**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

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|---|---|
| **Centre name:** | St Joseph's Home |
| **Centre ID:** | OSV-0000245 |
| **Centre address:** | Abbey Road,<br>Ferrybank,<br>Waterford. |
| **Telephone number:** | 051 833 006 |
| **Email address:** | ms.waterford@lspireland.com |
| **Type of centre:** | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| **Registered provider:** | Little Sisters of the Poor |
| **Provider Nominee:** | Caroline Kissane |
| **Lead inspector:** | Gemma O'Flynn |
| **Support inspector(s):** | Ide Cronin |
| **Type of inspection** | Announced |
| **Number of residents on the date of inspection:** | 50 |
| **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 his/her registration.

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

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

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

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 18 July 2016 07:45 | 18 July 2016 17:45 |
| 19 July 2016 06:55 | 19 July 2016 13:40 |

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

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

**Summary of findings from this inspection**

This report sets out the findings of an announced two day inspection for the purposes of renewal of the centre's registration. The centre had also applied to vary the conditions of their registration by increasing their occupancy from 50 to 51.

St. Joseph's Care Home is situated just outside Waterford City and is run by a

religious order. It is set on a large, private site with well maintained grounds. On the day of the inspection there were 49 residents present and one resident in hospital.

As part of the inspection process, inspectors met with residents, the person in charge, the assistant director of nursing, the management team, various staff members, the religious sisters who augment care and assist in social and dining activities, relatives and volunteers. Practices were observed and documentation was reviewed.

Overall, inspectors found that care was delivered to a high standard. Residents were supported to live as independently as possible and it was evident from resident feedback and documentary evidence seen, that they were consulted about their care and the governance of the centre. Residents lived in a purpose built environment, over three floors and the accommodation was divided into two 'units'. The centre was clean and very well maintained, with appropriate furnishings and ample private and communal space. Staff and resident interactions were respectful, friendly and genuine and residents reported that they felt very safe in the centre and well looked after.

Inspectors observed the dining experiences and a sample of activities on offer and these were found to be of a high standard. Feedback from residents was that they were very satisfied with same.

Overall, strong governance arrangements were in place and the person in charge demonstrated detailed knowledge of each resident and of the day to day issues in the centre. Some improvements were required in the area of management systems such as auditing to ensure that learnings were determined and improvements were brought about as a result of the monitoring review.

18 outcomes were inspected against and the judgements in relation to each outcome are stated in the table above.
Non compliances are discussed in detail in the body of the report and in the action plans at the end of the report.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Statement of Purpose***
***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The statement of purpose was available in the centre and it consisted of the aims, objectives and ethos of the centre Its statement reflected the services which were to be provided for the residents.

It contained all of the information required by Schedule 1 of the Act and had been reviewed in 2016.

It was evident that the statement of purpose was implemented in practice.

**Judgment:**
Compliant

***Outcome 02: Governance and Management***
***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**
Governance, Leadership and Management

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

**Findings:**
It was evident that there were sufficient resources in place to ensure the effective

delivery of care, as described in the statement of purpose.

There was a clearly defined management structure. The person in charge was an experienced nurse who was involved in the daily delivery of the service. She was involved in the running of the centre on a regular and consistent basis and this was evident in her interactions with the inspector and the residents and staff throughout the course of the inspection. She was supported in her role by an experienced assistant director of nursing. A clinical nurse manager had recently been appointed. She supported the management structure and was responsible for such matters as conducting audits and supervision of staff.

The person in charge had autonomy regarding financial expenditure and explained the robust, procedures relating to same. As the centre is a registered charity, expenditure was submitted to a board of trustees for review.

There were management systems in place to ensure that the service provided was safe and appropriate to the residents' needs, however these required review and improvement. Examples of audit reviews carried out included: falls, medication management, care plans, infection control, call bells and the use of restraint. Some of the information obtained via audit was meaningful and elicited detail that gave oversight of issues arising in the centres. For example, in the review of falls, the information analysed included the time that the fall took place and the location. An action plan was developed for the next quarter in an effort to minimise the occurrence of falls in the centre such as changing shift times to ensure adequate staff numbers were present at all times during the day.

However, the audit process was not sufficiently developed to support continuous quality improvement. The action plans developed following the audits were not sufficiently progressed to ensure that quality improvements were sustained. For example deficits found in the falls, medication management audits were found in subsequent audits. For example, in a medication management audit, gaps were identified in nurse signatures confirming administration of medication. This was an issue also identified on inspection and had been previously identified in three consecutive audits.

In some audits reviewed, for example, continence and infection control audits, the audit questions had not been adapted to specifically reflect the processes in the centre. It was evident that audits were not adequately utilised to develop improvements over time, for example one audit reviewed showed a dis-improvement in compliance of the course of three consecutive audits but there was no action plan to address this.

A comprehensive annual review had been undertaken and the review included feedback from residents, relatives and practitioners visiting the centre. It also reviewed adverse incidents occurring in the centre. It set out what had happened in the centre and included a plan for the next 12 months which included further development of the sensory room, personalised visual aids for residents with dementia and personalised door numbers that held special meaning for residents with dementia.

**Judgment:**
Substantially Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a guide to the centre available to residents. This was a bound pamphlet style book that was accessible and informative. It gave an overview of the services provided, included information on the complaints process and information about visiting times. It was given to residents upon admission and was available in the centre should a resident wish to peruse it.

A contract of care was completed for each resident. It dealt with the care and welfare of the resident in the centre and set out the services to be provided. It also included the fees to be charged to residents and included details about those services that the fee didn't include.

**Judgment:**
Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge of the designated centre was a suitably qualified and experienced nurse manager and had extensive experience in nursing the older adult. She worked full time in the centre and was available outside of her rostered hours also.

She demonstrated sound clinical knowledge of the residents and their needs and demonstrated that she was involved in the governance of the centre on a regular and consistent basis. She had good knowledge of the Regulations governing the centre and

was informed regarding her duties under the Act.

Residents and staff could identify her as the person in charge and the general consensus of feedback to the inspector was that the person in charge was approachable and supportive should there be any concerns. It was relayed to the inspector that the person in charge kept all informed of any impending changes in the centre.

**Judgment:**
Compliant

***Outcome 05: Documentation to be kept at a designated centre***
***The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Complete records were maintained in the centre. Overall records were easily retrievable, accurate and up to date. As discussed and actioned in outcome 11, some improvements were required in the review and updating of resident risk assessments and care plans.

There were policies that reflected the centre's practice and these were seen to be implemented in practice and understood by staff. Policies reviewed by inspectors had been reviewed in 2016 and been updated to reflect best practice.

**Judgment:**
Compliant

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

**Theme:**
Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**
The assistant director of nursing was the person appointed to deputise in the event that the person in charge was to be absent from the centre for 28 days or more. There had been no incidences whereby this had occurred in the recent past. The assistant director of nursing was always available in the centre if the person in charge had to leave.

She was a nurse with many years experience in nursing the older adult. Staff were able to identify her and she was seen to be involved in the delivery of care throughout the course of the inspection. On the day of inspection she was seen to supervise meal times in the main dining room to ensure adequate practices were implemented.

Staff and residents were able to identify her as a person participating in management and staff confirmed she was approachable if they had any concerns they wished to raise.

**Judgment:**
Compliant

***Outcome 07: Safeguarding and Safety***
***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**
Safe care and support

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

**Findings:**
There was a policy on and procedures in place for the prevention, detection and response to abuse. Staff had received training and were able to demonstrate their knowledge regarding abuse, how to recognise it and the reporting structures to follow should any concern arise. Staff who spoke with the inspector confirmed that management were approachable and that there were no barriers to reporting any issues.

As well as the required policy, an additional guidance document was available to staff to assist them in the management of bruising of a vulnerable person. Policies had been updated in June 2016.

Residents told the inspector that they felt very safe in the centre and that they attributed this to the kindness of the staff and the religious sisters.

The person in charge discussed in detail the steps that would be taken in the event of an allegation of abuse and she was aware of her reporting obligations to the relevant bodies.

There were systems in place to ensure positive behavioural support was delivered to those residents who required it. The relevant policy had been reviewed in April 2016. Staff who spoke with the inspector were knowledgeable about the care plan interventions developed to assist residents who required positive behavioural support. A policy regarding the use of restraint in the centre was based on national guidelines and there evidence of alternatives to restraint being utilised in the centre such as low low beds. Bed rail assessments were carried out prior to implementation and if the use of bed rails was requested by a resident, efforts were made to use the least restrictive method possible, for example, using one bed rail instead of two. There was documentary evidence in resident care plans of trials in relation to reducing bed rails and evidence of residents being consulted in this process.

A robust finance policy was in place and this had been reviewed in April 2016. The centre was acting as agent for some residents and clear records were maintained in this respect. Documentary evidence seen demonstrated robust, transparent management of resident finances.

**Judgment:**
Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
The centre had policies and procedures relating to health and safety. There was a safety statement in place and it had been reviewed in April 2016. There was a comprehensive risk management policy which set out the requirements of the Regulations.

There were some systems in place for the identification of hazards and risk assessments with relevant controls put in place. The person in charge said that daily hazard inspections were conducted to identify new and arising issues and it was expected that staff would report any concerns. Maintenance records confirmed that staff brought concerns to the Buildings Services Manager and these were dealt with accordingly. However, risk assessments were not regularly reviewed to ensure that the controls in place continued to be adequate and were implemented. For example, the controls

recorded on a risk assessment for balcony areas on each unit, dated November 2010, were no longer implemented but the risk assessment had not been updated to reflect same.

Inspectors found there was no formal protocol in place for identifying hazards and not all hazards had been identified to ensure appropriate controls were implemented where necessary. For example the water boilers in communal areas were not risk assessed and a fire door held open with a door wedge presented a risk, as the door would not automatically close in the event of a fire. Other common hazards did not have a general risk assessment such as the use of a mechanical hoist and the use of bed rails, it was noted however, that risk assessments in relation individual resident use were carried out and stored in resident files.

A comprehensive record of adverse incidents occurring in the centre was maintained and this included incidents relating to both residents and staff. Details pertaining to any follow up investigation were logged. For example, in a significant adverse incident involving a resident, clear written evidence of what had occurred was available for review, a risk assessment was carried out after the event and where it was determined that the expertise of an allied health professional was required, the resulting review was recorded with the incident. A hazard alert was then completed and this was sent to the centre's units to alert staff of the incident and included any action associated with same. However, some staff weren't familiar with these hazard alerts but demonstrated that this information was also available from other sources such as morning/ evening handover, the nurses' notebook and via meeting minutes.

As discussed in outcome 2, an audit of incidents occurring in the centre was not carried out to enable the identification of trends and enhance learnings although it was evident that incidents were appropriately investigated and closed out on an individual basis.

There was a plan in place to deal with major emergencies and each resident had an individual plan for assisting with their evacuation should the need arise.

There were infection control procedures in place. Staff who spoke with the inspector demonstrated an awareness of the procedures and were aware of what precautions to take in the event of a healthcare associated infection. A clear colour coded cleaning system was in place and was followed. Special bags were available for soiled linen to minimise staff handling same. The laundry facility was clearly divided into dirty and clean areas and was very well maintained on the day of inspection. Laundry staff were knowledgeable about the processes for dealing with infected linen. Household staff were aware of the precautions to take if a resident had a healthcare associated infection.

There was evidence that staff had been trained in moving and handling techniques, certificates of completion were available for review and dates showed that the majority had been completed in 2015 and ongoing training in 2016 was apparent. Equipment such as mechanical hoists were seen to be utilised by staff.

Suitable fire equipment was available in the centre and checks were documented as required. Fire exits were unobstructed and fire exits were accessible. Records shown to the inspector showed that the fire alarm was serviced regularly but not four times per

year as is required. Fire safety equipment was serviced annually as required and as seen in the centre's records.

The Buildings Services Manager delivered fire training to staff and told the inspector that the local fire service were due to visit the centre in November 2016 to review the systems in place and advise accordingly. He said that the fire training was delivered to small groups of staff to ensure that time could be given to the subject matter. Staff who spoke with the inspector were clear about what to do in the event of a fire. However, although a weekly alarm was activated and staff were required to implement part of the fire evacuation protocol, unannounced drills did not take place. The person in charge told the inspector that horizontal evacuations took place when training was delivered. The inspector was not satisfied that this met the requirements of a drill as although it went through the evacuation procedure, it was part of a training session and did not test staff responses. For example, there was no review of the time, location and length of time the evacuation took. There was no documentary evidence of what went well in the drill and what could be improved upon. Therefore, drills did not provide a learning opportunity to ensure that in the event of a fire, the evacuation of residents was done so without delay.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Safe care and support

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

**Findings:**
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. There were processes in place for the handling of medicines, included controlled drugs which were in line with current guidelines and legislation.

The inspector accompanied a nurse on part of her medication round and found that medications were given in line with current guidelines and the nurse was familiar with the guidelines pertaining to medication management. The inspector observed and reviewed the practices relating to controlled drugs and found that records tallied with the records kept and checks were carried out as required by nursing staff. The person in charge told the inspector, that the nurses' shift started ten minutes before the health care assistants shift to allow for a timely medication handover prior to the commencement of a new shift.

Medication fridge temperatures were monitored daily. Drug reference publications were available should nursing staff need to refer to them. There was a system for recording medication errors, the inspector was told that since the introduction of a new medication dispensing system, medication errors had been reduced to nil.

In a sample of drug charts reviewed, the inspector found gaps in documentation. For example, signatures were absent in administration records. Audits of medication administration records had been carried out and although this issue had been identified, the same issue occurred across three consecutive audits. Therefore it was not evident that meaningful learnings and improvements in practice had resulted following the audit process.

Some medications were crushed prior to administration without being individually prescribed as such by the prescriber.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Safe care and support

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

**Findings:**
A record was maintained of all incidents occurring in the centre. This was available for review by the inspector and contained good detail of the event as well as any pertinent follow up information. A quarterly report had been submitted to the Authority as required by the Regulations.

However, not all notifications were submitted as required. For example, a serious incident involving a resident who subsequently required hospital treatment had not been submitted to the Authority. However, the inspector was satisfied that documentation and staff knowledge of the incident demonstrated that appropriate action had been taken to ensure appropriate care was delivered.

**Judgment:**
Substantially Compliant

***Outcome 11: Health and Social Care Needs***
***Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care.***

***The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.***

**Theme:**
Effective care and support

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

**Findings:**
Overall, the inspector was satisfied that care was delivered to a high standard and met the needs of the residents. Staff who spoke with the inspector demonstrated detailed knowledge of residents' needs and each staff member's account of residents' needs was consistent with their colleagues. However, some improvements were required to ensure that processes for review of clinical risk assessments and care plans were fully implemented by the relevant staff.

It was evident that residents' health care needs were met through timely access to medical treatment. General Practitioners (GP) visited the centre on a routine weekly basis and other GPs retained by some residents visited as required. The centre had a dedicated 'GP practice rooms' on the ground floor of the centre should a resident wish to use it. A specific chiropody room was also available in the practice rooms.

A detailed pre-admission assessment was completed by the person in charge for all residents and these were seen in a sample of the resident files reviewed by the inspector. Access to allied health professionals was available and a physiotherapist visited the centre weekly and as well as working individually with residents, also completed manual handling risk assessments for residents, these were displayed discreetly in the residents' bedrooms.

General risk assessments were completed for residents such as a resident's risk of leaving the centre without prior notice. Clinical risk assessments were completed using validated tools and included: nutrition, falls risk, skin integrity, dependency levels and risk of depression. However, in the sample of residents' files reviewed, not all clinical risk assessments had been reviewed at least four monthly as required. Also, a risk assessment seen for a resident who smoked was inadequate as it was not clear as to how the user determined the ultimate risk. The staff member assisting the inspector could not explain how it was used either. Therefore, it was impossible to assess if the controls in place were adequate as the resident in question had health issues that required consideration in the risk assessment and it was not evident that consideration had been given to those issues.

Practices enabling the prevention and early detection of ill health were in place. For example, monthly observations such as weight, blood pressure and pulse. However, there was documentary evidence that these did not always occur monthly. The clinical nurse manager demonstrated that she was aware of these omissions and was working

towards ensuring staff were fully compliant with the centre's policy in this regard.

Care plans were in place which were informed by the nursing assessments and these were person centred in their approach. There was documentary evidence that residents and or their relative had been involved in the development and review of same. The questionnaires forms completed by relatives prior to the inspection also confirm consultation about care plans took place.

Whilst care plans gave some good information, it was observed by the inspector that the documentation required streamlining to ensure that important details were not overlooked and to ensure that the care plan itself fully directed care. For example, a resident had been seen by a speech and language therapist for a swallowing assessment, the care plan itself was not updated to reflect same but documented in an appendix page until the next four monthly review. Another care plan seen required review to ensure there were strategies in place to guide care. For example, it was documented that a resident may be more at risk of falls at certain times than others, there was no information to guide staff to ensure an appropriate response at those times. This was discussed with the clinical nurse manager.

Systems were in place to ensure information about residents was provided and received when they were absent or returned from another care setting. Copies of information received were seen in resident files, however, it was not the practice of the centre to retain a copy of the transfer information sheet that they sent with a resident who was transferred to hospital, therefore only a template was available for review. This was discussed with the clinical nurse manager.

Treatment was given with the resident's consent. In a resident's file viewed by the inspector it was evident that a resident had the right to refuse treatment and the associated risk had been explained to and understood by the resident.

**Judgment:**
Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***
***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**
Effective care and support

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

**Findings:**
The design and layout of the centre was found to be in line with the statement of purpose. The centre was purpose built and was bright, modern and spacious with a homely feel throughout despite its large layout and size. The design and layout promoted residents' dignity, independence and wellbeing. Each resident's bedroom had their name on the door, a private letterbox and a working doorbell.

The centre had applied to increase the number of beds by one for which they were registered. This bedroom was inspected throughout the course of the inspection and was found to meet the needs of prospective residents.

The premises were maintained to a very high standard with suitable heating, lighting and ventilation. The centre had ample furnishings, fixtures and fittings to ensure a comfortable, homely residence.

The centre had ample communal space with numerous private sitting rooms available, these were tastefully decorated. A reminiscence room, a sensory room, an aromatherapy room, physiotherapy room, chiropody room, GP rooms and hair salon were further examples of the accommodation available to residents.

On the day of inspection, the centre was seen to be very clean and suitably decorated and residents and family members confirmed their satisfaction with the decor. A resident told the inspector that her bedroom was cleaned daily and she could ask the housekeeping staff to come back at a later time if she wished.

The layout of the centre supported freedom of movement. An elevator operated between floors and residents were seen to use the lift unaided. Grab rails were in situ to assist residents to mobilise safely. Good signage was in place and the annual review conducted in the centre set out a plan to increase signage and to make it personal for residents with dementia to assist them in navigating the centre.

Bedrooms were furnished to a high standard and were very spacious. All bedrooms were single occupancy with a large, well equipped ensuite shower, toilet and wash hand basin. There was a sufficient supply of hot and cold water and records indicated that water temperatures were regularly checked. Each bedroom seen had the furniture required by the Regulations including a lockable space. Residents were permitted to bring their own furniture and personal effects and the inspector saw that some had personal wall art hanging, musical equipment and soft furnishings in place.

There was ample space for the movement of any specialised / assistive equipment that a resident might require.

A separate bath was in place should a resident wish to use it.

A functioning call bell was in operation and staff were seen to answer resident calls in a timely fashion throughout the course of the inspection. Residents who spoke with the inspector confirmed that staff always responded quickly, both day and night.

**Judgment:**

Compliant

***Outcome 13: Complaints procedures***
***The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.***

**Theme:**
Person-centred care and support

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

**Findings:**
There were policies and procedures in place for the management of complaints. The procedure was displayed in prominent locations throughout the centre, for example, in high traffic areas such as the elevator between resident floors.

The procedure was straight forward. The person in charge was the person nominated to deal with all complaints and an appeals process was in place should a resident require it. It was the centres policy to make residents aware of the outcome of any complaint within 14 days.

A record was maintained of complaints and the accompanying documentation regarding subsequent investigations was seen to be comprehensive. It also included information regarding any change in practice following the investigation and included the signatures of staff to whom the complaint pertained.

The process for documenting whether or not the complainant was satisfied with the outcome of the complaint was not always consistent and required review. This was discussed with the person in charge as it is a requirement of the Regulations and this process was satisfactorily reviewed and a copy forwarded to the inspector the day after the inspection.

There was no person nominated in the complaints policy to oversee complaints were appropriately responded to and records maintained. This is a requirement of the regulations. This person is required to be someone who is available in the designated centre and separate to the person nominated to deal with complaints. Whilst the person in charge was able to tell the inspector who this person was, the policy did not reflect same and required amendment, this was completed by the person in charge prior to the close of inspection.

Residents who spoke with the inspector stated that they would not hesitate in making a complaint if they felt the need to do so.

**Judgment:**
Compliant

***Outcome 14: End of Life Care***
***Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.***

**Theme:**
Person-centred care and support

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

**Findings:**
There were written operational policies and protocols in place for end of life care which staff were familiar with. Facilities were in place so that residents received end of life care in way that met their individual needs and wishes and respected their dignity and autonomy. A sample of care plans were reviewed and these addressed the emotional, psychological and spiritual needs of the resident. There was evidence that residents were actively involved in their end of life care planning. The process of review of care plans required improvement, this is discussed in detail in outcome 11.

Family and friends were facilitated to be with the resident when they were dying and a family overnight room was available should it be required. Residents had a choice as to the place of their death and residents wishes on whether or not to be resuscitated were recorded. There was access to palliative care services as required.

Religious and cultural practices were facilitated in the centre. The centre itself was managed by a catholic religious order had excellent onsite chapel facilities should residents wish to use them. A specific room was available adjacent to the chapel that enabled residents/family/friends to pay their respects to the remains of the deceased.

Information leaflets were available throughout the centre in relation to bereavement and support services available.

**Judgment:**
Compliant

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

**Theme:**
Person-centred care and support

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

**Findings:**
There was a comprehensive policy for the monitoring and recording nutritional intake which was implemented in practice. Processes were in place to ensure that residents did not experience poor nutrition and hydration. For example, if a resident was losing weight, they were referred to the dietician and had weekly weights undertaken. A validated nutritional tool was completed and reviewed on a monthly basis. Food and fluid charts were also available if so required.

The catering manager spoke with the inspector and demonstrated detailed knowledge of residents likes and dislikes in relation to food. There was a communication noticeboard in the kitchen and there was a system in the dining room for ensuring residents requiring fat free diets received same. The clinical nurse manager was responsible for updating the diet list for all residents and the catering manager was updated by the clinical nurse manager of any changes. The catering manager was able to discuss this process in detail and a dietary requirements list was displayed in the kitchen.

Residents were offered choice and a menu was displayed at the entrance to the dining room and also on televisions in communal areas. Residents were able to tell the inspector what was on the menu for lunch on the day of inspection. A lunch menu was distributed to residents the day preceding the meal and orders were taken, however, residents could change their mind if they so wished and the inspector observed a resident request an alternative at lunch time and this request was accommodated without issue. Residents told the inspector that if there was something they wanted off menu that this was facilitated with ease.

Lunch was served 'French trolley style' which allowed for a relaxed, intimate and individualised dining experience. Music played softly in the background, adding to the overall relaxed ambience. Drinks were available and accessible throughout the meal.

Food was cooked onsite and included ample home baking. Snacks were distributed daily and residents spoke of ringing for a cup of coffee whenever they desired if they didn't feel like making one themselves. Small kitchenettes were on each floor and there was access to tea and coffee making facilities for residents and visitors.

**Judgment:**
Compliant

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

**Theme:**
Person-centred care and support

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

**Findings:**
There was evidence that residents were consulted about how the centre was planned and run. An annual questionnaire was distributed to residents and included meaningful questions such as ' are you able to speak with staff'; 'do staff come quickly when called' and 'do you get enough to eat and drink'. Responses seen were, overall, very positive and actions in response to feedback had been undertaken such as increasing the hours of a specific activities service.

Resident meetings were held on a monthly basis and residents who spoke with the inspector confirmed this. Detailed minutes were maintained along with follow up action plans. Residents spoke of receiving the minutes of any meeting they missed. Resident meetings allowed for consultation in regards to changes in the centre. For example, it had been decided in conjunction with residents to change the time of daily mass to allow more time for activities afterwards.

Residents were kept up to date with what was happening in the centre. Pictorial news was available on TV screens in communal areas and included information about the day's activities, mass time and the daily menu. The weekly activity schedule was displayed in and around the centre, including the elevator which was used by many residents. The parish newsletter was available on each floor and newspapers were widely available.

The centre had recently employed a new activities coordinator and had increased her hours. The person in charge discussed plans regarding specific training for developing activities for residents with dementia for the activities coordinator, training which the person in charge had completed herself. The centre had its own bus and residents told the inspector of day trips to local coastal towns.

Residents expressed satisfaction with the activities and the new activities coordinator. The inspector observed a resident to lead a large group of residents in an exercise class and there was great engagement and laughs had by all involved. Another resident played a keyboard whilst other residents sang along and there were lots of activities in the dedicated arts and crafts room which one of the religious sisters was very involved in. For example, a local milliner came to the centre to show residents how to make hats and a selection of hats that residents had made were displayed in the centre. A regular draw was held in the arts and crafts room and on the day of inspection prizes included a selection of jewellery and gift wrapped selections. Residents were seen to spend time outside on the day of inspection, eating ice-creams and taking advantage of the fine weather.

A specific reminiscence room was available to residents and this had ample memorabilia displayed on tables for resident to peruse. Residents were involved in maintaining the

items and the inspector was told how one resident had ensured that all items were dust free and looking their best for the impending registration inspection. The inspector found that this approach was very person centred and facilitated the residents to live in the centre in the same way they would live in their own homes before their admission. The person in charge was in the process of developing a dedicated sensory room for residents.

**Judgment:**
Compliant

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

**Theme:**
Person-centred care and support

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

**Findings:**
There was a policy on residents' personal property and possessions. Property was kept safe and each resident had a lockable storage unit in their bedrooms. A robust laundry system was in place. Families were responsible for labelling clothes and one of the unit sisters who spoke with the inspector said that the small laundrette facilities on each unit were used if a resident had some items that were unlabelled so as to minimise the risk of them going missing.

A clear laundry system was in place which ensured that residents clothing was returned to them and residents who spoke with the inspector confirmed they were happy with the laundry service.

Resident property lists were maintained in the sample of resident files reviewed.

**Judgment:**
Compliant

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

***Regulations 2013 are held in respect of each staff member.***

**Theme:**
Workforce

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

**Findings:**
There was evidence of sufficient staff on duty on the day of inspection. There was an actual and planned rota available for review. There was a nurse on duty at all times. The day shift had two registered general nurses on duty each day and they were supported by the clinical nurse manager who worked 8am-4pm, Monday to Friday.

At night, one nurse was rostered on duty and the person in charge and the assistant director of nursing were on call in the centre should their assistance be required. A night nurse who spoke with the inspector confirmed that this arrangement was sufficient and any call made to either party resulted in a prompt response. The person in charge agreed that due to the size and layout of the building, staffing levels were kept under review to ensure the residents' needs were fully met. Staff who spoke with the inspector said that there was sufficient staff on duty day and night. Resident and relative feedback forms, completed for the Authority, did not raise any concerns with staffing levels.

There was an education programme in place and the person in charge had completed a recognised 'train the trainer' course so as to deliver courses in house, such as training in dementia. Other continuing professional development included infection control, medication management, nutrition and updating palliative care skills. Mandatory training such as fire training and manual handling was in place, up to date and delivered on an ongoing basis.

Copies of the Regulations and of the revised Standards as published by the Authority were available at the nurses' stations. Information pertaining to best practices in the area of healthcare were also available for review.

There were effective recruitment procedures in place and a sample of staff files reviewed met the requirements of the Regulations. Up to date registration was on file for nursing staff. Volunteer files were sampled and these met the requirements of the Regulations also.

A policy was in place for the recruitment of staff and this had been reviewed in March 2016. The person in charge told the inspector how residents had been involved in the recruitment policy and had put forward questions that they wished to be included in the interview process.

Appraisals were done on an annual basis and there was evidence of this in the staff files reviewed. Staff were supervised via the presence of the person in charge, assistant director of nursing and nursing staff. The assistant director of nursing was seen to supervise meal time in the main dining room. Staff confirmed that management were

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| approachable if they had any concerns. Staff who spoke with inspectors said that management were receptive to new ideas and would make changes to systems if necessary. |
| **Judgment:**<br>Compliant |

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.


### Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.


### *Report Compiled by:*


Gemma O'Flynn
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

**Provider's response to inspection report**[1]

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| **Centre name:** | St Joseph's Home |
| **Centre ID:** | OSV-0000245 |
| **Date of inspection:** | 18/07/2016 |
| **Date of response:** | 19/08/2016 |

## Requirements

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

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

## Outcome 02: Governance and Management

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The audit process was not sufficiently developed to support continuous quality improvement. The action plans developed following the audits were not sufficiently progressed to ensure that quality improvements were sustained. For example deficits found in the falls, medication management audits were found in subsequent audits.

Audit questions had not been adapted to specifically reflect the practices in the centre,

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

for example, the infection control audit and the continence audit.

**1. Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
1) We have created a simple Centre Specific Audit Tool for collating and studying Audit information – Incident Identification and Learning outcomes summary sheet. (completed)

2) A monthly Quality Indicator Tool, will be used. (We have it ready to use). This will help develop a centre specific programme of audits.

3) Some of our clinical audit tools are already centre specific, however – we are working on those (3) that are generic to make them more centre specific. (End of August – almost completed this process of creating new tools).

4) Monthly Clinical and Health and Safety Governance Audit and Review Meetings will be held. The First took place on Wednesday 27th July to decide how to go forward to ensure that all audits are "sufficiently progressed to ensure that quality improvements were sustained". Next Meeting 31st August.

5) We will be receiving updated training on Clinical Governance and Audit from an external Consultant. (Mid-September).

Audit Recording Tool – completed 29th July 2016.
The 3 Centre Specific Clinical Audits to be developed and ready for use by 31st August. Their use then will follow the normal audit schedule until year end. Training dates to be arranged for Mid-September with External Consultant.

**Proposed Timescale:** 30/09/2016

**Outcome 08: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Risk assessments were not regularly reviewed to ensure that the controls were implemented and that they continued to control the identified risk.

There was no formal protocol in place for identifying hazards and not all hazards had been identified to ensure appropriate controls were implemented where necessary, for example, water boilers in communal areas and a door wedge propping open a fire door.

Other common hazards in designated centres did not have a general risk assessment, such as the use of a mechanical hoist and the use of bed rails

**2. Action Required:**
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
1) We are developing a Centre Specific Health and Safety Audit tool, to complement to Health and Safety Risk Register already in place. Our Building Services Manager will develop this over the coming 4 weeks. This will serve as a "formal protocol in place for identifying hazards"

2) Hazard Alerts are already issued – however, going forward to ensure all staff have read them unit signature lists will be distributed with them to ensure ALL staff members are aware of what they contain.

3) Any outstanding reviews of risk assessments will be completed by the Building Services Manager by 31/8/2016.

4) Any new hazards identified by the Audit tool – will be risk assessed as they are identified, and as necessary – hazard alerts will be issued. 31st August 2016 for the Tool to be developed. Usage to be implemented thereafter. Ongoing.

**Proposed Timescale:** 31/08/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records viewed by the inspector showed that the fire alarm was serviced regularly but not four times per year as is required.

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

**Please state the actions you have taken or are planning to take:**
The Fire Alarm was serviced Q1-Q4 from March 2015-March 2016.
1) I have written to the Contractors who perform this testing to inform them that as indicated by the HIQA inspector these services should take place from Jan-Dec in any given year and that any failure to achieve 100% testing each year may make us seek other contractors. Letter Sent 30th July 2016
2) This year's services are thus far acceptable as Q1 and Q2 are completed. We will monitor the situation.
3) The Company are re-issuing a contract with the assurances we require within it.

**Proposed Timescale:** 30/07/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Unannounced fire drills did not take place. The person in charge told the inspector that horizontal evacuations took place when training was delivered. The inspector found that this did not meet the requirements of a drill as although it went through the evacuation procedure, it was part of a training session and did not test staff responses.

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

**Please state the actions you have taken or are planning to take:**
1) 2 Un-announced Fire Drills have taken place on Thursday 21st July – one with night staff and one with day staff and have been documented and will be reviewed at the Governance Meeting of the 31st August. This meets the legislative requirements. Going forward we will establish that the minimum number of drills each year will be 2. However we have suggested that we may aim for 4 annually – this is to be discussed at the governance meeting on the 31st August as fire drill with evacuation can cause distress to the residents in their "home".
2) As noted in the Report – the Fire Department are also coming on site to assist with further – evacuation simulations/ Fire Drill in November 2016. (This had been agreed early in 2016)
3) Last year we had 5 evacuation simulations during training. Training will continue to have evacuation simulations. However, Learning from the Un-announced drills will be imparted during these training sessions.

**Proposed Timescale:** 31/08/2016

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medications were crushed prior to administration, without being prescribed as such by the prescriber.

In a sample of drug charts reviewed, there were gaps in documentation. For example,

signatures were absent in nurse administration records.

**5. Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
The Kardex of all residents receiving crushed medications – are currently signed/prescribed by their G. P. at the top of the page.
However:
1) The CNM is to re-issue Kardex to GP's for additional signatures beside each medication that is to be crushed. And the word "crushed" to be written beside each medication. This will occur in the First 2 weeks of August, this has commenced and will be reviewed at the governance meeting on the 31st August.
2) The frequency of the MAR chart audits will be increased to monthly – to endeavour to ensure compliance with signatures by nursing staff. Once full compliance is achieved the intervals of audits may be lengthened again. First Audit to be completed prior to the Governance meeting of 31st August so that it can be reviewed at same.
3) All nursing staff have completed Medication Management Updates, however, any staff nurse who is identified as consistently failing to sign for medications, will be offered closer supervision by the CNM, until full compliance is achieved.

**Proposed Timescale:** 31/08/2016

**Outcome 10: Notification of Incidents**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all notifications were submitted as required. For example, a serious incident involving a resident who subsequently required hospital treatment had not been submitted to the Authority.

**6. Action Required:**
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

**Please state the actions you have taken or are planning to take:**
1) The notification that was missing has now been submitted on the 21st July 2016.
2) At Governance Meetings – all notifications will be discussed/to ensure no further oversight in reporting occurs.

**Proposed Timescale:** 21/07/2016

| Outcome 11: Health and Social Care Needs |
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| **Theme:**<br>Effective care and support<br><br>**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**<br>Risk assessments were not always reviewed within four monthly periods.<br><br>Monthly health observations such as weight checks were not always carried out monthly as per the centre's intended practice.<br><br>Care plans were not always updated to reflect assessments by allied health professionals and as such the changing needs of the resident.<br><br>**7. Action Required:**<br>Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.<br><br>**Please state the actions you have taken or are planning to take:**<br>We currently review all care plans 4 monthly from the date of the last update, this gives differing dates of review.<br>1) Going forward – all reviews will be done within the same time-frame for all residents.<br>2) Nurses will ensure monthly weights are performed for those residents who require monthly weights.<br>3) Nurses will re-write the care plan, immediately a change is noted/needed. The CNM has issued guidelines following the inspection to all nurses requesting this. (Guidelines issued 4/08/2016) |
| **Proposed Timescale:** 30/09/2016 |
| **Theme:**<br>Effective care and support<br><br>**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**<br>Copies of resident transfer notes were not retained in the centre and were therefore not available for review.<br><br>**8. Action Required:**<br>Under Regulation 25(1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre for treatment at another designated centre, hospital or elsewhere, to the receiving designated centre, hospital or place.<br><br>**Please state the actions you have taken or are planning to take:** |

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| Previously we had not been asked to keep copies of transfer notes.<br>All nurses will copy transfer notes and keep on file. Guidelines issued to nurses by CNM on 4/8/2016 |
| **Proposed Timescale:** 31/08/2016 |