Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	St Joseph's Hospital
Centre ID:	0284
Centre address:	Mount Desert Lee Road Cork
Telephone number:	021-4541566
Email address:	carevillage@bonsecours.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Bon Secours Health System Ltd
Person authorised to act on behalf of the provider:	Pat Lyons
Person in charge:	Nollaig Broe
Date of inspection:	9 July 2013
Time inspection took place:	**Start:** 09:00hrs **Completion:** 18:40hrs
Lead inspector:	Caroline Connelly
Support inspector(s):	Ann O'Connor
Type of inspection	☒ **announced** ☐ **unannounced**
Number of residents on the date of inspection:	65 which included one resident in hospital
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of 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*.

This inspection report sets out the findings of a monitoring inspection, in which 18 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☒
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☒
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☒
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☒
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☒
Outcome 18: Suitable Staffing	☒

This was the fourth inspection of St Joseph's Nursing Home by the Health Information and Quality Authority's Regulation Directorate. This monitoring inspection was announced and took place over one day. As part of the monitoring inspection inspectors met with residents, relatives, the person in charge, a number of Bon Secours sisters, the clinical nurse managers (CNM), the hospital accountant/facilities coordinator, staff nurses, care staff, catering staff, cleaning staff, administration, activities coordinator and other members of staff. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The findings of the inspection are set out under 18 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*. Residents' comments are found throughout the report.

A new clinical nurse manager had been appointed since the last inspection and she underwent an interview with the inspectors. She displayed a good knowledge of the standards and regulatory requirements and was found to be committed to providing quality person-centered care to the residents.

The person in charge and the provider were very proactive in response to the actions required from the previous inspections and the inspectors viewed a number of improvements during the inspection which are discussed throughout the report. The inspectors found the premises, fittings and equipment were of a very high standard, were clean and well maintained and there was appropriate use of colour and soft furnishings to create a homely environment. There was a good standard of décor throughout.

The collective feedback from residents and relatives was one of great satisfaction with the service and care provided.

The person in charge was involved in the day-to-day running of the centre and was found to be easily accessible to residents, relatives and staff. There was evidence of individual residents' needs being met and the staff supported residents to maintain their independence where possible. Community and family involvement is encouraged with residents saying their relatives/visitors felt welcome at any time and were able to dine with residents in the restaurant whenever they wished.

The inspectors found that improvements were required in medication prescribing and administration, involving residents and relatives in their care planning process and there were a small number of improvements required in relation to documentation and emergency planning.

These improvements as outlined below are required to comply 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*. The provider was required to complete an action plan to address these areas.

These improvements included:

- medication management
- completion of the residents registrar
- emergency planning
- involvement of residents and relatives in residents care plans.

Section 41(1)(c) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Leadership, Governance and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1

There is a written statement of purpose that accurately describes the service 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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The statement of purpose and function was viewed by the inspectors; it described the service and facilities provided in the centre. It identified the staffing and numbers of staff in whole time equivalents and also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose was found to be very comprehensive, easy to follow and met the requirements of legislation.

Outcome 2

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Contracts of care had been implemented for residents and were seen by the inspectors. The contracts were comprehensive, were agreed within a month of new admissions and they stipulated details of the service provided, the fee to be paid and what was included and excluded from that fee. The contracts were stored in residents' care plan files but the fee page was stored in the office on some contracts seen, it would be best practice to keep the contract and fee page stored together.

Outcome 3
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The Person in Charge is Nollaig Broe who is the Hospital Manager/Director of Nursing. She reports to the CEO who is the nominated provider. There is also a management team that support the provider and person in charge, which includes a hospital accountant/facilities coordinator, clinical nurse manager and members of the Bon Secours order.

The person in charge is an experienced nurse and manager and is actively involved in the day-to-day organisation and management of the service. She had a good reporting mechanism in place to ensure that she is aware and kept up-to-date in relation to the changing needs of the residents. Staff, residents and relatives all identified the person in charge as the one with the overall authority and responsibility for the service and residents and relatives identified her as being easily available to all.

She was found to be committed to providing quality person-centered care to the residents and had made numerous changes and improvements within the centre. She was found to be very proactive in her response to all the actions required from previous inspections and displayed a commitment to be compliant with legislative requirements.

Outcome 4
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:
Regulations 21-25: 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:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Residents' 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 * ☒

The directory of residents was found to be missing a number of details which included the name of the GP and telephone number of the GP and where the resident was admitted from.

Staffing Records

Substantial compliance ☒ Improvements required * ☐

Medical Records

Substantial compliance ☒ Improvements required * ☐

Insurance Cover

Substantial compliance ☒ Improvements required * ☐

Outcome 5
The Chief Inspector is notified of the proposed absence of the person in charge from the designated 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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There has been no period of time when the person in charge was absent for 28 days but the staff were aware of their obligation to notify the Authority if this were to happen.

The person in charge works fulltime and is supported in her role by three clinical nurse managers (CNM1) who cover for the person in charge in her absence. A new CNM had taken up post since the last inspection and the inspectors met with her during the inspection and she was found to be committed to her management and clinical role within the centre.

The clinical nurse managers work opposite each other so there is always a senior nurse on duty during the week and at the weekends and senior staff nurses take charge of the centre at night time. There is also a team of Bon Secours sisters who provide pastoral care and an advocacy service to the residents.

Theme: Safe care and support
Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility

to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

One of the CNMs is the trainer for elder abuse and is undertaking update training for staff. The inspectors viewed records maintained of staff's attendance at elder abuse training. Staff interviewed informed the inspectors that they had attended training on elder abuse and held discussions in order to increase their awareness and understand clearly their responsibilities. The staff interviewed demonstrated an awareness of what to do if an allegation of abuse was made to them and told the inspector there was no tolerance to any form of abuse in the centre.

Any allegations of abuse in the past had been reported to the authority in line with regulatory requirements and appropriate action taken.

Residents' finances were safeguarded by the policy on the management of residents' accounts and personal property. The inspector saw a record of all money and valuables kept in the safe for safekeeping for residents, along with a list of all withdrawals or lodgements which were signed and properly receipted. The records were also the subject of audit.

Outcome 7
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Clinical risk assessments are undertaken including fall risk assessment, nutritional assessments, pressure sore prevention, and assessments for dependency, continence, moving and handling and restraint.

The inspector viewed the centre-specific safety statement which was revised March 2013. There was a risk management policy which covered clinical and non-clinical risk. Comprehensive risk assessments were viewed which identified hazards, dealt with risks to the environment and set out actions and controls to manage these. There is a health and safety risk management committee which is led by the person in charge with representation from all areas of the service. The committee meets regularly and minutes of the meetings were seen by the inspector for meetings held in April 2013. A departmental/ward health and safety check is undertaken on all areas on a regular basis the inspector saw records of the check held in April 2013.

The fire policies and procedures viewed by the inspector were centre-specific. The fire safety plan was viewed by the inspector and found to be very comprehensive. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the building. Fire training and fire evacuation training was provided to staff on various dates in 2012 and 2013. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The inspector examined the fire safety register with details of all services carried out which showed that fire fighting, fire safety equipment and fire alarms had been serviced in April 2013 and May 2012.

The inspectors observed staff abiding by best practice in infection control with regular hand washing, and the appropriate use of personal protective equipment such as gloves and aprons. Hand sanitisers were also present at the entrance to the buildings and throughout staff and resident areas.

There is an emergency plan in place and the inspectors were informed that the Bon Secours hospital could be used to provide accommodation for residents in an emergency situation if they had to evacuate the hospital and were unable to return. However, this was not formalised and outlined in the emergency plan nor did the plan detail action to be taken in the event of the kitchen or laundry not being in operation and other emergency situations.

Outcome 8
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

Action(s) required from previous inspection:

Ensure if medications are being crushed this is prescribed and signed by the doctor.

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.

Inspection findings

Medications were seen to be stored and disposed of appropriately in line with An Bord Altranais Guidance to Nurses and Midwives on Medication Management (2007). The inspectors noted that some medication practices were not in keeping with national guidelines and regulations.

The inspectors observed nurses undertaking medication rounds and administering the lunch time medications. The inspector observed medications being administering from the medication signing sheet and not from the original medication prescription sheet as is required by legislation. The prescription sheet was present in the folder along with another prescription sheet for PRN medication but this was not consulted during the medication round. The current system in use was cumbersome due to the different prescription charts and medication times and route were not clearly identified on the prescriptions.

It was not clearly identified on the prescription charts and signed by the GP for all residents who required their medications crushing as required by legislation. Maximum doses were not written on all PRN medications which could lead to errors.

A local pharmacist provides a comprehensive service and is available on a daily basis. The pharmacist also provides training and undertakes audits of the medication processes.

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. Nurses were checking the quantity of medications at the start of each shift. The nurses displayed a good knowledge of medications and the procedure outlined for administration.

Outcome 9
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspectors saw that there was a comprehensive log of all accidents and incidents that took place and that these were reported to the Chief Inspector as required by legislation. The inspectors reviewed these notifications prior to and during the inspection and was satisfied with actions taken.

The person in charge has notified the Regulation Directorate of all other incidents and quarterly returns as required by Article 36 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge had completed audits on resident accidents and incidents. These, along with audits of medication, are presented in a report and in graph format to the best practice committee on a quarterly basis. The results of these audits were also discussed with all staff to heighten awareness and identify trends; the inspectors were informed that there have been changes and improvements made to practice as a result.

The person in charge was in the centre every day and constantly monitored the quality of care the residents received and spoke with all residents daily to establish their experience of the services. There is an active residents committee in place which allows residents to raise issues and bring forward their experiences and suggestions of the care; this will be discussed further in Outcome 16.

There was evidence of other regular audits taking place which included audits on project safety, audits in the catering department, care planning, cleaning audit, audit on infection prevention and control and a laundry audit. As discussed in Outcome 7 audits on the premises were undertaken using health and safety checklists. The management team were able to describe the learning from these audits which led to changes and improvements made to practice as a result.

The inspectors were satisfied that the whole area of clinical risk audit and review of the quality and safety of care was of a high standard throughout the centre and recommended continual development of same and further auditing of clinical care.

Outcome 11

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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

Action(s) required from previous inspection:

Resident's assessed needs are to be set out in an individual person-centred care plan developed and agreed with the resident and/or their representative, and other staff as appropriate and reviewed on a three monthly basis or sooner as required by the changing needs of the resident.

Inspection findings

Residents may retain their own general practitioner (GP). However, most of the residents are under the care of one GP practice that offers a regular service three days per week and more frequently if required. Medications are reviewed by the GP and with the pharmacist at least every three months and sooner if required.

This was seen on the medication charts and in the medical notes. An on-call doctor service is used for out-of-hours cover if required.

Residents had good access to multidisciplinary services. Fit for life provided physiotherapy on a group basis and also on an individual basis for the residents and detailed assessments and plans were seen in some residents notes. Occupational therapy (OT) is assessed through the public health nurse and visits are made to residents in-house. Optical services are provided by a visiting optician who completes the assessments in the centre. Those who wish to attend a local optician are supported and accompanied either by a relative or a staff member. Dental services were provided via a local hospital dental clinic. A chiropodist visits regularly and residents are seen as needed. Speech and language services and dietician advice is received from a dietician from a nutritional company who provides advice and training for staff and assesses and recommends treatments for residents. The hairdresser visits twice weekly and more frequently as required and provides a full hairdressing service in the hair and beauty room which residents told the inspector they really enjoyed. Beauty therapy is provided weekly which included nails, waxing and massage.

On the last inspection the inspector noted that there was not a comprehensive system and policy on obtaining consent from residents for photographs or restraint. On this inspection that was rectified and consent forms were completed in residents records.

There were continual improvements in residents' records since the last inspection. The residents now had a plan of care for their social and recreational needs and the assessments and care plans were more person-centred. However, there continued to be no evidence of the care plan being developed and agreed with the resident or their representative (in the case of residents who had cognitive impairment).

The inspectors were satisfied to note that staff were working towards a restraint-free environment and had made numerous changes to practice to ensure bedrails were being used as a last resort. Bed and chair alarms had been purchased. Records of the residents being restrained were viewed by the inspectors and a full assessment for the need for restraint had been completed.

There is a comprehensive activity programme in place and the inspectors spoke with the activity coordinator. The programme includes bingo, fit for life, music afternoons, social outings, cinema evenings, beauty care and hairdressing, skittles, bowls, quizzes, newspaper reading and discussion and individual activity programmes. The Bon Secours sisters, the chaplain, volunteers and the activities coordinator visit residents on a one-to-one basis in their bedrooms to provide pastoral and spiritual care, music therapy, newspaper reading, listening and talking to each resident that does not wish to partake in activities.

There are a number of volunteers from the community who come in and spend time with the residents. Other volunteers run a trolley service for the residents allowing them to buy toiletries, sweets and minerals.

Outcome 12
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

St Joseph's Hospital is a purpose-built residential service with two further rooms converted to single ensuite rooms in 2011 increasing the bed capacity to 65 beds. The main entrance leads onto a spacious reception and lobby area with a range of service rooms including a hairdressing/beauty room, a restaurant, activities/therapies room and a lovely chapel.

The residential area of St Joseph's contains six units branching out from a central reception and administrative area. Each unit is self-contained and includes a living room/dining room, a kitchenette and sluice room and has access to courtyard gardens. Accommodation is provided in 55 single and five double bedrooms, all bedrooms are spacious and have ensuite toilet, shower and wash-hand basin facilities except for one bedroom. Assisted bathrooms are available throughout and extra toilet facilities are found close to the dining room and other public areas.

The premises is brightly decorated and very well maintained with a high standard of décor and furnishings throughout. It is surrounded by well kept landscaped grounds, which are broken up by a number of attractive seating and patio areas. The day of the inspection was particularly warm and there were numerous doors open out into the gardens from bedrooms, dayrooms and corridors. Residents were seen to move freely around the centre and many were seen sitting or walking in the gardens and grounds.

There was appropriate assistive equipment available to meet the needs of the residents, such as electric beds, hoists, pressure-relieving mattresses, wheelchairs and walking frames. Hoists and other equipment were all maintained and service records viewed by inspectors were up-to-date. The centre employs maintenance personnel who respond to all the day-to-day maintenance of the centre and equipment. The waste management system was well managed and secure, and staff demonstrated awareness of correct bags to use for domestic and clinical waste and contracts were in place for waste removal.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There is a policy and procedure for making, investigating and handling complaints. The policy is displayed in the main reception area and is also outlined in the statement of purpose and function and in the Residents' Guide. The person in charge informed the inspector that complaints are discussed at staff meetings and informed changes to practice.

The providers and person in charge conveyed a good understanding of the purpose of a complaints procedure. In practice, records of complaints and their outcomes were kept, with an independent appeals person nominated. Staff interviewed conveyed an understanding of the process involved in receiving and handling a complaint. The inspector saw that complaints, actions taken and outcomes were documented in accordance with best practice.

Residents and relatives told inspectors that they had easy access to the person in charge and the nurses on duty and felt they could report any complaints or concerns to them and these would be dealt with.

Outcome 14
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Residents' religious needs were facilitated with the provision of the centre's large chapel for quiet reflection and prayer. Residents were seen using the chapel and confirmed to the inspectors their enjoyment of same. Mass and rosary are held daily and there is a facility for residents to receive these ceremonies in their bedrooms via a TV channel if they do not wish to or are unable to attend the chapel. The Bon Secours sisters provide pastoral care to residents and relatives on a daily basis and at end of life. Residents of other religious denominations are visited by their ministers as required.

Care practices and facilities in place were designed to ensure residents received end-of-life care in a way that met their individual needs and wishes and respected their dignity and autonomy. Individual religious and cultural practices were facilitated and family and friends were facilitated to be with the resident end of life stage. Overnight facilities were made available for relatives' use if required.

Outcome 15
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspectors saw that breakfasts were served in the units but residents who are able to dine in the restaurant at lunchtime and tea time as do staff and visitors. Many of the residents were seen to enjoy their lunch and tea in the bright, relaxed central dining room where tables were set with condiments, appropriate cutlery and floral displays. Residents expressed satisfaction with the food, menu choice and the dining experience. Some residents choose to have their meals in their bedrooms or in the dining areas in the units but the majority of residents came to the dining room. Mealtimes were relaxed and unhurried with many residents remaining at the table after their meal to socialise. There was a gentleman playing the piano in the dining room throughout the lunch time which created a very relaxed atmosphere. This gentleman is a volunteer who comes in regularly to play for the residents at lunch time and is very well received by all.

The catering is provided by an external company and the manager of the catering company and the person in charge spoke with the inspectors of the themed days they have throughout the year the last one being an American theme day for the fourth of July which was enjoyed by all. There is a facility provided for any relatives who wish to use the restaurant to have refreshments or meals with their relatives and the inspectors saw relatives using and enjoying the service.

The catering manager meets with the residents on admission to establish likes and dislikes and he has good links with the nursing staff to establish special diets. He also conducts surveys with residents to establish their satisfaction with the food.

Residents told inspectors they had access to drinks and snacks throughout the day. Water coolers were seen in the dining room and jugs with water were seen on bedside tables in residents' rooms.

Residents' weight charts viewed by inspectors showed that weights were recorded monthly and changes in weight were reported and discussed with staff. Nutritional assessments were completed and dietary advice was received from a dietician at a nutritional company. Nutritional supplements were available for residents who required additional nutritional assistance.

Outcome 16
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors observed that residents' privacy and dignity was respected and promoted by staff. Adequate screening was provided in shared bedrooms and staff knocked before entering residents' bedrooms to ensure their privacy and dignity was maintained while personal care was being delivered.

The manner in which residents were addressed by staff was seen to be appropriate and respectful. Residents had a personal phone in their bedroom allowing for privacy in making and receiving phone calls.

Regular surveys are undertaken with residents and relatives to establish their views on the service this was discussed under Outcome 10.

There is a residents' committee in place that meets every two months; it is run by the activities coordinator. This committee allows residents the opportunity to have a say in the running of the centre, share their views and discuss relevant items such as smoking, menus, policies, practices and activities. The inspector saw minutes of these meetings and the progress made from one meeting to the next, issues discussed included meals and mealtimes, activities and outings. Residents also informed the inspector that they can talk with the nurses and the person in charge whenever they need to.

One of the nursing staff runs a relative's support/advocacy group for relatives to ask questions and identify issues and any changes they feel are required.

There are suggestion boxes available for residents' comments and suggestions and the person in charge and CNM's talk to the residents and relatives daily and look for any issues or areas that require addressing.

There is an open visiting policy in operation and this was confirmed by residents and relatives. Residents and relatives commended staff on how welcoming they were to all visitors' and a visitors' room was available for their use if they wished to visit in private.

Outcome 17
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors saw, and residents confirmed, that they were encouraged to personalise their rooms. Residents' bedrooms were large, very comfortable and many were much personalised with residents' pictures and photos.

Plenty of storage space was provided for clothing and belongings and lockable space was also provided. All bedrooms except for one have an ensuite shower and toilet facility, again with plenty of storage space for toiletries.

The system in place for managing residents' clothing was effective. The personal laundry is undertaken in the centre's laundry. Following residents' agreement all clothing was discreetly marked on admission. This helped to ensure clothing from the laundry was returned to the correct resident. The laundry was organised and was staffed to meet the needs of the residents. Residents stated that they were happy with the way their clothing and personal belongings were managed in the centre.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
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

Action(s) required from previous inspection:

The actions from the previous inspection were completed.

Inspection findings

Residents and relatives spoke positively regarding staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity.

There was a clear management structure and staff were aware of the reporting mechanisms. Staff demonstrated a clear understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care to the residents.

Centre-specific, evidence-based recruitment policies and procedures were reviewed by inspectors. Staff records showed that staff were recruited and inducted in accordance with best practice.

On the day of inspection, there were four nurses on duty in addition to the person in charge, two CNM's and 12 care staff. The inspectors reviewed staffing rotas, staffing levels and skill mix and were satisfied that there were sufficient staff on duty to meet the needs of the residents. There was a low turnover of staff evident and staff confirmed they enjoyed working in the centre.

The inspectors found that there was a good level of appropriate training provided to staff and staff were supported and encouraged to keep their knowledge base current. One of the staff is a moving and handling instructor and has provided moving and handling training for staff. Staff had completed mandatory fire and evacuation training, elder abuse training and training in infection control.

A large number of the care staff have completed Further Education Training Awards Council (FETAC) level 5 courses and others are in the process of completing same. Training records showed that a number of nursing staff and some care staff have completed training in:

- wound care
- continence promotion
- nutritional training
- venapuncture
- issues in caring for the elderly
- mission training
- first aid
- hazard Analysis Critical Control Point (HACCP)
- medication management.

Registration details with An Bord Altranais for 2013 for all nursing staff were seen by the inspectors.

A staff development and appraisal system was implemented for all nursing and care staff. Inspectors saw, and staff confirmed, that the staff facilities were of a good standard with changing area, showers and dining facilities.

The inspector viewed a number of staff files and found them generally to be comprehensive. The files viewed contained full and satisfactory information in relation to staff in respect of matters identified in Schedule 2 of the Health Act 2007 (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2009 (as amended) for majority of staff files seen. However, it was noted that Garda Síochána vetting was not available for one staff member.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge and the two clinical nurse managers on duty 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:

Caroline Connelly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

11 July 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	St Joseph's Hospital
Centre ID:	0284
Date of inspection:	9 July 2013
Date of response:	29 July 2013

Requirements

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

Theme: Governance, Leadership and Management

Outcome 4: Records and documentation to be kept at a designated centre

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

The directory of residents was found to be missing a number of details which included the name and telephone number of the GP and where the resident was admitted from for a number of residents.

Action required:

Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) in a manner so as to ensure completeness, accuracy and ease of retrieval.

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

Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Regulation 27: Operating Policies and Procedures Standard 1: Information Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The details were available on residents' notes and our patient information management system, however, the directory of residents is now completed to reflect same. Staff have been made aware that this information must be recorded in full in all three places.	1 August 2013

Theme: Safe care and support

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: The emergency plan was very comprehensive for fire but required updating to take into account action to be taken in the event of the kitchen or laundry not being in operation and other emergency situations.
Action required: Update the emergency plan to contain the requirements of the regulations for all emergency situations.
Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Regulation 30: Health and Safety Regulation 31: Risk Management Procedures Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are currently reviewing our emergency plan to ensure specific emergencies that were not already, are included. We are in discussion with health and safety and best practice regarding this and will be in a position to make changes to our policy and make	31 August 2013

staff aware of same shortly.	

Outcome 8: Medication management

1. The provider has failed or is failing to comply with a regulatory requirement in the following respect: Some medication prescription practices were not in keeping with national guidelines and regulations. Prescriptions for crushed medications were not signed by the doctor on all charts of residents having crushed medications. Medications were being administered from the sign in sheet and not the prescription sheet as required by legislation. Maximum doses were not written on all PRN medications which could lead to errors.	
Action required: Ensure if medications are being crushed this is prescribed and signed by the doctor.	
Action required: Ensure maximum doses are outlined on all PRN medications.	
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 25: Medical Records Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Regarding crushing of medication for residents, it is our practice to ensure all residents who have their medication crushed is prescribed for and signed by the doctor. However, on this occasion this was omitted on my resident's script. This has been rectified and going forward staff have been advised to regularly check to ensure this action is complete.	30 September 2013

Regarding maximum doses for all PRN medications. It is our practice to ensure all residents on PRN medication have maximum doses on their script, however, on this occasion it was omitted. We are constantly working with our GP, pharmacist and staff to ensure this is flagged and recorded as soon as possible. All scripts are being checked at present to ensure all PRN medications contain maximum dose. CNM's, RGN's, GP and pharmacist have been made aware of this. We have comprehensive written operational policies relating to ordering, prescribing, storing and administration of medication to residents. We are currently reviewing all our medication practices to ensure best practice at all times. We are in discussion with our GP, pharmacist, CNM's & RGN's to ensure our medication system is in keeping with National Guidelines and Regulations. When this review is complete, we will amend our policy and ensure all staff are familiar with same.	

Outcome 11: Health and social care needs

1.The provider has failed or is failing to comply with a regulatory requirement in the following respect: There was no evidence that residents care plans were discussed and agreed with the resident as is required by legislation	
Action required: Resident's assessed needs are to be set out in an individual person-centred care plan developed and agreed with the resident and or his/her representative and other staff as appropriate and reviewed on a three monthly basis or sooner as required by the residents changing needs or circumstances.	
Reference: Health Act 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11:The Resident's Care Plan	
Please state the actions you have taken or are planning to take with time scales	**Time scale**
Provider's response: All care plans are discussed with the resident or their representative (in the case of residents who have cognitive impairment) however, it is difficult at times to ensure all individual care plans and assessments are individually signed by the resident or their representative. This has been brought to the attention of the RGN's	31 August 2013

& CNM's. A new form has been devised to ensure when RGN is completing and assessing care plans/ assessments that a record is made to show documentary evidence that these assessments have been discussed with the resident or their representative. The policy is being updated, being communicated to staff and then being rolled out.	