gaps in the employment history for some staff and there was not a satisfactory explanation for the gaps documented in the curriculum vitae. Additionally, while each employee had the required number of references, there was not always a reference from the most recent employment and they were not always verified. There was an up-to-date vetting disclosure report for all staff in compliance with the National Vetting Bureau Act 2012.

Judgment:
Substantially Compliant

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:
Notifications were submitted as required for when the person in charge was absent from the centre. There are adequate arrangements in place for when the person in charge is absent.

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

Findings:
There was an up-to-date policy on, and procedures in place for, the prevention, detection and response to abuse. Staff spoken with by the inspector were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse. Residents spoken with by the inspector stated that they felt safe in the centre. There were no allegations of abuse. Training records indicated that not all staff had attended up-to-date training on prevention, detection, and response to abuse.

There were adequate records in place in relation to residents' finances. The centre did not act as pension agent for any residents. The centre held small sums of money for safekeeping on behalf of residents and there were adequate records maintained detailing transaction made by or on behalf of residents.

There was a policy in place for working with residents that have responsive behaviour. There were a number of residents in the centre with responsive behaviour. A sample of care plans reviewed by the inspector contained adequate detail in relation to the care of these residents, including triggers and de-escalating tactics. Staff spoken with were knowledgeable of individual resident's behaviour and the most appropriate means to provide care to the resident. However, not all staff had attended up-to-date training on responsive behaviour.

A restraint free environment was promoted. A number of residents had bedrails in place and there was a risk assessment completed prior to the use of bedrails and safety checks while bedrails were in place. While there was evidence of the exploration of alternatives to the use of bedrails, this was not the case for the use of a lap belt. The inspector was not satisfied that all alternatives were explored prior to the use of the lap belt, including an assessment as to the suitability of seating arrangements by an occupational therapist. From discussions with staff it was clear that the lap belt was being used as a falls prevention measure, which is not in compliance with national guidance or with the centre's own policy on the use of restraint.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
There was an up-to-date safety statement that was signed and dated. There was an up-to-date risk management policy that contained all the requirements of the regulations. There was an emergency plan that detailed what to do in the event of an emergency, including the safe placement of residents in the event of a prolonged evacuation.

The inspector reviewed the accident and incident log. There was insufficient evidence available to demonstrate that there was an audit of accidents and incidents for trends as an opportunity for learning to minimise the risk of recurrence. There were reasonable measures in place to prevent accidents with safe floor covering, handrails on corridors and grab rails in showers and toilets. Training records indicated that not all staff had up-to-date training in patient moving and handling.

Suitable fire equipment was provided and records indicated that it was serviced on an annual basis. Records indicated that the fire alarm was serviced quarterly, however, emergency lighting was only serviced annually and not quarterly as recommended. There were daily checks of emergency exits to ensure they were unobstructed, however, the documentation needed to be updated to include additional exits in the new section of the centre.

Training records indicated that a small number of staff required updated fire safety training. Staff members spoken with by the inspector were knowledgeable of fire safety practices, including horizontal evacuation. There were regular fire drills and records were available of what took place during the drill and any learning from the drill. However, most fire drills took place in the same section of the premises and during the daytime. The provider was advised to vary the fire drill procedure and to simulate nigh time drills.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

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

Findings:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The processes in place for the handling of medicines, including controlled drugs, were generally safe and a random sample of controlled drugs counted indicated they were correct. The controlled drug cupboard was a locked cupboard within a locked cupboard. Medication requiring refrigeration were stored appropriately and the fridge temperature was monitored.

Medication administration was observed and staff were seen to adhere to appropriate medication management practices. Medication and prescription charts were legible. Where crushed medications were required this was appropriately prescribed in this format. There were appropriate procedures for the handling and disposal for unused and out of date medicines. At the time of inspection no residents were responsible for their own medication administration.

A system was in place for reviewing and monitoring safe medication management practices. Medication audits were conducted by the clinical nurse manager and improvements were implemented where required. Medication errors were recorded. The pharmacist was facilitated to meet their obligations to residents.

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:
The inspector reviewed the accident and incident log. Based on the records available, all notifications were submitted in compliance with regulations..

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an

individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The inspector was satisfied that residents' health care needs were met to a good standard through appropriate medical and nursing care.

The inspector reviewed a sample of residents' records, which included comprehensive biographical details, medical history and nursing assessments. There were records of comprehensive assessments on admission and at regular intervals thereafter using recognised assessment tools. Care plans were developed based on these assessments. An electronic system of care planning was in the process of being introduced, but had not yet been completed. From a sample of care plans viewed, some were personalised and provided good guidance on the care to be delivered, however, some care plans were generic and did not provide adequate guidance on the care to be delivered. For example, the care plan of a resident that was a high risk of falling did not contain adequate information in relation to mobilisation requirements or assistance required when transferring to and from bed or chair.

Residents had access to GPs of their choice, and to allied healthcare services including dietetics, speech and language, physiotherapy, occupational therapy, chiropody and palliative care. GPs visited the centre and there was evidence that residents were reviewed regularly. Out-of-hours GP services were also available.

There were opportunities for residents to participate in activities. There was a full time activities coordinator. Most activities were carried out by a large group of volunteers who were supervised by the activities coordinator. Activities included live music, Sonas, arts and crafts, exercise classes, and board games

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):

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 Killorglin town. The centre is divided into three sections, St. Bridget's, St. Patrick's and the recently constructed new wing, St. Mary's.

At the time of the inspection St. Mary's wing had only recently been occupied and accommodated 20 residents in 20 single en suite bedrooms. There were 12 residents in St. Bridget's in four twin and four single bedrooms; and eight residents in St. Patrick's in four twin bedrooms. Due to the transfer of residents to St. Mary's wing, a number of bedrooms in St. Bridget's and St. Patrick's wings were vacant and would remain so until renovations were complete.

The bedrooms in St. Mary's wing were large, bright and spacious and were furnished with a double and single wardrobe, chest of drawers, bedside locker with lockable storage, comfortable armchair and bedside table. The en suites were also large and contained a shower, toilet and wash hand basin. Beds in the new wing had been replaced since the last inspection and were now all profiling beds with low-low capability and integrated bedrails. In addition to the bedrooms, there was a large, bright reception area with seating for residents with a view to the outside through large windows and glass paned doors. St. Mary's also contained a nurses' station; secure clinical room; secure clinical dressings room; linen room; storage room; additional staff and residents' toilet facilities; a small dining room that was also used for some activities; sluice room; hairdressers salon; kitchenette with dining table and chairs for residents and their visitors; and seating areas. There was also a large, secure outdoor space that was accessible from different parts of the centre.

Plans were in place for the renovation of St. Bridget's and St. Patrick's but this had not yet commenced. Bedrooms in these wings that had previously been used to accommodate three residents, now accommodated two residents allowing more space between beds. There was suitable screening in these shared bedrooms to support privacy and dignity during the provision of personal care. St. Patrick's and St. Bridget's appeared to be clean throughout, however, some work was required in relation to the décor as there was significant amount of chipped paintwork. The corridors were narrow and there was limited natural light in comparison to St. Mary's wing.

Communal space in the older wings comprised 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 comprised 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.

Residents had access to appropriate equipment such as hoists, wheelchairs and speciality beds and mattresses. There were ceiling hoists in all of the new bedrooms and also in the bedroom designated as the palliative care room. Maintenance records were available demonstrating a programme of preventive maintenance for equipment such as beds, baths, hoists, hoist slings, wheelchairs, and weighing scales. Handrails were provided in bath, shower and toilet areas and handrails were provided on corridors. There was a large chapel that was easily accessible.

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:
There was an up-to-date policy on the management of complaints and the complaints procedure was on prominent display in the centre. There was a nominated person to deal with complaints and an independent appeals process.

The inspector reviewed the complaints log which indicated that all complaints were investigated and the outcome of the complaints process were recorded. The record also detailed whether or not the complainant was satisfied with the outcome of the complaints process.

Residents have access to an advocate and contact details were on display.

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):
No actions were required from the previous inspection.

Findings:
There was an up-to-date policy on the management of end of life. There was evidence of discussion with residents and family members in relation to end of life preferences and this was documented in care plans.

Records indicated that residents care needs were met at end of life to a good standard with appropriate referral and review by palliative care services, where indicated.

The centre had a designated palliative care room, so the option of a single room at end of life was usually available. Family and friends were supported and facilitated to remain with residents at end of life, should they so wish.

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

Findings:
The inspector observed staff interact with residents in a caring and respectful manner. Residents appeared to be familiar with staff and staff were familiar with residents. Where support to carry out activities of daily living was being provided, it was done in a discreet way, however, independence was promoted and residents were not in any way rushed to complete activities.

Based on a sample of staff files reviewed during this inspection the inspector was

satisfied that staff were being recruited and vetted in line with the regulations. All staff nurses had up-to-date registration with An Bord Altranais agus Cnáimhseachas na hÉireann. All new staff had undergone induction training. Volunteers had their roles set out in writing and all were Garda vetted.

The person in charge was supported by a clinical nurse manager. An actual and planned roster was maintained in the centre with any changes clearly indicated. The staffing complement included catering, housekeeping, administration and maintenance staff. Over the course of the inspection, the inspector was satisfied that the needs of residents were being met.

Based on records seen by the inspector improvements were required in relation to staff training. Not all staff had attended mandatory training in fire safety, safeguarding residents from abuse or responsive behaviour. These actions are addressed under relevant outcomes elsewhere in this report. Additionally, not all staff had attended up-to-date training in manual and people handling. All nurses had completed training in relation to medication management.

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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	St Joseph's Home
Centre ID:	OSV-0000287
Date of inspection:	30/08/2017 and 31/08/2017
Date of response:	12/10/2017

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:
Improvements were required in relation to governance and management. For example:
- there were deficits in staff training
- there was an inadequate programme of audits
- governance and management meetings had lapsed.

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

1. 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:
The deficits in staff training are currently being addressed. We have sourced excellent Instructors/Educators and have re informed staff of the necessity to attend the mandatory education scheduled in order to remain active on the roster.
The Fire Training has been completed to date with last training held on the 13th September 2017.
Manual Handling training for all uncertified staff has been scheduled for the 5th October. After this date all staff will be certified.
CPR training is scheduled for the 24th October 2017.After this date all staff will be certified.
Further Care planning education sessions are scheduled for the 1st December as 4 remaining nurses had not received this training.
Responsive Behaviour Training is also being held on the 1st December for staff who are currently uncertified.
Training for safeguarding a vulnerable adult has been booked for 15th November and am also waiting for dates to schedule a staff member to enrol in the train the trainer course for safeguarding a vulnerable adult in order to have our own approved onsite educator. This is to be confirmed by Nursing Homes Ireland.
In order to prevent this deficit reoccurring in staff training the updated Training Matrix will be reviewed quarterly and our sourced educators booked accordingly. This will be budgeted for at the beginning of the Year.

Audit schedule has been commenced with the following to be adhered to:
Medication Audits to continue Monthly.
A Complete Infection Control Audit is currently being completed by Friday the 6th of October 2017 and going forward there will be an infection control audit completed every 3 to 4 months.
There will be a monthly review of Accidents and Incidents with a monthly audit based on Findings. On 14th September 2017 this audit was an audit on falls.
An Audit on Restraints has been completed on the 28th September and restraints will be audited 3 monthly in a plan to move towards a restraint free environment.
Care plan Audits are being commenced on the 4th of October 2017 and will be regularly reviewed and audited in the future.

The governance and management meetings have been recommenced the next one taking place on the 4th October and then continuing on the first Wednesday of each month.

For training, by 31st of December 2017 and then constantly reviewing and updating training Matrix quarterly.
Audit schedule has been put in place as mentioned above.

Proposed Timescale: 31/12/2017

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract of care did not include terms relating to the bedroom to be provided to the resident and the number of other occupants, if any, of that bedroom.

2. Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
The Contract of Care now includes and highlights the specifics of that bedroom allocated to the resident and the occupancy of the room.

Proposed Timescale: 30/08/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract of care included a small monthly fee for activities, however, it did not clearly specify what the fee covered.

3. Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
The contract of care monthly fee has been revised with the details of the fee specified as follows:
Contribution to aromatherapy products, massage lotions, manicure essentials and confectionary.

Proposed Timescale: 30/08/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the maintenance of Schedule 2 documents. For example:
• there were gaps in the employment history for some staff and there was not a satisfactory explanation for the gaps documented in the curriculum vitae
• while each employee had the required number of references, there was not always a reference from the most recent employment and they were not always verified.

4. 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:
All staff CVs have been reviewed and staff have been asked to update CVs where gaps have been noted. All references to date are correct and verified.
To prevent this occurring in future the PIC will be overseeing the CVs and references in order to comply with regulations.

Proposed Timescale: 31/10/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had attended up-to-date training on responsive behaviour.

5. 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:
Staff training on responsive behaviour has been scheduled for the 1st December 2017.In future the training matrix will be reviewed quarterly and education sessions booked accordingly.

Proposed Timescale: 01/12/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector was not satisfied that all alternatives were explored prior to the use of a lap belt, including an assessment as to the suitability of seating arrangements by an occupational therapist. From discussions with staff it was clear that the lap belt was being used as a falls prevention measure, which is not in compliance with national guidance or with the centre's own policy on the use of restraint.

6. 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:
I have sourced a private OT who will be involved in our facility when OT assessments are needed, as the HSE services are not covering voluntary facilities.
The resident with the use of the lap belt was assessed on the 27th September 2017 by a private OT and her report is awaited. Also a trial with alternatives to the lap belt is being scheduled in the coming week with family and staff 1 on 1 involvement.

Proposed Timescale: 22/10/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records indicated that not all staff had attended up-to-date training on prevention, detection, and response to abuse.

7. 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:
On the 15th November 8 staff are booked for safeguarding a vulnerable adult. I am also awaiting a date back on future training for 2018 on abuse for Staff.

Proposed Timescale: 15/11/2017

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:

There was insufficient evidence available to demonstrate that there was an audit of accidents and incidents for trends as an opportunity for learning to minimise the risk of recurrence.

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

Please state the actions you have taken or are planning to take:
An Audit schedule has been commenced with the following to be adhered to:

There will be a monthly review of Accidents and Incidents with a monthly audit based on Findings. On 14th September 2017 this audit was an audit on falls.

Proposed Timescale: 14/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records indicated that a small number of staff required updated fire safety training.

9. 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:
Fire training for all staff has been completed and is up to date as of 13th of September 2017.The training matrix will be reviewed every 3 months and mandatory training booked accordingly.

Proposed Timescale: 01/11/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records indicated that the fire alarm was serviced quarterly, however, emergency lighting was only serviced annually and not quarterly as recommended.

10. Action Required:
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
The electrician was contacted and quarterly services for emergency lighting have been guaranteed for future. Last service was August 2017. The next service will be on the 30th of November 2017.

Proposed Timescale: 30/11/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were daily checks of emergency exits to ensure they were unobstructed, however, the documentation needed to be updated to include additional exits in the new section of the centre.

11. Action Required:
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
The documentation has been updated for review of the emergency exits for the new building St. Marys Unit. This documentation will be reviewed regularly as ongoing construction works will continue; to ensure appropriate daily checking occurs and that documentation is accurate.

Proposed Timescale: 30/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Most fire drills took place in the same section of the premises and during the daytime. The provider was advised to vary the fire drill procedure and to simulate night time drills.

12. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
A fire drill had been scheduled in the new build St. Marys for 28th September at night time and in future the fire drills will be rotated in different sections and between day time and night time. This fire drill could not occur due to programming issues by the contractor and is rescheduled for the 5th October 2017.

Proposed Timescale: 01/11/2017

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:
From a sample of care plans viewed, some were personalised and provided good guidance on the care to be delivered, however, some care plans were generic and did not provide adequate guidance on the care to be delivered. For example, the care plan of a resident that was a high risk of falling did not contain adequate information in relation to mobilisation requirements or assistance required when transferring to and from bed or chair.

13. 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:
All care plans are currently being reviewed and uploaded into our electronic care record system from our previous written care plans. Staff Nurses are being educated in documenting person centred care plans. The audit on the care plans will take place beginning of October and a further study day on care plans has been scheduled for the 1st December.

Proposed Timescale: 01/12/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
St. Patrick's and St. Bridget's appeared to be clean throughout, however, some work was required in relation to the décor as there was significant amount of chipped paintwork. The corridors were narrow and there was limited natural light in comparison to St. Mary's wing.

14. 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:
All the chipped paintwork issues will be resolved by 16th of October 2017. Please find attached maps and timeframes for phases one, two and three refurbishment

Proposed Timescale: 16/10/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training records indicated that not all staff had up-to-date training in resident moving and handling.

15. 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:
A moving and Handling day has been scheduled for the 5th October 2017 and all uncertified staff will attend same. Training Matrix in the future will be reviewed 3 monthly in order to book educators prior to expiration of certificates.

Proposed Timescale: 05/10/2017