Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report Designated Centres under Health Act 2007

Centre name:	St Joseph's Hospital
Centre ID:	537
Centre address:	Ardee, Co. Louth
Telephone number:	041-6583304
Fax number:	041-6853663
Email address:	Brighide.Lynch@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Provider (HSE)
Person authorised to act on behalf of the provider:	Brighide Lynch
Person in charge:	Eileen Dullaghan
Date of inspection:	13 and 14 September 2011
Time inspection took place:	**Start:** 10:00 hrs **Completion:** 19:45 hrs **Start:** 08:00 hrs **Completion:** 17:15 hrs
Lead inspector:	Sonia McCague
Support inspector(s):	Siobhan Kennedy
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **Unannounced**

About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

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.

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.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

St Joseph's Hospital is situated on the outskirts of Ardee town and is within walking distance with a pedestrian footpath leading to shops and business facilities. The centre is signposted from the main road, has a bordered fence and located at the end of a landscaped driveway of mature trees and countryside.

The centre caters for nine male and 15 female residents over 65 years of age requiring short and long-term general nursing care. The centre facilitates four respite persons and can cater for residents with dementia. However "those who have a tendency to wander" is an exclusion criterion.

Resident accommodation is located on the ground and first floor with support services accommodation located in the basement and on the second floor. A passenger lift services all floors in addition to a central main stairwell.

Ground floor accommodation consists of two areas, a male ward and a female unit. The male area accommodates up to nine male residents and has two four-bedded rooms and one single bedroom. Toilets and bathrooms are located in close proximity to residents' rooms and the day/dining room. Other facilities include a sluice room, storage rooms/areas and nurses office.

The female unit accommodates up to 10 female residents and consists of one three-bedded room, one two-bedded area with an adjoining one bedded area that shared the same entrance and four single bedrooms. Toilets and bathrooms are located in close proximity to residents' rooms and the day/dining room. Other facilities in the unit include a nurses' office, smoke room, quiet/visitors' room, hairdressers room, sluice room, storage rooms and storage cupboards. The day/dining area is open planned with a kitchenette for preparing, serving and washing up at meal times and is used throughout the day for snacks.

First floor female accommodation includes one single bedroom and a large room with four beds and a sitting area with a fireplace. Two assistive toilets and one bathroom are located in close proximity to residents' rooms the day/dining rooms, and an activity room. A sluice room and kitchenette are also provided on this floor.

Facilities on the second floor include a meeting area, administration offices and clinical room, family/visitors and residents' kitchenette, staff canteen and a storage room.

Facilities located in the basement include the main kitchen and its auxiliary rooms such as dry foods room, freezer, cold room, kitchen staff room, utility and toilet.

A chapel adjoins the centre and a mass service is available on a weekly basis.

Car parking is available at the front and side of the centre.

A well maintained sensory garden with raised flower beds, garden furniture and a water feature is located to the front on the centre. In addition, a colourfully planted and well maintained enclosed garden is located of the unit with seating areas accessible from the sitting room.

Date centre was first established:			1960	
Number of residents on the date of inspection:			23 (one in hospital)	
Number of vacancies on the date of inspection:			0	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents	3	10	10	0
Gender of residents			**Male (✓)**	**Female (✓)**
			8	15

Management structure

St Joseph's Hospital is operated by the HSE and the nominated person on behalf of the Provider is Brighide Lynch, Area Coordinator, Services for Older People, Louth Local Health office. The Person in Charge is Eileen Dullaghan, Director of Nursing who manages the centre on a day-to-day basis and who reports Brighide Lynch.

Clinical nurse managers, staff nurses, health care assistants, multi-task attendants, catering and domestic staff and administrative staff support the Person in Charge to carry out her duties and responsibilities.

Summary of compliance with 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*.

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007.

Inspectors met with residents, relatives, and staff members over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider, the person in charge and the key senior manager, all of whom had completed the Fit Person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form, supporting documentation and many satisfaction questionnaires which had been completed by residents and relatives.

The findings of this inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are detailed within the report.

The inspector also assessed the action taken by the provider and person in charge in response to the four actions set out in the Action Plan of the report of the previous inspection carried out on 3 March 2010. The required improvements related to the premises and reducing residence in multi-occupancy room and provision of storage, assessment and care plans and maintenance of staff files in line with schedule 2. All areas identified for improvement had been progressed and/or addressed in line with the response and timescales set by the provider.

Inspectors were satisfied that the care provided to residents was of a good standard. The services and facilities outlined in the centres' statement of purpose were reflected in practice and served to meet the needs of residents. Inspectors found the management to be well organized who demonstrated good leadership resulting in substantial compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Inspectors were satisfied that residents and as appropriate their representatives were involved in care planning and in the operation of the centre. Recruitment practices were robust and staff were knowledgeable about residents' needs and preferences and of their duties and responsibilities under the legislation and the Authority's standards. Staff were seen to be approachable, considerate, respectful and caring in their interactions with residents and relatives.

The physical environment was in the main suitable for its stated purpose and was homely, comfortable, and well maintained. Staff promoted the privacy and dignity of all residents in shared rooms and further reviews of the premises was to be carried out in accordance with the Authority's standards by 2015.

Systems and practices in relation to the health and safety of residents', fire safety, the management of risks and storage of personal belongings required further improvements.

These areas for improvement are described under the outcome statements and related actions are set out in the Action Plan at the end of this report.

Section 50 (1) (b) of the Health Act 2007

Compliance with 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*.

1. Statement of purpose and quality management

Outcome 1
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.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

The statement of purpose is comprehensive and meets the requirements of Schedule 1 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

The person in charge demonstrated that she and the managerial team had introduced systems to monitor the quality of care provided and quality of life experienced by residents in the centre. Documentation reviewed by the inspectors confirmed that audits and residents' surveys were carried out. Monthly data was collated on a number of topics for example medication management, slips, trips and falls, and use of restraint devices. Areas for improvement had been identified, communicated to the resident and family members and an action plans put in place to address any shortcomings. A review of resident records confirmed that audit and investigation findings had been discussed and learning communicated to staff and those concerned.

Outcome 3
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.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

The complaints procedure was prominently displayed within the centre and also described in the residents' guide and the statement of purpose. The person in charge was identified as the nominated complaints officer and an appeals process was available through the HSE, complaints officer.

Residents and relatives indicated that they felt confident to approach the person in charge and any of the staff with their concerns at any time and believed that concerns or complaints would be addressed in a timely manner.

2. Safeguarding and safety

Outcome 4
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.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings

Measures were in place to protect residents from being harmed or suffering abuse. At the time of inspection there were no recorded incidents or allegations of abuse.

The person in charge and clinical nurse managers had responsibility for coordinating an in-house training programme that included elder abuse training. Documentation reviewed confirmed that staff had received training from the elder abuse officer on identifying and responding to elder abuse and that the issue had been discussed at staff and resident meetings.

A policy and procedure was in place and staff who spoke with inspectors were knowledgeable on the different forms of abuse and the actions to take in the event of an allegation, incident or suspicion of abuse.

Residents spoken with and those who completed questionnaires confirmed that they felt safe in the centre.

Discussion with an administrator and review of a sample of resident records confirmed that an external audit is carried out annually and robust systems were in place to ensure residents' finances were handled in a transparent manner and in accordance with the Authority's standards.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

Practices in relation to the health and safety of residents and the management of risk promoted the safety of residents, staff and visitors but some improvements were required.

There was a centre-specific health and safety statement in place which had been signed by all staff members and dated 2011. However, the policy was dated 2009. There was also a comprehensive risk management policy with referenced policies to meet the requirements of regulation 31. Despite this, inspectors noted the following risks and found limited recorded evidence of measuring or controlling the following risks:

- a crack in one bath (male floor) was covered with an allevyn dressing and not recorded in the maintenance log
- window handle was missing and the window taped with silver tape in St Mary's day room
- privacy locks not available in all assisted bathrooms
- water temperatures some areas such as in first floor bathroom was over 43^{o}C

- poor ventilation was noted in the smoke room and in rooms occupied by cleaning trolleys and equipment.

Inspectors viewed training records which showed that all staff had not received training in moving and handling. The person in charge acknowledged this and told inspectors that two staff members had recently completed an instructors course in manual handling. These staff members had planned to provide training to staff. Training dates had been confirmed for the next month.

Arrangements were in place for investigating, recording and reporting of learning from serious/adverse events involving residents. This was evidenced by review of a bedrail safety incident. There was evidence that the clinical risk manager met with and supported the safety representatives to discuss the management of risks and ensure audits contributed to risk management.

Measures had been put in place to facilitate the mobility of residents and to prevent accidents. These included the provision of call bells, a passenger lift, handrails in circulation areas, grab-rails in assisted toilets and safe flooring in toilets and bathrooms. The centre had a wide corridor enabling easy access for residents in wheelchairs and those people using walking frames or other mobility appliances. Inspectors observed residents moving independently around the corridors using their individual mobility aids.

The environment was observed to be bright and clean both inside and outside the premises. Appropriate arrangements were in place for the segregation and disposal of waste. Inspectors viewed receipts from an authorised contractor for the removal of clinical waste.

The kitchenettes and main kitchen was clean. There was a food safety management system in place and catering staff who were interviewed had received food handling training.

Personal protective equipment, such as gloves and aprons, and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff who were interviewed demonstrated knowledge of the correct procedures to be followed.

The Authority had received correspondence from the HSE fire officers in relation to statutory fire safety obligations and awaits a declaration from a “competent person” of substantial compliance in this regard. A fire safety risk assessment was carried out 1 July 2011 and a report dated 15 August 2011 was provided to inspectors and discussed with the person in charge and provider. The report outlines 21 fire safety risks rated as high that are recommended to be remedied within three months and 18 fire safety risks rated as medium and recommended to be remedied within 12 months. Inspectors pointed out that many of the identified and reported risks remain outstanding at this time. For example, latches remained on exit doors and hinges to hold doors open remained in place.
The provider told inspectors that she would communicate with her senior managers and fire officers to determine and establish plans to address deficiencies and risks.

There was a fire safety policy and procedures in place. Fire instruction notices were displayed and exit signs and doors were indicated clearly. However, inspectors attempt to exit a double door fire exit on the first floor was unsuccessful as the push bars failed to release the doors. Inspectors sought assistance from staff in this area who were unable to open these doors to exit via this escape route. Further assistance was requested and after many attempts staff managed to release this exit but were unsure if the doors lock deactivated in the event of an alarm. In addition, and despite records to confirm staff attendance at fire training, staff were not able to explain fully to the inspectors the fire evacuation procedures or where fire panels were and some said they had not practiced mock evacuation from the first floor. Further training dates for evacuation were arranged and to take place 20 and 29 September 2011.

Fire safety documentation, including records of fire drills and maintenance of fire safety equipment were reviewed. The person in charge told inspectors that the means of escape were inspected on a regular basis and the outcome recorded. However, inspectors noted that while records to indicate escape routes and lighting were checked, lights along escape routes were not working and the presence of cobwebs along internal escape stairwells and on the final exit door would indicate otherwise. The person in charge addressed this during the inspection and cited they would monitor this regularly.

Fire safety equipment was serviced on an annual basis. However, maintenance reports were not recorded in the fire register. The person in charge contacted the servicing company who provided information to show that the fire alarm and emergency lighting was serviced. However, inspectors noted limited emergency lighting for internal fire exits. The person in charge agreed to refer this matter and another regarding the fire safety status of the central and main stairwell to fire officers.

There was an internal emergency plan in place with emergency procedures and contact numbers.

Outcome 6
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings

There were robust processes in place for the handling of medicines, including controlled drugs. These were assessed as safe, secure and in accordance with current guidelines and legislation. Controlled drugs were stored securely in a double locked cupboard and stock levels were recorded at the end of each shift.

Inspectors had opportunity to observe the administration of medication. Observation of administration practices and discussion with registered nurses confirmed they had an understanding of appropriate medication management and adhered to professional guidelines and regulatory requirements.

As result of a changed practice, the centre had updated the medication policy with current procedures for prescribing, administering, recording and storing of medication. Review of records and observation of practice indicated that these procedures were implemented. There were appropriate procedures for the handling and disposal of unused and out of date medicines.

A medication audit carried out this year which identified shortcomings in practice, the findings from auditing medication management were communicated to nurses and learning brought about changes and improved practices.

The person in charge had maintained a list of the names and a copy of the signatures of all nurses involved in the administration of medication.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

Inspectors found a high standard of evidence-based nursing, medical and allied health care. Within the hospital, residents had access to a range of services that included physiotherapy, occupational therapy, chiropody, and dietetics.

Mental health services and dentistry were also available through GP referral. All residents remained under the care of their own GPs and a total of six GPs visited the centre. The sample of medical records reviewed confirmed that the health needs and medications of residents were being monitored on an ongoing basis and no less frequently than at three-monthly intervals.

Residents had opportunities to participate in meaningful and spontaneous activities, appropriate to their interests and preferences. The care team had daily responsibility for overseeing activity provision. Residents were very complimentary of the weekly arts classes and pointed out artwork displayed along corridors and stairways. Life story accounts and social care assessments had been completed for each resident which was used to inform their activity programme. A resident dog "Cara" was seen playfully interacting with residents in the unit and in the garden. Residents and relatives were satisfied with the range of facilities and activities on offer.

The arrangements to meet residents' assessed needs were set out in individual care plans, which were drawn up with the involvement of the resident and as appropriate his/her representative.

Care records reviewed confirmed that comprehensive person-centred care plans were in place which was subject to regular review. In accordance with policy, a checklist was completed on admission for all residents and review dates for future assessments were recorded. Recognised assessment tools were used to promote health and address health issues. These included risk assessments for falls, moving and handling, nutrition, tissue viability and cognitive functioning. Appropriate measures had been put in place to manage and evaluate care.

Outcome 8
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.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings

A policy was in place for caring for residents at end of life. There were facilities provided for relatives to stay over in the centre with the resident at end of life.

A nurse and a health care attendant had recent training in palliative care and arrangements were in place for additional training to be provided. The person in charge and other staff described very good relations with the local HSE palliative care team. The person in charge told the inspector that staff can access the palliative care team for support and guidance. She also said that they had been involved in the hospice friendly initiative that raised staff awareness and brought about improvements for residents at the end of life and for their relatives.

Arrangements were in place with local clergy to provide regular services in the adjoining chapel and visits to residents unable to attend services.

Outcome 9
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.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings

The inspectors observed breakfast and the lunchtime meal and examined menus. It was evident that residents received a nutritious and varied diet that offered choice. Mealtimes were relaxed social occasion that provided opportunities for residents to interact with each other, and with staff. In the dining areas, table settings for residents included condiments, a selection of drinks and cutlery and crockery with napkins or clothing protectors. The menu was clearly displayed and the inspectors observed staff discussing the menu options with individual residents. Staff were seen dining with and sitting with residents assisting them to eat. Inspectors saw that residents who needed their food pureed or mashed had the same menu options as others and the food was presented in appetising individual portions. Catering staff were informed and knowledgeable about the dietary needs of residents and were aware anybody who required a special diet. Between main meals, staff offered residents a variety of snacks and drinks. Fresh fruit and jugs of fresh water were readily available in communal areas and in residents' rooms. Drinks were refreshed on a regular basis.

Residents were complimentary of the food and company provided at meals.

A copy of the most recent environmental health report was available (September 2010) and the person in charge stated that findings were since remedied.

4. Respecting and involving residents

Outcome 10
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.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

The inspectors examined a sample of the completed contracts of care that had been agreed with residents. While these were comprehensive and set out the overall care and services provided to residents, the fee charged, was inaccurate.

Outcome 11
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.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings

A residents' forum had been established and this provides residents with an opportunity to express their opinions and views and participate in the operation of the centre. Feedback was also encouraged through a suggestion box and the use of resident satisfaction questionnaires, which sought information on a variety of topics such as nutrition, the quality of care, accommodation, activities, staffing and the environment.

Residents interviewed indicated that they were satisfied with the level of privacy afforded them in all aspects of personal care. The inspectors observed that staff addressed residents in an appropriate and respectful way. Staff were seen to knock before entering bedrooms and waited for permission before entering. In the shared bedrooms, curtains were used to ensure that privacy and dignity was maintained.

There were no restrictions on visiting. Residents were able to meet with visitors in their bedrooms or in the visitors' sitting and or dining room. The inspectors observed good interactions between staff, residents and their relatives/visitors and were informed that the managerial staff team speak with each resident on a daily basis. Relatives informed inspectors that they could contact the centre at any time with in a 24 hour period regarding the residents' wellbeing. Residents were given the opportunity to exercise as much choice and control as possible over their own lives and to retain their independence as far as possible, for example, residents participated in maintaining their garden and had brought their dog to the vet for treatment.

Outcome 12
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.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings

Residents' clothes were mainly laundry off site or by relatives. Laundry facilities were available to residents in the centre and those consulted were content with the laundry system in place. Inspectors examined residents' clothing and found that these were adequately assigned with residents' names. There were no recorded or reported complaints regarding residents' clothing/laundry.

Staff had made great efforts to make the environment as homely as possible and each resident had a wardrobe/locker facility. Personal items such as photographs, ornaments, rugs and other personal mementos were mainly within single and twin bedrooms. Shared/multiple-occupancy rooms were more clinical in nature and provided only limited space for residents' personal property and belongings. Inspectors saw many clinical items, creams, lotions and powders were stored on top of lockers which appeared cluttered and this detracted from a homelike and person centred service. While this was not an issue for residents receiving respite care, it may impact on residents receiving continuing care and could be improved. Notwithstanding this, staff had acquired additional storage for residents who had been in the centre for a number of years in the form of a communal cupboard accessible to all off a foyer.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings

The person in charge is a registered general nurse with the required experience in the area of nursing of older people as well as additional training in gerontology,

health and safety, and management. She had worked in older person residential services in Louth since 1984 as a staff nurse, clinical nurse manager and assistant director of nursing and had taken up the director of nursing post in St Joseph's Hospital in 2004. Throughout the inspection process, the person in charge was seen to be competent and committed to the delivery of good quality care to residents informed by open consultation and on-going audit and review of practice. Inspectors also observed that she provided good leadership to staff and demonstrated a strong commitment to person-centred care.

The person in charge's knowledge of the regulations and standards and her statutory responsibilities was sufficiently demonstrated to inspectors throughout the inspection and during the fit person interview. Adequate arrangements were in place to provide cover when the person in charge was off duty or on leave. Inspectors also interviewed the clinical nurse manager two and met with the clinical nurse manager one who deputised in the absence of the person in charge. Both were knowledgeable of the regulations and Authority's standards and of their statutory responsibilities when working as the person in charge.

The management structure ensured sufficient monitoring of and accountability for practice. The person in charge advised that the person nominated to act on behalf of the provider, Brighide Lynch, visited on a six to eight weekly basis and was available by phone as necessary. However, there was no formal record retained of these meetings or of the issues discussed.

All staff who spoke with inspectors were knowledgeable about the needs of residents in their care and had an understanding of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the Authority's standards. Copies of the relevant legislation and standards were available in clinical areas and had been discussed with staff during daily handovers and staff meetings.

Outcome 14

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.

References:

Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

The inspector found that at the time of this inspection, the levels and skill mix of staff were sufficient to meet the needs of residents. The inspector viewed the staff duty rota for a three-week period which indicated that these were the usual arrangements in place within the centre. Annual leave and other planned/unplanned staff absences were covered from within the existing staffing complement.

A clear and transparent policy was in place for the recruitment, selection and vetting of staff. A review of five personnel files indicated that records for staff had been maintained in accordance with the relevant legislation. Vetting arrangements were also in place for volunteers. However, a personnel file for one person working at the centre was not available on the days of inspection.

All qualified nurses were registered with An Bord Altranais and the person in charge had maintained an up to date record of their current professional identification numbers. Care staff employed, had completed or were undertaking training in the care of older people at Further Education and Training Awards Council (FETAC) level five or equivalent. The person in charge had recently completed a training needs analysis and told inspectors that this information would inform future training programmes and the introduction of professional development plans for staff.

A comprehensive training programme was in place and individual staff training records had been maintained. Staff had attended a range of mandatory and other training relevant to the operation of the centre and the needs of residents. Examples of training included moving and handling, nutrition, infection control, palliative care, venepuncture, cardio-pulmonary resuscitation, food hygiene, medication management, house-hold model of care and adult protection. Training in fire safety had been provided this year; however, all staff had not attended training or practical drill/mock evacuations and was unsure of the evacuation procedure in the event of an emergency. This matter is referred to in outcome 5.

Staff notice boards in the canteen and treatment room had posters advertising forthcoming training events, draft policies and other information which promoted communication among staff. In addition, staff communication books, daily reports and staff meetings were in place to further maximise communication within the centre.

Through questionnaires and in discussion with inspectors, staff were variously described as “helpful”, “excellent”, “always available” and “respectful”.

6. Safe and suitable premises

Outcome 15

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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

A description of the premises is set out previously in this report. There were six single bedrooms and a single occupancy room that adjoins a two-bedded room. There were three bedrooms accommodating four persons and one bedroom with three beds. Each bedroom had wash hand basin facilities and sanitary facilities were located close by. Staff had made great efforts to make multiple-occupancy rooms homely. The centre was originally constructed as a house and as previously reported, presented challenges to promoting resident privacy and dignity. The use of multiple-occupancy rooms for high dependency residents has been reviewed and reduced in line with the Authority's standards and requirements within the previous inspection response and timeframes has been actioned to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The provider and person in charge assured inspectors that ongoing review and assessment of the premises would be maintained in line with standard 25 and the six year timeframe from the implementation of the standards.

The environment was bright, clean and well maintained throughout. Residents reported that the centre offered a homely comfortable environment and told inspectors that they enjoyed the lifestyle provided. Communal areas such as dining/dayrooms had a variety of pleasant furnishings and comfortable seating. Staff had researched and implemented a household model of care that promotes a person centred homelike environment in a communal living setting.

Communal facilities included a three lounge/sitting room/dining rooms, a chapel, a recreation/art room, a quiet room and an overnight guest room/kitchenette. There was also a clinical room, a main kitchen, cleaning rooms, and three sluice rooms and staff facilities. The kitchen had separate cleaning facilities, a HACCP system was in place and the Environmental Health Officers records were available and found to be in order.

There was a range of assistive equipment available such as profiling beds, hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. Hoists, the lift and other equipment had been maintained and service records were up-to-date. The service of equipment took place within the past year. A chair lift was in place and due to be serviced to support residents in the event of the passenger lift failure. There was adequate storage available for assistive/auxiliary equipment.

The grounds of the building are well maintained and planted with trees, shrubs and flowers. Garden furniture is provided for the use of residents and visitors. A smoke room is available in the Unit and a smoking area, with tables, chairs and a wooden gazebo is provided to the rear of the building, which is surrounded by a walkway. There are a number of ramps provided for access and egress.

7. Records and documentation to kept at a designated centre

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

References:
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings
** Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's guide

Substantial compliance ☒ Improvements required* ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required* ☐

General records (Schedule 4)

Substantial compliance ☒ Improvements required* ☐

Operating policies and procedures (Schedule 5)

Substantial compliance ☒ Improvements required* ☐

Directory of residents

Substantial compliance ☒ Improvements required* ☐

Staffing records

Substantial compliance ☒ Improvements required* ☐

Medical records

Substantial compliance ☒ Improvements required* ☐

Insurance cover

Substantial compliance ☒ Improvements required* ☐

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings

Practice in relation to notifications of incidents/accidents was satisfactory. The person in charge had a written procedure in place containing a list of all incidents which were required to be notified to the Authority. Changes in management had been notified since the previous inspection. Inspectors reviewed recorded incidents that had occurred in the centre and found that all relevant incidents had been notified to the Chief Inspector as required.

Outcome 18
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.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings

There were two clinical nurse managers who oversee the delivery of care in the centre when the person in charge is off duty on leave. There had been no absences

of the person in charge for such a length that required notification to the Chief Inspector.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, two clinical nurse managers and eight other staff members from other disciplines to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Sonia McCague
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

19 September 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	St Joseph's Hospital
Centre ID:	537
Date of inspection:	13 and 14 September 2011
Date of response:	24 October 2011

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, 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*.

Outcome 5: Health and safety and risk management

1(a) The provider is failing to comply with a regulatory requirement in the following respect:

The Health and Safety policy was dated 2009

1(b) The provider is failing to comply with a regulatory requirement in the following respect: Risks including the following were not recorded or managed appropriately:

- all staff had not received training in moving and handling
- a crack in one bath (male floor) was inappropriately covered with a wound dressing and not recorded in the maintenance log as requiring attention
- window handle missing and window taped with silver tape in St Mary's day room
- privacy locks not available in all assisted bathrooms
- water temperatures some areas such as in first floor bathroom was over 43^{o}C
- poor ventilation was noted in the smoke room and in rooms occupied by cleaning trolleys and equipment

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

1(c) The provider is failing to comply with a regulatory requirement in the following respect:

Written confirmation from a "competent person" that all the requirements of the statutory fire authority have been complied with is outstanding.

A fire safety risk assessment was carried out 1 July 2011 and a report dated 15 August 2011 outlines 21 fire safety risks rated as high that are recommended to be remedied within three months and 18 fire safety risks rated as medium and recommended to be remedied within 12 months. Inspectors noted that many of the identified and reported risks remained outstanding.

All staff had not received fire training with practical evacuation drill, staff were not able to explain fully to the inspectors the fire evacuation procedures or where fire panels were.

Fire safety documentation, including maintenance of fire safety alarm system and emergency lighting was not recorded in the fire register.

Escape routes, final exits and lighting checks were inadequate.

The person in charge referred the matters of limited emergency lighting in internal fire exits and the fire safety status of the central and main stairwell to fire officers, for assurance that they meet the required statutory legalisation.

1 (a) Action required:

Put in place written (current) operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

1(b) Action required:

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Provide training for staff in the moving and handling of residents.

1(c) Action required:

Take adequate precautions against the risk of fire, including the provision of suitable fire equipment.

Provide adequate means of escape in the event of fire.

Make adequate arrangements for detecting, containing and extinguishing fires; giving warnings of fires; the evacuation of all people in the designated centre and safe

placement of residents; the maintenance of all fire equipment; reviewing fire precautions, and testing fire equipment, at suitable intervals.

Make adequate arrangements for the evacuation, in the event of fire, of all people in the designated centre and the safe placement of residents.

Make adequate arrangements for reviewing fire precautions, and testing fire equipment, at suitable intervals.

Provide suitable training for staff in fire prevention.

Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with

Maintain, in a safe and accessible place, a record of all fire alarm tests carried out at the designated centre together with the result of any such test and the action taken to remedy defects

Maintain, in a safe and accessible place, a record of the number, type and maintenance record of fire-fighting equipment

Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

Reference:

Health Act, 2007
Regulation30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: ***1. (a)*** The Health and Safety Statement for St. Joseph's has been correctly dated 2011	Completed
1. (b) Two members of staff have recently completed training as manual handling instructors. They have already completed three training days for staff, and training will be ongoing until all members of staff have	March 2012

had their mandatory training.	
1. (b) A replacement bath has been sourced for the male floor bathroom as the crack in the existing bath cannot be rectified.	December 2011
Broken window handles have been replaced.	October 2011
Locks have been installed in assisted bathroom areas.	Completed
All taps have been fitted with thermostatic controls.	Completed
A new fan has been installed in the resident's smoking room to improve ventilation.	Completed
Awaiting completion of the installation of ventilation in the household storage areas.	December 2011
1. (c) A fire safety risk assessment was carried out 1 July 2011 and a report dated 15 August 2011 outlines 21 fire safety risks rated as high that are recommended to be remedied. Due to the age of the building, HSE Estates have informed us that they are proceeding with the necessary planning applications for St. Joseph's in order to carry out the necessary refurbishment work to meet the risks identified in the fire risk assessment. Following planning permission, HSE Estates will proceed to develop a specification/schedule of works which will enable them to have the work competitively tendered in accordance with normal procurement procedures. Estates have guaranteed funding the cost of the foregoing works from the existing capital allocation for Services for Older People. Fire escape routes are cleaned on a regular basis. Bulbs have been replaced and new lighting has been installed to improve visibility on each stairwell. Weekly checks are completed by the general operative and verification of this is entered into fire log book. We await written confirmation from a competent person regarding compliance with the statutory requirements following completion of the work carried out as above. Fire evacuation training now includes practical evacuation from the first floor.	Work in progress Work in progress April 2012

Fire control training is ongoing. Staff are informed of the procedure to follow in relation to opening the fire exit door on the first floor and the location of fire panels throughout the hospital. All future training sessions will emphasise this information. All staff have signed an action plan to indicate they are aware of the entrance and egress procedure from the exit door on the first floor. The fire evacuation policy has been amended to detail compartmentation evacuation of all people throughout the centre including the safe placement of residents. A contract is in place with an external company in relation to the maintenance and testing of fire equipment and a record of same is maintained. All records detailing work carried out by the contracted company will now be kept in our administration office with the fire log register.	Completed Ongoing Ongoing

Outcome 12: Residents' clothing and personal property and possessions

2. The provider is failing to comply with a regulatory requirement in the following respect: Shared/multiple-occupancy rooms were clinical in nature and provided limited space for residents' personal property and belongings resulting in cluttered locker ledges.
Action required: Provide adequate space for a reasonable number of each resident's personal possessions and ensure that residents retain control over their personal possessions.
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Personal belongings of residents are now kept in the enclosed part of their locker to ensure there is no evidence of clutter on their locker. Additional storage space has been provided for residents where necessary.	 Completed

Any comments the provider may wish to make:

Provider's response:

We would like to acknowledge the courtesy and respect the Health Information and Quality Authority's inspection team showed to residents, visitors and staff throughout the inspection process.

Provider's name: Brighide Lynch
Date: 24 October 2011