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 Unit
Centre ID:	OSV-0000597
Centre address:	Bantry General Hospital, Bantry, Cork.
Telephone number:	027 52904
Email address:	stjosephsward.bgh@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa O'Donovan
Lead inspector:	Geraldine Ryan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
22 July 2014 07:45	22 July 2014 18:00

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

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

Summary of findings from this inspection

This inspection was the sixth inspection of this facility carried out by the Authority, the most recent being a follow up inspection carried out the 14 August 2013. The inspector noted that the one action relating to premises, generated from that inspection, was not completed.

As part of the inspection the inspector met with residents, relatives and staff members. A number of relatives and residents completed questionnaires prior to the inspection and while the feedback was very positive in all aspects of the service provided, there was one reference to staffing levels, particularly in the evening time. This is discussed in further detail under outcome 16: Residents' rights dignity and consultation.

The inspector observed practices and reviewed documentation such as the Statement of Purpose (SoP), residents' contracts of care, care plans, medical records, the menu, accident logs, complaints log, records of residents' finances, policies and procedures, staff meetings, the directory of residents, records of deceased residents, residents' meetings, audits and staff files.

The action plan at the end of this report identifies where some improvements are required to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: Statement of Purpose

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

Theme:
Governance, Leadership and Management

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

Findings:
The Statement of Purpose (SoP) consisted of a statement of the aims, objectives and ethos of the centre and provided a clear an accurate reflection of the facilities and services provided.
It contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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:
On the day of inspection there was evidence of sufficient resources to ensure the effective delivery of care in accordance with the SoP.

Management systems were in place to ensure that the services provided were safe, appropriate to residents' needs, consistent, and effectively monitored. There was a clearly defined management structure that identified the lines of authority and

accountability. The unit was based in a general hospital. The recently appointed person in charge (PIC) reported to an assistant director of nursing (ADON) and the director of nursing (DON).

The quality of care and experience of the residents were monitored and developed on an ongoing basis. The centre had a robust system in place, benchmarked against the Standards, to review and monitor the quality and safety of care and the quality of life of the residents on a regular basis. There was evidence of improvements brought about as a result of the learning from monitoring reviews; for example, findings from a catering audit resulted in the provision of heated plates for serving evening tea.

There was evidence of consultative meetings held with residents and their representatives. These meetings were facilitated by the appointed advocate.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
A comprehensive residents' guide in respect of the centre was available to each resident. A folder containing this information was located at each resident's bedside.

Each resident had a written contract agreed on admission, signed and dated. The contract dealt with the care and welfare of the resident in the centre. The sample of contracts reviewed set out the services provided and the details of all fees being charged to the resident and a description of services that may incur a fee.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The PIC had worked in the centre as a key senior manager prior to her appointment as PIC. She was employed in a full time capacity and had the minimum of three years experience in the area of nursing of the older person within the previous six years.

The PIC ably demonstrated her clinical knowledge and knowledge of the legislation and her statutory responsibilities. She was engaged in the governance, operational management of the centre on a regular and consistent basis. On the day of inspection, it was evident that the centre was managed by a suitably qualified and experienced manager.

The PIC displayed in-depth knowledge of the residents and their backgrounds. Residents and relatives were very familiar with the PIC.

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:
The records listed in Schedules 2 and 5 of the Health Cat 2007 (Care and Welfare of Residents in designated centres for Older People) Regulations 2013 were maintained and in a manner so as to ensure security, completeness, accuracy and ease of retrieval. However, the directory of residents (Schedule 3) required review to ensure that it contained all matters stipulated by the Regulations. Records pertaining to staff records (Schedule 4) also required review to ensure that records reflected the most up to date verification of staff training.

The centre was adequately insured against accidents or injury to residents, staff or

visitors.

Residents, to whom records referred, were able to access them.

The centre had centre-specific policies, underpinned by the overarching suite of Health Services Executive (HSE) policies, which reflected the centre's practice. There was evidence that staff had signed they had read the policies.

There was evidence that the policies, procedures and practices were regularly reviewed to ensure that the changing needs of the residents were met. Policies included up to date best practice guidelines.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
Appropriate arrangements were in place for the management of the centre during the absence of the PIC. The acting KSM, a suitably qualified person with commensurate experience, was the identified person to take on the role of the acting PIC.

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):
No actions were required from the previous inspection.

Findings:
The centre had policies and procedures in place for, the prevention, detection and response to abuse.

Staff training records reviewed indicated that training was ongoing. A number of staff spoken to knew what constituted abuse and were aware of what to do in the event of an allegation, suspicion or disclosure of abuse. Staff were aware of the reporting procedure in this matter. It was evident that processes were in place to monitor systems in place to protect residents and that there were no barriers to residents or staff disclosing abuse.

Robust systems were in place to safeguard residents' money and property. The administrative officer responsible for this process demonstrated the procedures and safeguards in place in relation to residents' finances.

The centre had a policy on, and procedures in place for managing behaviours that challenge. This was duly reflected in the care plans of residents who exhibited a challenging behaviour. There was evidence that training had been provided to staff on this matter.

The centre's policy on the use of restraint gave clear guidance to staff on its' use. Staff had received training of the use of restraint. A sample of residents' records reviewed indicated that any restraint used was subject to assessment, consultation and review. There was evidence that regular checks were performed on residents on whom a restraint was used.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
The centre had up to date policies and procedures relating to health and safety.

A risk management policy inclusive of the specified risks set out in Regulation 26 (1) was available. There was evidence that the risk register contained risks pertinent to the residents accommodated in the centre.

A plan was in place for responding to major incidents or causes of serious disruption to

essential services or damage to property.

It was evident that a clinical nurse specialist (CNS) in infection control regularly reviewed practices in relation to the prevention of infection and provided education to staff. Satisfactory procedures consistent with the standards published by the Authority were in place for the prevention and control of healthcare associated infections.

Arrangements were in place for investigation and learning from incidents and adverse events involving residents. There was evidence that measures were in place to prevent accidents in the centre and grounds. Closed circuit television (CCTV) was used throughout the whole campus and a HSE policy was in place to guide staff on it's use.

While records indicated that training for staff on safe manual handling practices was ongoing, it was difficult to ascertain from records if staff training was up to date. This was addressed and actioned under Outcome 5.
Residents who availed of a hoist had their own designated sling. Residents had access to one standard hoist and one standing hoist. The second standard hoist was being serviced. Two single rooms had an overhead hoist facility installed.

On the day on inspection, all fire exits were unobstructed. There was evidence that fire precautionary checks were performed on a daily basis. Suitable fire equipment was provided. Records reviewed indicated that the fire alarm was serviced on a quarterly basis and fire safety equipment on an annual basis. Procedures for the safe evacuation of residents and staff in the event of fire were prominently displayed throughout the centre. While training for staff on fire prevention was ongoing and records reviewed evidenced this, one staff member had not attended training on fire safety since commencement of employment in February 2014 and it was unclear if all staff had attended refresher training.

Clinical equipment had been checked and serviced.

The centre had a looped security system, located at the exits, which was activated via a bracelet worn by a resident mobilising within the vicinity of the loop.

As part of the application to renew registration, the provider had forwarded to the Authority written confirmation from a competent person that all the requirements of the statutory fire authority were complied with.

Judgment:
Non Compliant - Major

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

Theme:
Safe care and support

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

Findings:
The centre had operational policies relating to the ordering, prescribing, storing and administration of medicines to residents in line with guidance issued by An Bord Altranais agus Cnáimhseachais na hEireann. One of the staff nurses in the centre was a registered nurse prescriber.

The processes in place for the handling of medicines including controlled drugs, were safe and in accordance with current guidelines and legislation. A spot check evidenced that the total of controlled drugs in the secure press corresponded with the documented balanced checked at each staff handover.

Staff were observed adhering to appropriate medication management practices.

An in-house pharmacy serviced the centre. There was evidence that measures were in place for the recording, storing and disposal of out of date medication.

Regular auditing of medication management was carried out. A review of a sample of medication prescription and administration charts indicated that practices employed concurred with the centre's policies on medication management.

A designated medication fridge was securely stored in the clinical room. A record of the daily temperature of the fridge was recorded. The clinical room was clean and well organised.

Each resident had their medication stored in a secured facility by or near their bedside.

Judgment:
Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
A record of all incidents occurring in the centre was maintained and, where required, notified to the Chief Inspector. Notifications and quarterly reports were forwarded to the Authority and within the appropriate timeframe.

Where there had been no such incidents, a nil return was made under section 65 of the Health Act.

A review of the log of incidents in the incident book corresponded with the notifications forwarded to the Authority.

There was evidence that incidents were discussed at incident review meetings held at regular intervals.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
The health care needs of residents were met through timely access to medical treatment. Residents had access to a broad range of allied health care services, located on the hospital site, which reflected their diverse care needs. Services included referral to specialist consultancy in aged care, consultant psychiatry, a consultant in specialist palliative care, clinical nurse specialists in palliative care and infection control, dental care, physiotherapy, occupational therapy, dietetic services, speech and language (SALT), pharmacy, chiropody and optical services. Records reviewed evidenced that up to date reviews and advices by allied health professional were reflected in residents' care plans. There was evidence that the care delivered encouraged the prevention and early detection of ill health.

The assessment, care planning processes and clinical care accorded with evidenced based practice and with the centre's policies/procedures. A sample of care plans reviewed reflected that care was delivered to the resident according to the care plan. It was evident that care plans were reviewed regularly.

Each resident had been assessed immediately before or on admission to identify his/her care requirements and choices.

Residents had access to four general medical practitioners (GPs). There was evidence

that residents/relatives were actively involved in the assessment and care planning process and that care plans were initiated within 48 hours of the resident's admission.

It was evident on the day of inspection that treatment or care was given to residents with their consent. A policy on seeking consent was being updated. The care and treatment of the residents reflected the nature and extent of the residents' dependencies.

There was evidence that the clinical care of residents with co-complex medical needs was based on evidence based practice. Residents with episodic challenging behaviour, a wound, a history of falls, diabetics, a requirement for a sub-cutaneous fluids, weight loss, a smoker, were clinically assessed and had appropriate care planning to guide and inform staff.

Residents who availed of bedrails were supervised and checked on a regular basis and records reviewed indicated this. Practices were concurrent with the centre's policy.

Residents spoken to were aware of their care plans and knew where they were located and stated that care plans had been discussed with them.

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

Findings:
While the design and layout of the centre was in line with the statement of purpose and the centre was homely with sufficient furnishings, fixtures and fittings, the provision of adequate sitting, recreational and dining space separate to the resident's private accommodation continued to be inadequate. A day room (65m2) was also used as:
- a dining room
- a sitting room
- for residents' activities
- a store for equipment and furnishings.

Two dining tables were located in the day room. On the day of inspection, eight

residents dined in this room (five residents at the large table, one resident at the smaller table while two other residents availed of the use of specialised seats). Should all residents accommodated in the centre choose to dine in the day room for their meal, this could not be facilitated due to the size of the room. Other residents dined at their bedside or while in bed.

The premises and the grounds were well-maintained with suitable heating, lighting and ventilation.

The centre was clean and suitably decorated with memorabilia.

The centre's accommodation included five four-bedded rooms and four spacious single bedrooms. The size and layout of the bedrooms were suitable to meet the needs of residents. A sufficient number of toilets, bathrooms and showers were provided for the residents. There were wash hand basins in each bedroom.
Each bedroom could accommodate for each resident:
- a bed
- bedside locker
- wardrobe
- a lockable facility
- a high back chair
- any specialised/assistive equipment or furniture that a resident might require.

Shared rooms provided:
- privacy for personal care by means of curtained screening
- free movement of residents and staff
- free movement of a hoist or other assistive equipment
- free access to both sides of the bed.

The centre was located on the first floor of the hospital. Residents had access to a roof top garden, suitably furnished.

Additional storage for residents' belongings was located in one side of the linen room. Large plastic containers identified with the resident's name, were stored in this room.

There was a functioning call bell system adjacent each to resident's bed, toilets and showers, and adjacent the fire equipment located in the roof top garden.

A separate kitchenette with cooking facilities was serviced from the main kitchen.

While residents had access to equipment which promoted their independence and comfort, storage for such equipment was an issue resulting in two hoists being stored in an unoccupied single bedroom. Records indicated that equipment in the centre was regularly checked by a suitably qualified person.

There was satisfactory provision of hand rails and grab rails throughout the centre. A lift facility aided the residents' movement between floors. Closed circuit television (CCTV) was used and appropriate signage was displayed with regard to the use of CCTV.

There was evidence that a maintenance and décor programme was ongoing. A second store room had recently been converted to an office for the PIC. This provided a private space for the PIC to meet with residents, families or staff. A quiet room was also used as a snoezelen facility for residents' relaxation and as a private room where residents could meet visitors in private. The centre had two sluice rooms, wheelchair accessible toilets and showers, a clinical room, a general office and a seated area at the end of the corridor.

One of the single bedrooms was a designated room for the care of a resident at end of life. Overnight facilities for families were available in this room.
Residents and their families had access to a church and canteen services, located on the ground floor.

Staff changing rooms were provided and were incorporated as part of the larger campus.

There was ample provision of car parking for visitors and staff. The centre was located within walking distance from the town.

Judgment:
Non Compliant - Major

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 evidence that the complaints of residents, families were listened to and acted upon. Records reviewed indicated that all complaints were investigated with responses and outcomes noted.

There were processes in place to implement learning from complaints. A nominated person separate to the person nominated in Article 34 (1) (c) was identified to ensure that all complaints were appropriately responded to. Residents had access to an advocate who visited the centre very regularly.

The complaints procedure was displayed in a prominent place and a copy of the procedure was at each resident's bedside.

The inspector met with residents' relatives who spoke in a very positive manner of the care their relative received.

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:
The provider's self-assessment and overall self assessment of compliance identified a minor non-compliance with Outcome 14 and Standard 16. This minor non-compliance referred to the status of staff training. However, on the day of inspection, on foot of the actions implemented post the self assessment, the inspector deemed the centre complaint.

The inspector reviewed the centre's policy on end-of-life care and noted that the policy was up to date and inclusive of comprehensive guidance for staff. There was evidence that staff had signed that they had read the policy.

There was evidence that residents received care at the end of his/her life which met their physical, emotional, social and spiritual needs. Residents who spoke to the inspector spoke in a positive manner with regard to their care. Some residents expressed that in the event of becoming unwell, they would like to go to the acute services while other residents stated that they would prefer to be cared for by the staff in the centre. There was evidence that residents were aware of and had participated in care planning in relation to end of life care. This information was captured in the residents' care plans. There was evidence that some residents chose not to discuss the matter. The PIC and staff stated how beneficial it was for staff to have up to date information regarding the residents' preferences for care at end of life.

Remembrance events for deceased residents were organised.

Staff training records indicated staff had attended in-house training facilitated by an external trainer, on end of life care and the Irish Hospice Foundation (IHF) programme 'What matters to me'.

Staff had received training on the use of a syringe driver (a mechanical pump used to administer medications) in symptom management. The centre had a syringe driver on site. A procedure to guide staff on the operation of the pump was available. Training on the use of the pump and on other matters pertinent to palliative care was facilitated by the consultant led specialist palliative care team based in the hospital.

Staff were knowledgeable in how to physically care for a resident at end of life and voiced how it was a privilege to be there for the resident and their families at this time.

Religious and cultural practices were facilitated. Residents had the opportunity to attend religious services held in the centre and had access to ministers from a range of religious denominations. The centre's policy included guidance to staff with regard to facilitating and engaging in cultural practices at end of life. Residents had access to a church located on the ground floor.

Family and friends were facilitated to be with the resident approaching and at end of life. The centre had four single bedrooms and five four-bedded rooms. Tea/coffee/snacks facilities and meals were provided for relatives. Canteen services were open from morning to 18:00hrs daily. Open visiting was facilitated. There was some provision of private sitting space. Overnight facilities for families, were available.

There was evidence in residents' care plans that residents had choice as to the place of death. The inspector reviewed a sample of care plans of deceased residents and noted that the residents had timely access to the GP and the out-of-hours service and specialist services. Care practices, plans and facilities were in place so that residents received end-of-life care that met their individual needs and wishes.The sample of residents' end of life care plans reviewed, captured explicit guidance to staff for that resident's care. There was evidence that residents' families were kept informed.

Medication records reviewed indicated that medication management was regularly reviewed and closely monitored by the GP. Reviews by and advices from the specialist palliative homecare team were recorded, signed and dated on the residents' notes.

Documentation indicated that, within the last two years, 8 of 14 deceased residents had their end-of-life care needs addressed without the need for transfer to an acute hospital.

The PIC stated that upon the death of a resident, his/her family or representatives were offered practical information (verbally and written) on what to do following the death and that this included information on how to access bereavement and counselling services.

There was a protocol for the return of personal possessions. Residents' inventories were completed on admission and updated regularly thereafter.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

Findings:
The inspector reviewed the PIC's self-assessment questionnaire and the overall self assessment of compliance with Regulation 20. The PIC had assessed the centre as being non compliant due to the inaccessibility of tea/coffee facilities. This issue had been addressed and measures were now in place to ensure that tea/coffee and snacks were available at all times to relatives. The inspector deemed the centre compliant.

The centre had up-to-date policies on food and nutrition. The environmental health officer (EHO) had recently visited the centre.

A record of staff training submitted to the Authority indicated that staff had attended a broad range of training and that education sessions were ongoing.

The inspector observed mealtimes including breakfast, mid morning refreshments, lunch and evening tea. Breakfast was served from the kitchenette from 07:00hrs. Residents had their breakfast served in bed or at their bedside.

Snacks and hot and cold drinks including prune juices, orange juices and fresh drinking water were readily available throughout the day.

On the day of inspection, staff levels were adequate to meet the needs of the residents during mealtimes. Residents having their meals were appropriately assisted and received their meal in a timely manner.

Assistive cutlery or crockery required for a resident with reduced dexterity was available. Residents had access to an occupational therapist.

The inspector reviewed records of resident meetings and overall the residents were very complementary of the food on offer and it was evident that any issue raised was immediately addressed and the head chef informed. If a resident had a particular request, this was accommodated.

The inspector met with the head chef who confirmed that she communicated regularly with the centre and displayed an in-depth knowledge of residents' dietary requirements, menus, food choices and preferences. The chef regularly met with the dietician to review and evaluate the nutritional content of the food on offer. A recent audit, viewed by the inspector, clearly indicated how the natural enrichment of foods made a significant difference to the nutritional value of the menu on offer to the residents. A two weekly seasonal menu was in operation. The chef produced recently signed off menus which offered choice for lunch and evening tea.

Meals were prepared in the main kitchen and transported to the centre's kitchenette where food was subsequently plated. Up-to-date information on diets and dietary

requirements to guide staff, was available. The head chef attended the residents' meeting when possible and received the minutes of these meetings.

Staff had in-depth knowledge of residents' likes and dislikes and particular dietary requirements.

The centre's policy on communication captured the dining experience. The implementation of pictorial menus was at discussion stage.

There was evidence that choice was available to residents for breakfast, lunch and evening tea. The breakfast choice included a variety of hot and cold cereals, breads, juices or boiled eggs. Residents confirmed that a staff member came around daily informing them of what was on the menu and confirmed that they had a choice in the menu. The menu of the day was displayed on the dining tables and described on the notice board.

A sample of medication administration charts reviewed evidenced that nutritional supplements prescribed for residents by the GP or the nurse prescriber, were administered accordingly.

Lunch was served at 12 noon. The inspector noted that lunch, in sufficient portions, was plated and presented in an appetising manner. While staff informed the inspector that residents could choose to have their meal in the dining room or in their room, the space available in the dining room dictated how many residents could dine in the dining room. One resident informed the inspector that she would prefer to go to the dining room but it was not always possible. On the day of the inspection, 11 residents dined in their bedrooms.

Residents voiced how the lunch was 'tasty', 'delicious' and 'hot'. Choices of desserts were available. Staff were observed assisting residents, particularly residents with a cognitive impairment, in a sensitive and discreet manner. Staff were observed using the mealtimes as an opportunity to chat and interact with residents. The inspector noted a staff member describing the meal to residents and asking residents if they wished to wear protective attire.

The dining room was a communal room which was also used as a sitting room, an activities room and to store equipment. This was discussed in detail under Outcome 12. This communal room was bright and access to the roof top garden was via this room.

Evening tea was served at 16:00hrs. St. Joseph's unit was the only unit on the campus that received the evening tea trolley from the main kitchen in order to serve the evening tea at 16:00hrs. Evening tea trolleys for the other units in the general hospital were transported from approximately 16:40hrs onwards. This is discussed in more detail under Outcome 16: Residents' rights dignity and consultation.

Residents had access to dietetic services, SALT services and occupational therapy and there was evidence of this in residents' care plans. Advices from allied services were incorporated into residents' care plans.

Residents' weights were recorded regularly and it was evident that the documentation of a weight loss/gain prompted an intervention once a concern was identified. There was evidence that residents had a malnutrition universal screening tool (MUST) assessment on admission and regularly thereafter. Records reviewed indicated that staff completed a daily record of residents' nutritional and fluid intake/output and there was evidence that a food chart was in place for residents with a diminished nutritional intake. Care planning, with regard to residents who experienced a weight loss was comprehensive.

The inspector noted information in residents' care plans regarding the recording of blood sugars and corresponding documentation of this information in residents' progress nursing notes.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Minutes of residents' meetings reviewed depicted how residents were consulted on the how the centre was run. Feedback was regularly sought from residents and relatives.

A room was available for residents to receive visitors in private. The centre had a varied activities programme which reflected the diverse needs of the residents. One to one sessions were also available to residents who preferred this.

Residents had access to an i Pad and two residents used the device to skype friends and relatives.

It was evident that residents received care in a dignified manner and that the residents' privacy was maintained at all times.

Residents' communication needs were highlighted in their care plans and practices observed concurred with the centre's policy and demonstrated that staff were aware of the different communication needs of residents.

Residents had access to televisions, newspapers and information on local events.

Visitors were noted coming and going throughout the day of inspection. However, as noted under Outcome 15: Food and Nutrition, evening tea was served at 16:00hrs. St. Joseph's unit was the only unit in the campus that received the evening tea trolley from the main kitchen in order to serve the evening tea to residents at 16:00hrs. Evening tea trolleys for the other units in the general hospital were transported from 16:40hrs onwards. The PIC was asked to review the duty roster to ensure that the time of evening tea was to the benefit of the resident and not at the behest of the duty roster where it indicated that staff came on duty from 08:00hrs and staff levels gradually reduced from approximately 14:00hrs onwards.

Judgment:
Non Compliant - Major

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

Theme:
Person-centred care and support

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

Findings:
The centre had a policy on residents' personal property and possessions. Adequate storage space was provided for residents' personal possessions. Arrangements were in place for the regular laundering of linen and clothing and the safe return of residents' clothing.

The method of recording and co-signing of residents' financial records was in concurrence with the centre's policy.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

Findings:
On the day of inspection there were appropriate staff numbers and skill mix to meet the needs of residents, and to the size and layout of the centre. There was an actual and a planned staff rota.

Training records reviewed indicated that an ongoing programme of staff training was in progress. The education and training provided was reflected in the centre's SoP. While both mandatory and a broad range of training was available to staff, it was difficult to discern from the records, the status of the most up to date training staff had attended. This was captured and actioned under Outcome 5. It was evident that staff had access to education and training to meet the needs of residents. Staff also had access to a practice development co-ordinator and it was evident that the centre had close links with the co-ordinator.

All staff were supervised on an appropriate basis and staff were aware of the centre's policies and procedures.

There were effective recruitment procedures that included checking and recording all required information. The requirements of Schedule 2 with regard to staff recruitment were met.

All relevant members of staff had up-to-date registration with the relevant professional body.

Volunteers were Garda vetted and received supervision appropriate to their role and level of involvement in the centre.

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:

Geraldine Ryan
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 report[1]

Centre name:	St. Joseph's Unit
Centre ID:	OSV-0000597
Date of inspection:	22/07/2014
Date of response:	19/08/2014

Requirements

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

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:
Not ensuring that the directory included the information specified in paragraph (3) of Schedule 3.

Action Required:
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

Please state the actions you have taken or are planning to take:
A patient management system is in place which captures most of the data required under Schedule 3. An additional log book will be established on the unit to capture the remainder of the required data.

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

Proposed Timescale: 30/09/2014

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not ensuring that records pertaining to staff records (Schedule 4) reflected the most up to date verification of staff training.

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 new template for the recording of staff training will be put in place and be available for the Chief Inspector.

Proposed Timescale: 30/09/2014

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:
One staff member had not attended training on fire safety since commencement of employment in February 2014 and it was unclear if all staff had attended refresher training.

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:
The identified staff member has attended informal training. Formal training is arranged for September 2014 where a unit specific fire training session will be delivered to include requirements under Regulation 28(1) (d).

Proposed Timescale: 31/12/2014

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not providing premises which conformed to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

There was inadequate provision of sitting, recreational and dining space other than the resident's private accommodation.

The provision for the storage of clinical equipment was inadequate.

The size of the communal space provided for residents was inadequate to accommodate the 24 residents that could be accommodated in the centre.

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 HSE and HIQA work closely together on the implementation of all standards for our residents in our older person facilities. We meet on a monthly basis and ensure all our standards are implemented appropriately. As regards our infrastructural standard, the HSE has carried out extensive reviews and indeed a work plan of each of our centres and this has been given to the Department of Health. The Department have committed to work closely with us on implementation, but obviously this is finance dependent and we are currently awaiting a response from the Department on when extra Capital funding will be made available to complete this work. We will continue to closely liaise with HIQA nationally on this issue and we will advise local inspectors of any updates available to us.

Proposed Timescale: Ongoing.

Proposed Timescale:

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The time that evening tea was served to the residents was determined by the staff duty

roster.

Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
Additional staff have been recruited and are currently participating in an orientation programme. A review of the roster is planned in order to facilitate increased choice for residents in relation to tea time.

Proposed Timescale: 31/10/2014