Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated Centres under Health Act 2007

Centre name:	St. Joseph's Centre
Centre ID:	0102
Centre address:	Crinken Lane Shankhill Co. Dublin
Telephone number:	01 2823000
Email address:	Brid.omeara@sjog.ie
Type of centre:	☐ **Private** ☒ **Voluntary** ☐ **Public**
Registered provider:	St John of God Hospital Limited
Person authorised to act on behalf of the provider:	Emma Balmaine
Person in charge:	Brid O' Meara
Date of inspection:	2 July 2012
Time inspection took place:	**Start:** 08:00 hrs **Completion:** 19:15 hrs
Lead inspector:	Angela Ring
Support inspector:	Linda Moore
Type of inspection	☐ **announced** ☒ **unannounced**
Date of last inspection:	6 and 7 Feb 2012

About inspection

The purpose of inspection is to gather evidence on which to make judgements about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met 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* under 18 outcome statements. The outcomes set out what is expected in designated centres.

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.*
Outcome 2 *The quality of care and experience of the residents are monitored and developed on an ongoing basis.*
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*
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.*
Outcome 5 *The health and safety of residents, visitors and staff is promoted and protected.*
Outcome 6 *Each resident is protected by the designated centre's policies and procedures for medication management.*
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.*
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.*
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 discreet and sensitive manner.*
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.*

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

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain

The 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 Centre was established in 1961 and was moved to a purpose-built centre in Shankill in 1994. The premises are divided into two units, Carrigeen and Kilcroney, and there are 60 residential places for residents over 65 years of age. There are 58 places for residents with dementia requiring long-term care and there are two beds for residents requiring short-term respite care. There were two residents admitted for respite care on the day of inspection.

There is a day-care service for 120 places which is managed and staffed separately to the residential service. This service is located in a designated area adjacent to the reception, and older people attending this service have separate dining facilities. It was not inspected by the Health Information and Quality Authority (the Authority).

Carrigeen unit has 10 twin bedrooms and 12 single bedrooms, two of the single bedrooms has an en suite toilet, shower and wash-hand basin. There is a separate bathroom with a wash-hand basin and toilet shared between each twin bedroom and the single bedrooms. Living space consists of a residents' lounge, one small conservatory and two enclosed courtyards. There is also a staff station, a treatment room, a sluice room, adequate storage space and two assisted bathrooms, one of which contains a shower as well as a bath.

Kilcroney unit contains four twin bedrooms and twelve single bedrooms, nine of the single rooms have en suite shower, toilet and wash-hand basin. Each bedroom has a wash-hand basin. There is a separate bathroom with a wash-hand basin and toilet shared between each twin bedroom and each single bedroom. There is an open plan high dependency area called Cuain Aobhainn on this unit. It is divided into two twin-bedded areas and a four-bedded area for residents with maximum dependency needs. These residents also have access to an assisted bathroom. Living space includes a small conservatory, a residents' lounge, and two enclosed courtyards. There is a chapel of repose and a waiting room. There are two assisted bathrooms, a sluice room, a treatment room and adequate storage space.

There are two dining rooms separated by a lounge with a kitchenette which are shared by residents from both units. Residents can access the two courtyards from the dining room. An oratory is adjacent to the dining/lounge area.

Other facilities include a large recreation room, a sensory room and a physiotherapy room shared between both units. There is a visitor/family room next to the recreation room. The main kitchen is to the left of the main entrance, and the laundry room, staff changing and dining facilities are to the right of the entrance. The administrative offices are next to the reception area at the entrance.

Car parking is to the front and side of the building.

Date centre was first established:	1994
Date of registration:	26 October 2010
Number of registered places:	60
Number of residents on the date of inspection:	58 + 1 in hospital

Dependency level of current residents as provided by the centre:	Max	High	Medium	Low
Number of residents	37	10	9	2

Gender of residents	Male (✓)	Female (✓)
	✓	✓

Management structure

St. Joseph's Centre is under the auspices of the Order of St. John of God. Brother Laurence Kearns is the Chairperson of the Board of Directors of St. John of God Hospital Limited. The Chief Executive Officer (CEO), Emma Balmaine reports to Brother Kearns and the board of directors, she is the nominated Provider for the service. Brid O'Meara, the Person in Charge, reports to the CEO. The Person in Charge is supported in her role by an Acting Director of Nursing (ADON) and Anthony Maguire, the Administrative Manager who is responsible for non clinical issues such as finance, human resources, maintenance, catering and housekeeping.

The Chaplain, Clinical Nurse Managers (CNMs), nurses and care staff report to the Acting Director of Nursing who reports to the Person in Charge. The catering manager, housekeeping manager, finance officer and maintenance supervisor report to the Administrative Manager who reports to the Person in Charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	7	8	8	6	4	*

* the centre's chaplain, two maintenance staff and a number of volunteers were also in the centre on the day of inspection

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 an unannounced inspection. This inspection took place over one day. As part of the inspection, inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

This was the fourth inspection of this centre by the Authority. A registration inspection had been carried out on 6 and 7 January 2010 with follow up inspections on 10 November 2010 and 6 and 7 February 2012. The purpose of this inspection was to monitor how the provider and person in charge were developing the service to meet the requirements in the Regulations as several areas of significant improvement had been identified at the previous inspection.

The previous inspection highlighted that St. John of God's services were undergoing some re-structuring and re-organisation of its overall services. There had been significant change to the management structure in the previous year with a new named provider and person in charge. The provider was in the final stages of recruiting a new director of nursing and it was expected that this would further strengthen the governance structure and provide additional clinical leadership. The person in charge informed the inspectors that a task group had been recently set up to develop a strategic review and plan for the future direction of the centre in terms of the services to be provided.

Inspectors found that residents were highly dependent with complex dementia related conditions which required significant staffing levels and expertise to meet their needs. Inspectors found that there were insufficient staffing levels and organization of work to meet all residents' personal and social needs.

Although, several areas for improvements were still identified during this inspection, overall, inspectors found that there was a strong, stable governance structure in place. There was a committed management team who had plans in place to address most of the improvements required which are outlined in detail in the Action Plan at the end of this report. Inspectors found that the provider and person in charge were developing several of the policies and documents identified as areas for improvement since the last inspection and these were in draft form and yet to be approved and implemented. Inspectors also found that St John of God Hospital, Stillorgan provided increased support and expertise to St Josephs since the last inspection in areas such as risk management, practice development and infection control.

The areas identified for improvement include:

- Implementing best practice in the use of restraint
- updating the risk management policy, safety statement and emergency plan
- review of staffing levels and skill mix
- putting a system in place to ensure staff have adequate knowledge of measures to protect residents
- monitoring incidents
- updating the complaints policy
- provision of fire training
- provision of modified consistency food at mealtimes
- further development of activities for residents
- updating staff files
- updating the directory of residents and Residents' Guide.

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
Inspectors found that the statement of purpose had been updated to meet with the requirements in the Regulations and included the changes to management in the centre. Inspectors found that the statement of purpose accurately described the service that was provided in the centre. They were satisfied that the service met the diverse care needs of residents, as outlined in the statement of purpose which was kept under review by the provider.

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
Inspectors found that there was some monitoring and auditing of falls which are discussed in Outcome 5.

There was data being collected each month on key quality indicators such as use of psychotropic drugs, use of antibiotics, prevalence of wounds and the use of restraint. The person in charge explained to inspectors that this data had yet to be analysed. While there was a clinical governance system in place, the named provider and person in charge informed inspectors that the board of management had recently approved the development and implementation of a new comprehensive clinical governance system. This initiative will be carried out in conjunction with St John of God Hospital in Stillorgan who have provide support and expertise in areas such as practice development, risk management and infection control. The person in charge

explained that this initiative will address areas such as ongoing monitoring and analysis of incidents, complaints and prevalence of pressure ulcers.

There was no residents' committee within the centre due to the dependency level of residents.

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
Inspectors found evidence of satisfactory complaints management. However, they reviewed the complaints policy and found that although it was displayed in a prominent position, it did not comply with the requirements of the Regulations as it did not clearly state the appeals process.

There were a small number of complaints recorded in the complaints log and there was evidence of action being taken in response to the complaints, the outcome of the complaint and whether the complainant was satisfied.

Relatives told inspectors that they could speak to staff or the person in charge if they were dissatisfied with any aspect of the service.

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
Significant improvements were required to meet with the requirements in this Regulation.

Inspectors found that there were inadequate measures in place to protect residents from being harmed or abused. There were records to indicate that some staff had received training on identifying and responding to elder abuse. However, inspectors found that staff were not fully aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse. Inspectors reviewed the centres

policy on the prevention, detection and response to elder abuse and found that it did not give adequate guidance to staff on the types of abuse and the procedures for reporting alleged abuse and the procedures to follow when investigating an allegation of elder abuse. However, the person in charge gave inspectors a newly revised policy which was waiting for final sign off by the Order before being implemented in the centre.

The administration manager informed inspectors that no money was managed or kept in safe keeping for residents. There was a safe available for belongings if necessary.

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
Inspectors found that improvements were required in relation to the health and safety of residents and the management of risk to promote the safety of residents, staff and visitors.

Inspectors reviewed the emergency plan and found that it was insufficient to guide staff on the procedures to follow in the event of an emergency. The person in charge showed inspectors a newly revised draft procedure which was still in draft form and had yet to be finished and implemented.

There was a health and safety statement in place which had not been updated to reflect the changes in the management structure. The person in charge showed inspectors a new health and statement which was still in draft form and in development. The risk manager from St. John of God Hospital was assisting the person in charge with this initiative.

There was a risk management policy in place, although inspectors found that it did not address all the risks identified in the Regulations such as violence and aggression, assault, residents going missing, self-harm and accidental injuries to residents and staff. The risk management policy did not cover the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

There was one resident who smoked on the day of inspection. Inspectors found that this resident was supervised by staff at all times while smoking to ensure safety.

Improvements were made since the last inspection in developing a system for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents, but further improvements were required. Information on incidents was collected and analysed every three months. Inspectors reviewed the number of incidents that occurred in the previous months and found that there were still a high number of falls. Incident forms were completed for each incident. However, there was inadequate evidence of residents being monitored closely following a fall. Inspectors found that falls' risk assessments were completed for each resident, although care plans outlining the falls preventative strategies were not consistently developed for residents identified as high risk of falls. Despite the measures taken to reduce falls such as the use of very low beds, chair and bed alarms and medication reviews, there was still a significant number of falls in the centre. Inspectors also found that there was inconsistent supervision of residents in communal areas who were identified as high risk of falls which may have been a contributory factor.

In summary, inspectors found that further interventions and analysis was required to reduce the number of falls, to monitor residents post fall and to document the preventative strategies in place.

There was safe floor covering and handrails placed throughout the centre. Chemicals were locked in presses to ensure safety. There were adequate sluicing facilities available. Wall mounted dispensers containing hand sanitising gel were located at the entrance door and throughout the building.

The procedures for fire detection and prevention were in place. Inspectors reviewed service records which showed that the fire alarm system, emergency lighting and fire equipment were monitored. Inspectors read records which showed that regular inspections of fire exits were carried out and the fire exits were unobstructed. There was evidence of two fire drills taking place recently in the centre with the staff on duty. This was addressed since the last inspection.

There were training records which confirmed that some staff had attended training on fire prevention and response in the previous year. However, inspectors found that some staff spoken with were unclear about the procedure to follow in the event of a fire and the use of fire fighting equipment.

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

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

Inspection findings
Inspectors found that a new medication management policy had been developed with the assistance of the practice development nurse in St. John of God Hospital. The policy had not been implemented and was waiting agreement with the general practitioners (GP) in the area. Inspectors reviewed the draft policy and found that it was centre specific and provided guidance to staff.

Inspectors found that medication practices in general were satisfactory. However, some small improvements were required. Medications which required to be crushed were not individually prescribed by the GP and the maximum dose of as required medication (PRN) was not prescribed.

The CNM on duty told inspectors the procedures she followed to administer medication which was in line with best-practice guidelines. There were also records to indicate that nurses had attended training on medication management.

Medications that required special control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Nurses kept a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift.

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

The healthcare needs of residents were met. However, improvements were required in ensuring that residents' care plans were person centred to describe each resident's individual needs and the plan in place to address his/her needs.

Residents had good access to medical and allied health professionals. There was documentary evidence of residents being reviewed by occupational therapy (OT), speech and language therapy and chiropody. The nurse explained that the GPs visited regularly and were available as necessary. There was a system in place for each resident to be reviewed every three months by their GP and there was documentary evidence to support this.

Inspectors reviewed a sample of residents' care plans and noted that although nursing assessments and clinical risk assessments were carried out for residents, their care plans were not always developed to reflect the findings in the assessment. There was evidence of some relatives' involvement in the development of care plans. The care plans were reviewed every month. However, there was no evidence of the care plan being altered to reflect the current status of the resident's condition. There was a record of the resident's health condition and treatment completed on a daily basis, however the entries were not timed which is required as best practice by An Bord Altranais.

Improvements were required in the use of restraint. This was identified at the last inspection and had not been adequately addressed. Inspectors noted that bedrails were used for a large number of residents and lap belts were also used for residents. Improvements were required in providing training to staff to ensure their knowledge was in line with evidence-based practice. The centre's policy on restraint was inadequate and did not provide adequate guidance to staff. Inspectors reviewed files for a sample of residents and found that there was an inadequate assessment completed for the use of bedrails and lap belts and there was inadequate evidence of alternatives being tried prior to their use.

There were a small number of residents with wounds on the day of inspection. Inspectors found that there was an inadequate wound management policy in place. However, the person in charge explained to inspectors that she was in the process of developing and implementing a new wound management policy in line with best practice guidelines and there was documentary evidence to support this. There were currently inadequate assessments completed for each wound and the care plans were not updated to reflect the current plan in place to treat the wound. However, wounds appeared to be well managed despite the deficits in documentation.

Specialist pressure relieving equipment was in use for some residents identified as at risk of developing pressure ulcers. However inspectors found that that there was no system in place to ensure that these mattresses were at the correct setting for each individual resident.

Inspectors found that most residents' weights were recorded each month. While there was no means of weighing frail, immobile residents which posed a potential risk, inspectors found that nutritional risk assessments were used to identify all residents at risk and care plans were in place for some residents. Records showed that some residents were recently reviewed by a dietician and were prescribed supplements where necessary.

Inspectors found that there were a small number of residents with behaviours that challenged on the day of inspection and found that improvements were required. Inspectors observed staff responding well to these residents. However, there was inadequate documentation of the triggers to the residents' behaviour and the strategies used to address the behaviour and meet the residents' needs. Inspectors found that there was an inadequate policy on meeting the needs of residents with behaviour that challenges in place to guide staff. Although some staff had received training on responding to these residents' needs, there were other staff who had not.

Inspectors found that some improvements had been made in the provision of meaningful engagement for all residents with the appointment of a full-time activity coordinator. However, this was an area that required further improvement and development. Inspectors found that there were some opportunities for residents to participate in activities appropriate to their interests and capacities. Activities were facilitated by external agencies and these included exercise to music and singing. The administration manager explained that he was planning to organise for some volunteers to become involved in the provision of activities. However, inspectors observed residents in their bedrooms and in communal settings with little opportunity for meaningful engagement. Inspectors met with the activity coordinator who was

committed to providing activities of interest to residents. However, it was acknowledged by inspectors that this was a challenging role due to the high dependency levels of residents as many were unable to engage in group sessions and required one to one engagement.

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
There were no residents receiving end of life care on the days of inspection. However, inspectors found that there were adequate procedures in place to ensure that appropriate end of life care could be provided when necessary.

There was an inadequate policy on end of life care and the person in charge explained that they planned to develop a new policy on end-of-life care in the coming months. Inspectors saw evidence of a resident being reviewed by the local palliative care team who provided support and advice to the person in charge when required.

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 discreet and sensitive manner.

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

Inspection findings
Most residents dined in the main dining areas for each unit. Inspectors spent time in these rooms at lunchtime and found that the majority of residents required assistance due to their dependency level. Inspectors were satisfied that residents on normal consistency diet received a nutritious and varied diet. Inspectors noted that their meals were hot and well presented. Staff were seen assisting residents discreetly and there were a number of volunteers and relatives who also provided assistance to some residents. Residents confirmed that they enjoyed the food. Inspectors saw residents being offered drinks regularly throughout the day.

Inspectors spoke with the chef and catering manager and found that they had a good knowledge of residents' dietary needs and preferences. The catering manager told inspectors that a dietician had recently reviewed and approved their menus to ensure that they were of optimal nutritional value. Inspectors found that some positive initiatives had taken place at mealtimes since the last inspection where breakfast was served in stages to ensure it was served hot to residents who required assistance to eat.

Inspectors found that improvements were required in the provision of pureed food to make its appearance more palatable and appetising. The majority of residents were on a pureed diet and inspectors found that although the food was served in individual portions by catering staff, some nursing and care staff added gravy to the residents' food and mixed it together which made it look very unappetising.
Staff were not observed asking residents if they liked gravy on their meal. Inspectors also found that residents on pureed diet were not afforded the same choice at mealtimes as residents on normal diets.

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

Inspectors reviewed a sample of resident's contracts and found that they included details of the services to be provided for that resident and the items and services where additional fees would be charged.

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
Overall, inspectors found that staff treated each resident with respect and promoted their privacy and dignity. Staff were observed knocking on bedroom doors and waiting for permission to enter.

Residents were dressed well and their hygiene needs were well met. Inspectors observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents' civil and religious rights were respected. Mass took place on a daily basis. Residents were also given an opportunity to vote in the recent fiscal treaty referendum in the centre. Inspectors found that residents' relatives were consulted with about issues within the centre such as the timing of meals, through the use of questionnaires.

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
Inspectors found that there was adequate space for residents' possessions.

Inspectors met with the laundry staff and found they were aware of the correct procedures to follow and had received training in infection control. There was space for segregation, storage and labelling of clothes. Residents' clothes looked well cared for.

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 was a registered general nurse, had the relevant necessary experience and worked full-time in the centre. The person in charge is supported in her role by an ADON who deputises in her absence and two CNMs. The person in charge was engaging in continuous professional development by completing a master's degree in health services management and attending regular study days. She demonstrated an adequate knowledge of her responsibilities as outlined in the Regulations and Standards and demonstrated a commitment to making improvements in the running of the centre. Several staff spoke described her as being supportive and understanding.

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
As identified in the previous report, inspectors found that there were still inadequate levels of staff on duty during the day. This was highlighted at the previous inspection and although additional staff had been employed at night and during the day, there was still evidence of insufficient staff on duty to meet residents' needs due to their high dependency levels. All staff spoken with informed inspectors that although they enjoyed working in the centre and found the person in charge very approachable, there was inadequate staff on duty. They gave inspectors examples of having insufficient time to give the type of care they would like to give. Inspectors observed staff being very busy throughout the day and they appeared to be focused on task orientated care as oppose to person centred care. Inspectors observed that there was very little time for staff to engage with residents other than providing direct personal care.

Improvements were required in relation to the provision of information on staff files. Inspectors randomly examined the files of staff members and found that they did not contain all of the information required by the Regulations as some did not have three references, proof of identity and evidence that the person was mentally and physically fit for the purposes of the work they perform at the centre. Inspectors reviewed the centre's policy on recruitment and found that it did not meet with the requirements in the Regulations as it stated that two references were required.

Inspectors reviewed the file of a volunteer who worked in the centre and found that although Garda Síochána vetting was obtained, there was no written agreement of the person's role and responsibilities between the centre and the volunteer. The administration manager explained that this was a work in progress but had not yet been addressed.

Inspectors carried out a number of interviews with staff members and found that they were knowledgeable of the residents' individual needs and caring for older people with dementia. Inspectors observed them communicating with residents in a kind and respectful manner.

Inspectors reviewed records which indicated that some staff had received training on manual handling, fire procedures and the prevention, detection and response to elder abuse, medication management and swallowing problems. There was evidence that eight staff were due to attend a course on best practice in caring for those with dementia in the coming weeks. Further training on swallowing problems, nutritional assessment, manual handling, dementia and basic life support was planned for July and August 2012. The administration manager had collated all staff training on a spreadsheet to allow for close monitoring of staff training records. However, inspectors found that all staff had not received the required training in moving and handling.

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

The centre was warm, clean, bright and well maintained throughout.

Inspectors found that the layout of the large open plan multi-occupancy space with eight beds separated by one wall in between the two twin rooms and the four bedded room compromised residents' privacy and dignity. The design resulted in these beds being visible as people walked though the space. Equally people in the corridor could see when curtains were drawn around beds and would be aware that personal care was being given.

There was a secure and accessible outdoor space used by residents and visitors when the weather was fine. There was evidence of staff having access to assistive equipment to meet residents' needs, such as hoists and electric mattresses. Inspectors saw documentary evidence that the hoists were recently serviced.

There was adequate communal space for residents and space for residents to meet their visitors in private if they wished.

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:
Part 6: The records to be kept in a designated centre
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

There was a range of operational policies and procedures which were under review to ensure they were in line with evidenced based nursing practice. However, may of these had not yet been implemented.

Inspectors reviewed the Residents' Guide and found that it did not contain all the information required by the Regulations such as the terms and conditions of accommodation, a standard form of contract for the provision of services and a copy of the most recent inspection report.

Inspectors reviewed the directory of residents and found that it was generally up to date and included the required information for each resident. However, there was no record being maintained of the name and address of any authority, organisation or other body which arranged the resident's admission to the centre. The directory of residents was updated to reflect a resident transfer to hospital.

The provider had an insurance policy which provided extensive insurance cover of the service and complied with the Regulations.

Records relating to health care and staff recruitment are discussed under Outcome 7 and Outcome 14 of this report respectively.

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 was satisfactory. The provider and person in charge were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents.

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 appropriate arrangements in place for the absence of the person in charge. The person in charge and provider were aware of their responsibilities to notify the Authority for a prolonged period of absence but as yet this was not required.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, practice development nurse from St John of God and the administration manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements
The inspectors wish to acknowledge the co-operation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Angela Ring

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

12 July 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report*

Centre:	St. Joseph's Centre
Centre ID:	0102
Date of inspection:	2 July 2012
Date of response:	31 July 2012

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 3: Complaints procedures

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

The complaints procedure did not contain an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Action required:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The complaints procedure as displayed in St. Joseph's Centre has been amended to clearly reflect an Independent Appeals Process, as contained in the Policy and Procedure for Complaints in the Centre.	 31/07/2012

Outcome 4: Safeguarding and safety

2. The provider is failing to comply with a regulatory requirement in the following respect: There was an inadequate policy and procedures for the prevention, detection and response to abuse. There were inadequate arrangements in place for training staff or other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.	
Action required: Put in place a policy on and procedures for the prevention, detection and response to abuse.	
Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Safeguarding Vulnerable People Policy has been reviewed, updated and approved for St. Joseph's Centre and is operational from 1 August 2012. Copy attached. Training has been organised in Safeguarding Vulnerable People for all staff on 20 and 27 September 2012.	 01/08/2012 27/09/2012

Outcome 5: Health and safety and risk management

3. The provider is failing to comply with a regulatory requirement in the following respect:

The health and safety statement was not updated to reflect recent changes in the centre.

The risk management policy did not cover the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

The risk management policy did not adequately cover the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

There was an inadequate emergency plan in place for responding to emergencies.

Some staff did not have adequate knowledge of fire prevention and response.

All staff had not been provided with mandatory training on fire precautions and moving and handling.

Action required:

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

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

Action required:

Put in place an emergency plan for responding to emergencies.

Action required:

Provide suitable training for staff in fire prevention.

Action required: Provide training for staff in the moving and handling of residents.	
Reference: Health Act, 2007 Regulation 30: Health and Safety Standard 26: Health and Safety Regulation 31: Risk Management Procedures Standard 29: Management Systems Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
A review by the Risk Management Advisory Team of Adverse Incident Trends, Risk Assessment findings and current literature will inform operational policy and procedure development requirements relating to the Health and safety of residents, staff and visitors.	02/10/2012
The Risk Management Advisory Team will develop Risk Management system/process policies and procedures and Director of Nursing, in consultation with Nurse Practice Development Coordinator will develop clinical policies and procedures.	31/12/2012
The Risk Management Policy will be developed by the Risk Management Advisory Team, in consultation with Director of Service and key staff, to include identification, management and control of risk.	02/10/2012
The Risk Management Policy will take account of specified risks mentioned in the Regulations.	02/10/2012
An Emergency Plan encompassing all foreseeable emergencies will be completed in consultation with specialist expertise, including infection control, risk management, fire safety, nursing and maintenance.	02/10/2012
Training in Fire Prevention has been scheduled for all staff.	30/09/2012
A manual handling training schedule has been agreed and the Admin Manager and Director of Nursing will be allocated responsibility to oversee and ensure compliance with the schedule.	31/12/2012

Outcome 6: Medication management

4. The provider is failing to comply with a regulatory requirement in the following respect:

Medications which required to be crushed were not individually prescribed by the general practitioner (GP) and the maximum dose of as required medication was not prescribed.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management
Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
The updated medication policy is now complete and attached. Following a scheduled meeting with our pharmacy staff on 1 August 2012, the policy will go live on 6 August 2012.	06/08/2012
Education sessions for registered staff nurses have begun with two more education sessions scheduled to take place.	31/08/2012

Outcome 7: Health and social care needs

5. The person in charge is failing to comply with a regulatory requirement in the following respect:

Each resident's needs were not set out in an individual care plan developed and agreed with the resident.

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 8: Assessment and Care Plan Standard 11: The Residents' Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will be commencing a total review of the residents individual care plan in August 2012. In a bid to standardise the care plans and to ensure there is sufficient detail to guide staff in the delivery of appropriate care, an individualised care plan will be devised using the Dublin Mid Leinster Minimum Data Set, in conjunction with the resident, where applicable, and with the resident's specified person. This will be followed with education sessions for all care staff relating to person-centred care and good documentation of care. Each nurse will continue to be assigned named residents and they will be responsible for the review of these care plans every three months at a minimum.	 31/08/2012 30/11/2012

Outcome 7: Health and social care needs

6. The provider is failing to comply with a regulatory requirement in the following respect: There was no system in place to ensure that pressure relieving mattresses were at the correct setting for each individual resident. The use of restraint was not in line with evidence-based practice. The records maintained for residents with behaviours that challenge were not in line with evidence-based practice. The records maintained for residents with wounds were not in line with evidence-based practice.
Action required: Provide a high standard of evidence-based nursing practice.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 21: Responding to Behaviours that is Challenging	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Resident's weights are recorded on a monthly basis. Following this recording, the pressure relieving mattresses are set according to the weight of the resident, also, at monthly intervals. This will be reflected in the new wound care/pressure area prevention policy which is almost complete and will be ready for implementation by 31 August 2012. With the assistance of the staff in the Callan institute, we are revising our entire approach to restraint and the management of challenging behaviour. We will be developing policies in line with evidenced based best practice, followed by education sessions for all of our staff directly involved with residents care. Our revised wound care policy is almost complete and will be implemented by 31 August 2012.	 31/08/2012 30/11/2012 31/08/2012

Outcome 8: End of life care

7. The provider is failing to comply with a regulatory requirement in the following respect: There was an inadequate policy on end-of-life care.	
Action required: Put in place written operational policies and protocols for end-of-life care.	
Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: A committee has been formed in St. Joseph's to develop written operational policies and protocols for End Of Life Care. Policies to guide staff in the event of an emergency, to 'allow natural death' and 'do not attempt resuscitation' are being prioritised with a target date of 17 September 2012.	 30/09/2012

Outcome 9: Food and nutrition

8. The person in charge is failing to comply with a regulatory requirement in the following respect: Pureed food was not appetising in appearance. Residents on pureed diets were not afforded a choice.	
Action required: Provide each resident with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.	
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The menus in St. Joseph's Centre have recently been reviewed and approved by a dietician as being of optimal nutritional value. All residents, including residents on pureed diet, are now offered a choice of meal at mealtimes, consistent with their individual requirements. Gravy is now only served as required, e.g. with roast dishes, and is not poured over meals unnecessarily.	 31/07/2012 31/07/2012 31/07/2012

Outcome 14: Suitable staffing

<table>
<tr><td colspan="2">9. The person in charge is failing to comply with a regulatory requirement in the following respect:

There was an inadequate number of staff on duty to meet residents' needs.

The roles and responsibilities of volunteers working in the designated centre were not recorded in a written agreement between the designated centre and the individual.</td></tr>
<tr><td colspan="2">Action required:

Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.</td></tr>
<tr><td colspan="2">Action required:

Set out the roles and responsibilities of volunteers working in the designated centre in a written agreement between the designated centre and the individual.</td></tr>
<tr><td colspan="2">Reference:
Health Act, 2007
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications
Regulation 34: Volunteers
Standard 20: Social Contacts</td></tr>
<tr><td>Please state the actions you have taken or are planning to take with timescales:</td><td>Timescale:</td></tr>
<tr><td>Provider's response:

Our day staff has been increased since the recent inspection. There is now one extra care staff member on each shift from 8.00 am to 8.00 pm. We are planning interviews for staff nurses following a recent advertising campaign.

A full review of our dependency levels and related staffing needs and skill mix is being commenced with the assistance of the Director of the Callan Institute. Terms of reference have been agreed with an anticipated timeline for receipt of report the end of September 2012.

The roles and responsibilities of pre-existing Volunteers working in St Joseph's Centre are now clearly identified in a written agreement between St Joseph's Centre and each pre-existing Volunteer. These new agreements having been sent to each volunteer for signing, a copy of which is then to be returned to the Volunteer Coordinator and retained on file. A number of these have already been returned.</td><td>

31/08/2012

30/09/2012

31/08/2012</td></tr>
</table>

10. The provider is failing to comply with a regulatory requirement in the following respect:

The staff files did not meet with the requirements in the Regulations.

Action required:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.

Reference:

Health Act, 2007
Regulation 18: Recruitment
Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
An audit of all staff files in St Joseph's Centre is to commence, the purpose and function being to identify any document failures that might exist on a staff members files. The Audit to be conducted using Schedule 2 of the Regulations as the benchmark for required documentation in each Staff Member File. This Audit will be completed by the end of August 2012.	31/08/2012
Any gap in documentation identified as a result of the above mentioned Audit will be rectified by end of October 2012	30/10/2012
All recruitment to St. Joseph's Centre will be compliant with Schedule 2 of the Regulations.	31/07/2012
Our recruitment procedures are being amended to reflect this adherence.	31/08/2012

Outcome 15: Safe and suitable premises

11. The provider is failing to comply with a regulatory requirement in the following respect:

The layout of the multi-occupancy area did not meet the needs of residents.

Action required:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The St. Joseph's Architect will attend St. Joseph's Centre on 1 August 2012 to meet with the person in charge and review the current multi-occupancy room, in an attempt to address the physical design of the area. Any suggestions made will be presented to management team for further discussion and appropriate action.	 01/08/2012 31/10/2013

Outcome 16: Records and documentation to be kept at a designated centre

12. The provider/person in charge is failing to comply with a regulatory requirement in the following respect:

The directory of residents did not meet the requirements in the Regulations.

The Residents' Guide did not meet the requirements in the Regulations.

Action required:

Ensure that the directory of residents includes the information specified in Schedule 3 of the Regulations.

Action required:

Produce a Residents Guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.

Reference:

Health Act, 2007
Regulation 23: Directory of Residents
Standard 32: Register and Residents' Records
Regulation 21: Provision of Information to Residents
Standard 1: Information

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A review of the directory of residents has commenced to ensure compliance with Schedule of the Regulations. This project will be completed by 31 October 2012. Further to the merger of St Joseph's Centre with St John of God Hospital Limited, together with recent changes in key management positions and continuing review of the policies which guide St Joseph's Centre, in particular the statement of purpose and function, it is intended to revise the existing Residents' Guide. It is intended that the new Residents' Guide will fully reflect and capture all the recent changes to St Joseph's Centre together with policy and procedural changes soon to be introduced and be in full compliance with the Regulations. The new Residents Guide to be printed and available to all resident's by 1 January 2013.	 31/10/2012 01/01/2013

Any comments the provider may wish to make:

Provider's response:

St Joseph's Centre appreciates the advice and input from the Authority and welcomes the findings of this latest inspection. We acknowledge that we still have some way to go yet and are striving to achieve full compliance as outlined in our action plan. We look forward to the appointment of our new Director of Nursing at the end of August and this will assist the service to continue to develop in line with the core values of St John of God Hospitaller Services which are – Hospitality, Compassion, Respect, Justice and Excellence. The Board and Executive of St John of God Hospital Ltd fully support the Management Team in St Joseph's in achieving these standards.

Provider's name: Emma Balmaine, Chief Executive
Date: 31/07/2012