

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Joseph's Care Centre
Centre ID:	OSV-0000466
Centre address:	Dublin Road, Longford, Longford.
Telephone number:	043 333 2469
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Mary O'Donnell
Type of inspection	Announced
Number of residents on the date of inspection:	65
Number of vacancies on the date of inspection:	3

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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times

From: 10 January 2018 09:30 To: 10 January 2018 18:30

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	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This announced inspection took place to inform an application for renewal of the centre's registration. Inspectors followed up on progress with completion of the action plans from the last inspection of the centre in September 2016. Four of the seven action plans were satisfactorily completed. The other three non compliances would be addressed when the final two phases of a refurbishment project were completed. In the interim measures had been implemented to reduce the negative impact of multiple occupancy rooms on residents. The inspectors reviewed the details of unsolicited information received by the Health Information and Quality Authority (HIQA) in August 2017 regarding staffing levels, choice and insufficient activities available for residents in the evenings and at weekends. These issues were identified on the previous inspection and the provider had taken action to address this, with positive outcomes for many of the residents. However the centre had a group of residents with acquired brain injury and staffing arrangements and resources required review to ensure that the changing needs of these residents were met to enable them to make choices in a way that reflects their diverse needs and

rights. Following the inspection, the provider was required to assess the needs of individual residents with acquired brain injury and put a plan in place to ensure that their social needs are adequately met.

The inspectors met with the person in charge, members of staff, residents and their relatives during the course of the inspection. Documentation records such as the centre's policies, risk management (including fire safety) procedures and records, audits, staff training records and residents' records were reviewed among other documentation. Inspectors also reviewed feedback provided in pre-inspection questionnaires completed by 10 residents and 10 relatives. Comments from residents and their relatives were very positive regarding their satisfaction with the service provided, care given and the staff team in the centre. However, a number of residents and their relatives were dissatisfied with the arrangements in place to meet the social needs of residents, especially in the evening and at weekends.

Residents confirmed that they felt safe in the centre and had choice in their daily routine. Residents were protected from harm and abuse. All interactions observed by inspectors by staff with residents were courteous and kind. There was evidence that residents' feedback was welcomed and valued and their individual choices were respected.

The provider and person in charge held responsibility for the governance, operational management and administration of services and provision of sufficient resources to meet residents' needs. The person in charge demonstrated comprehensive oversight of the quality and safety of the service provided. There was evidence of continuous quality improvement resulting in positive outcomes for residents.

All staff were appropriately vetted and facilitated to attend mandatory and professional development training.

Completed refurbishment works to one unit in the centre had significantly improved residents' comfort and quality of life. However, further improvement was necessary to ensure residents' privacy and dignity needs were sufficiently met in the other two units in the centre. The second phase of a refurbishment programme, due for completion in Aug 2018 was delayed and works were due to begin in 2018.

Residents' healthcare needs were met to a good standard. Staff were knowledgeable regarding residents and their individual needs.

The Action Plan at the end of this report identifies non compliances and improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

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 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 inspectors were satisfied that the statement of purpose met the requirements of the Regulations. It described the service that was provided in the centre and was kept under review by the person in charge. The Statement of purpose had been updated to accurately reflect the complaints appeals process.

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:

The inspectors were satisfied that the quality and safety of care delivered to residents was monitored and developed on an on-going basis. Effective management systems were in place to support and promote the delivery of safe, quality care services.

There was a clearly defined management structure that identified the lines of authority and accountability. The person in charge reports to the general manager of community care, who in turn reports to the provider representative. The person in charge is supported in this role by the acting assistant director of nursing and a clinical nurse manager. The inspectors noted that the assistant director had been in an acting role since April 2012 and recommend that this arrangement be formalized to strengthen the governance of the centre. There was evidence of consultation with residents and their representatives. The general manager visits the centre and meets formally with the person in charge at monthly area meetings. Regular management team meetings are held and the management team also meet with staff to support two-way communication and share relevant information.

An auditing schedule set out the yearly plan. Audits carried out included health and safety, medication and clinical documentation. The results of audits were shared with staff for learning and will be used to inform the annual review. Oversight to ensure that audit action plans were fully implemented was an area for improvement. The inspectors found that four of the seven actions in the action plan from the last inspection in September 2016 were satisfactorily completed. Although not completed, the other three actions had been progressed and interim measures had been implemented to reduce the negative impact of multiple occupancy pending commencement of the final two phases of the centre's refurbishment.

However the provider did not adequately resource the service to ensure that the changing needs of younger residents were met to enable them to make choices in a way that reflects their diverse needs and rights. Following the inspection, the provider was required to assess the needs of individual residents with acquired brain injury and put a plan in place to ensure that their social needs are adequately met.

Judgment:

Non Compliant - Moderate

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 designated centre was managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service. The person in charge worked on a full-time basis in the centre. She is supported in her role by an assistant director of nursing and an administration nurse manager.

The person in charge demonstrated sufficient knowledge and implementation of the legislation requirements and was aware of her statutory responsibilities. The inspector was satisfied that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis and had demonstrated that she was committed to keeping residents central to service provision.

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):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors found that measures were in place to protect residents from being harmed or abused. Significant progress had been made to reduce the use of bedrails. However improvement was required in relation to documenting the rationale for the use of bedrails and the alternatives trailed before bed rails were put in place.

The inspectors reviewed the systems in place to protect residents from abuse and were satisfied that residents were sufficiently safeguarded. Allegations of abuse were followed up and the inspector was satisfied that the policy on safeguarding was fully implemented. There was evidence of consultation with the safeguarding team where appropriate. The inspectors saw that residents had access to the national advocacy services.

The inspectors reviewed the use of restraint and noted that appropriate risk assessments had been undertaken. Significant efforts were made to reduce the use of bedrails. Existing beds had been adapted to create low-low beds and additional equipment such as sensor alarms and half-length bed rails had been purchased to reduce the need for full-length bedrails. Improvement was required to document evidence that other alternatives had been trailed prior to the use of full-length bedrails and other restraints. All occasions where restraint was used was logged in the restraint register. The use of psychotropic and mood altering medications was strictly monitored and audited. Residents had access to both psychiatry and psychiatry of later life services and the medications were subject to three-monthly reviews. There was evidence that dosages were reduced and medications discontinued where appropriate.

This centre is a pension agent for some residents' social welfare pensions. The inspectors saw that individual accounts were in place and the pensions were paid directly to a resident's account. Quarterly statements were issued to the residents. The system was subject to external audit.

The inspectors were satisfied that residents were provided with support that promoted a positive approach to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff had received training and there was a policy in place to guide practice. Inspectors reviewed residents' files and noted that comprehensive assessments had been undertaken. Behaviours were monitored and analyzed on an on-going basis. In general detailed person-centred care plans were in place and possible triggers and appropriate interventions were documented.

Judgment:

Substantially 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 health and safety of residents, staff and visitors was promoted. A safety statement was available for the centre. Inspectors' findings confirmed that risk management was proactively managed in the centre. A register of all clinical and environment risks was maintained. All risks were assessed and there were associated controls in place to mitigate level of risk and potential for adverse outcomes for residents, staff and visitors. Areas of identified risk were regularly reviewed and updated as necessary. The information regarding the management of specified areas of risk outlined by Regulation 26 were in place to protect vulnerable residents. Controls were in place to protect some residents at risk assessed as being at risk of leaving the centre unaccompanied.

Accidents and incidents and near misses involving residents, staff and visitors were logged and necessary actions were implemented where necessary to prevent recurrence. Each resident has a falls risk assessment completed on their admission which was reviewed regularly thereafter and updated as their needs changed. Equipment such as low level beds, hand rails in corridors, toilets and showers, staff supervision and sensor equipment were used to reduce residents' risk of fall or injury. Handrails fitted on corridors were in a contrasting colour to the surrounding walls to enhance their visibility for residents with vision problems or dementia.

Residents were protected against the risk of fire in the centre. All residents had evacuation risk assessments completed and documented that referenced their day and night-time evacuation needs in terms of staffing and equipment. This information also took account of factors that could potentially hinder their timely evacuation such as dementia and impaired mobility. Fire safety management checking procedures were completed. Fire safety equipment was serviced and the fire alarm was tested on a weekly basis. All fire exits were checked daily and were clearly indicated and free of any obstruction. Fire safety training and opportunity to participate in a fire drill was provided for all staff by a designated member of staff employed by the provider who was trained in fire safety. Fire evacuation drills were completed and reflected testing of day and night-time staffing resources and conditions to ensure residents could be safely evacuated in an emergency. However, the documentation made available did not provide sufficient assurances that timely evacuation of residents from one compartment to another could be achieved within a reasonable timeframe.

The centre was visibly clean in all areas. An infection control policy was available and informed the procedures to be followed for management of communicable infection and an infection outbreak. The centre was visibly clean. Hand hygiene facilities were located throughout the premises and were used appropriately by all staff. Infection control audits showed high levels of compliance. Advice notices were prominently displayed at the entrance to mitigate the risk of influenza to residents. Residents and staff were offered vaccinations. Environmental cleaning procedures reflected best practice in infection prevention and control standards. Staff had attended training on hand hygiene and infection prevention and control.

Judgment:

Substantially Compliant

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):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

On the previous inspection improvement was required to ensure that the date when medications were opened was recorded.

This had been addressed. The inspectors found the policy on the utilization and maintenance of the centralized drug press had not been fully implemented.

The inspectors reviewed a sample of medication prescriptions and administration records and found that medication management practices were safe. Written evidence was

available that three-monthly reviews were carried out. The provider had employed a pharmacist to provide support and advice on medication issues. The pharmacist was available to meet with residents and also undertook audits and promoted best practice in relation to prescribing. The position of pharmacist had been vacant since September 2017 and the person in charge confirmed that the post was due to be filled in January 2018. The most recent audit evidenced how the loss of the pharmacist had impacted on the service. The centre held a small stock of medications for emergency use. The policy on the utilization and maintenance of the centralized drug press stated that the pharmacist was responsible for the monthly checking procedure and stock rotation. This had not been done since September 2017. None of the medications checked by inspectors had expired.

Medications were supplied weekly from a central pharmacy and a local pharmacist operated at weekends. The service had trained nurse prescribers. The policy on storage and return of unused medication was used to guide practice.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. The inspectors checked the balances and found them to be correct.

Judgment:

Non Compliant - Moderate

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):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors were satisfied that each resident's wellbeing and welfare was maintained by appropriate medical and allied health care. Residents had access to a medical officer and out-of-hours medical cover was available. Psychiatry and mental health of later life services were provided. A full range of other services was available on referral including speech and language therapy (SALT), occupational therapy, physiotherapy and dietetic services. Chiropody, dental and optical services were also provided. The inspectors reviewed residents' records and found that residents had been referred to these services and results of appointments were recorded in the residents' notes.

Inspectors found that residents had a comprehensive nursing assessment completed on admission and was reviewed three to four-monthly thereafter. The assessment process involved the use of approved tools to assess clinical risks and needs. Residents were routinely assessed for risk of malnutrition, falls, oral health, level of cognitive impairment and their skin integrity. Care plans were put in place to address identified needs and were regularly reviewed. Some care plans examined lacked sufficient detail to guide consistent care provision. Care plans were stored securely and the resident or their relative as appropriate was involved in the care plan development, review and evaluation. Residents and their relatives who spoke with inspectors knew about the care plans. Residents had end of life care plans which detailed their wishes for future care needs, their resuscitation status and place of care. The information was readily available to staff. Residents had timely access to palliative care services when required.

The inspectors reviewed the management of clinical issues such as falls prevention, wound care and diabetes and found they were well managed and were guided by robust policies. Areas for improvement were identified in the prevention of pressure sores. Inspectors noted that some pressure relieving mattresses were set above recommended parameters and did not provide optimal pressure relief. Care plans did not state the frequently residents assessed as being at increased risk should have their position changed and there were gaps in the turning charts reviewed. Residents with diabetes were appropriately managed and had access to specialist diabetic services. However they were not provided with individual glucose monitors in line with best practice.

There were systems in place to ensure residents' nutritional needs were met and that they did not experience poor hydration. The inspectors saw specific information relating to residents likes and dislikes was recorded in the care plans. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a three monthly basis or more frequently when indicated. Nutritional care plans were in place that detailed residents' individual food preferences. While recommendations made by dieticians and speech and language therapists were implemented in practice, they were not recorded in sufficient detail in residents' care plans. When required, nutritional and fluid intake records were appropriately maintained. The centre had a nutritional advisory group with resident representation which was chaired by a dietician. The centre had recently participated in a research project on obesity in residential care.

Judgment:

Substantially Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

The designated centre is a single storey premises located on a large campus from which other health services to the community are provided based in separate buildings. The centre comprises three defined residential units, Padre Pio, St Therese's and The Lodge. The Lodge is subdivided into Sunset Lodge and Autumn Lodge. The premises did not meet the requirements of the National Standards, and a three phase plan was developed to refurbish the three units. The refurbishment work is due for completion by 31 Aug 2021. The original plan submitted to HIQA had been revised and the timeframe for completion of Phase 2 had been extended. The provider was advised to submit revised plans and timelines to inform condition 8 of the centre's registration.

Phase one was completed. The Lodge was refurbished to a high standard and provided a suitable, homely and accessible environment for residents including residents with dementia. Resident accommodation in Autumn Lodge comprised nine single rooms and a palliative care suite. Sunset Lodge has five single rooms and six double rooms. There were adequate toilet and bathroom facilities, including wheelchair accessible bathrooms and showers. Best practice principles in dementia care were incorporated in the design, furnishings, signage and décor. Residents in both units had a day room, a dining room and a number of comfortable seating bays. There was a family room in Sunset Lodge and residents on both units had access to a well maintained secure garden.

Phase 2 reflected the refurbishment of St. Therese' Unit, the original plans had been revised and had gone to tender. The proposed completion date of August 2018 would not be achieved. The plan included a new 10 bedroom extension, as well as the refurbishment of the existing unit. Phase three included the refurbishment of the Padre Pio Unit due for completion by July 2021.

The number of beds in multi-occupancy rooms had been reduced but the layout and design of the multi occupancy rooms in St. Therese' and Padre Pio units posed challenges to staff in relation to supporting the privacy and dignity of residents and providing a comfortable and homely environment for residents. Staff had used imagination and creativity to maximize the potential of additional space created to benefit residents in the large rooms. Sofas, domestic tables and sideboards and pictures were provided, along with shelving for residents to display their personal items. Inspectors noted that the location of wardrobes was not convenient for residents to access their clothes and possessions. Each resident had a locker and a small wardrobe and a locked storage unit by their bedside.

Inspectors observed and relatives commented that the paintwork in some areas was in need of attention. The person in charge confirmed that maintenance paintwork had not been done because the refurbishment works were imminent. The screening rails in large

bedrooms had not been reconfigured to maximize the personal space for residents when beds had been removed.

There was appropriate assistive equipment for use by residents which was stored appropriately. All residents had access to external secure garden areas. Each garden had an exercise station and raised beds to facilitate residents who wished to garden. The garden areas were landscaped with shrubs and small trees and safe winding pathways. The person in charge advised the inspectors that she had procured funding to create a central garden. Work on this is due to begin in Spring.

Judgment:

Non Compliant - Moderate

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:

Inspectors found the complaints of each resident and their family were listened to and acted upon and there was an effective appeals procedure. The complaints policy was posted in communal areas and included in the 'Residents' Information' booklet.

Each unit maintained a complaints log and adequate details were recorded including the level of satisfaction or otherwise with the outcome. The inspector read a sample of complaints received and found that they were managed in line with the policy. Investigations had taken place and the complainant had been informed of the outcome in each case.

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:

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

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

Findings:

The ethos of the service upheld the rights, dignity and respect for each resident. The nursing assessment included an evaluation of the resident's social and emotional wellbeing. All staff optimised opportunities to engage with residents and provide positive connective interactions. The daily routine was organised to suit the majority of residents.

The activity co-ordinator was rostered five days each week to provide recreation and engaging activities for residents. In addition to activities held in the centre, younger residents also engaged in community services such as the phoenix centre, which was on site and the 'Mens' Shed'. External providers were also employed to provide music, art and dog therapy. There was evidence that activities were chosen in collaboration with residents. Group activities were organised such as Sonas, exercise classes, art and crafts, music sessions and hand massage. Ten staff were trained since the previous inspection and were now competent to facilitate group activities such as sensory programmes and exercise groups. Staff created opportunities for one-to-one activities, for residents who were unable or unwilling to participate in group activities. Inspectors noted that staff ensured that they met the social needs of residents who spent periods in their bedrooms. A 'Key to Me' document found in all residents' records examined, contained information about each resident's history, hobbies and preferences. This information was used to inform the care plans and planning of activities. Care plans were created to meet residents' social and emotional needs and a record was maintained of the various activities that each resident participated and engaged in. Staff acknowledged that the resources were not available to support residents who wished to participate in community activities. The person in charge had made an application for a personal assistant for a resident. When a resident expressed a wish to move to the community plans were put in place to support the resident to transition to the community.

Residents looked well groomed and they expressed satisfaction with how their clothes were maintained. The hairdresser was on-site five days each week.

Visiting was unrestricted except for protected mealtimes to allow residents to concentrate on their meals. There were rooms in all the units to meet with visitors in private.

There was evidence that residents received care in a dignified manner that respected their privacy. Staff were observed knocking on residents' bedroom doors and seeking the permission from residents before engaging in any care activity. Staff were seen to offer residents choice where possible. As discreet listening devices were not available, residents in multiple occupancy bedrooms could not listen to their television or radio without impacting on the others residents in the bedroom. Signs were placed on doors

to indicate that personal care was being delivered. Screens were drawn to provide privacy but malodours and conversations were not contained behind screens. This impacted on the privacy and dignity of residents in multiple occupancy bedrooms.

Residents were consulted and residents' meetings, chaired by an advocate were held every four months and there was evidence that issues raised by residents were acted upon by management. Dates for residents' meetings in 2018 were posted in communal areas. The independent advocate also met with residents on a weekly basis and there was evidence that her intervention on behalf of residents had improved their wellbeing. Two residents were availing of other advocacy services. The centre had developed a number of methods to support residents to maintain links with their local communities. Residents had access to phones and some residents used a computer for emails and Skype. The intergenerational project facilitated residents and young children to play games in the hall together. Residents were supported to go to local shops, hairdressers and dentists. They also had access to daily news papers TV and radio.

Activity provision was an area of non- compliance on the previous inspection in September 2016. The provider's action plan to address this had been completed and it addressed the needs of older residents and people with dementia. However resources were not in place to support younger residents to engage in age appropriate social activities in the community in the evenings and at weekends. In general, residents' relatives and families played a key role in meeting the social needs of residents. They visited daily and sometimes twice daily. They took residents on trips and facilitated overnight and weekend sleepovers. The service's mini-bus was available to residents from 11:00 -14:00 hours and was used for trips during the summer when the day care service was closed. Residents had not gone on any trips outside the centre since the summer. They did not engage in age-appropriate social events in the community such as the movies or football matches because there were no staff or personal assistant hours provided to support them. Residents including some older residents and relatives who completed questionnaires or met with inspectors expressed dissatisfaction with activity provision at the weekends and in the evenings. Inspectors checked rosters and found that there were fewer staff on duty in the evenings. In addition the twilight staff who had been rostered to provide additional staffing in the evenings was no longer on the roster. Inspectors learned that personal assistant hours had been withdrawn and now only one resident benefited from a personal assistant. Staff confirmed that boredom contributed to residents engaging in responsive behaviours. Inspectors concluded that although the service met the needs of residents when they were admitted, resources were not put in place to meet the changing needs of residents when their physical and health status improved. The service also did not have the resources to support some younger residents to exercise choice in their daily lives in a way that reflected their diverse needs.

Judgment:

Non Compliant - Major

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):

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

Findings:

Staffing resources to meet the activation needs of residents with acquired brain injury and dementia was an issue on the previous inspection. The action plan to address this had been completed with significant positive outcomes for many of the residents. However the staffing levels and shift patterns did not meet the needs of some residents with acquired brain injury. The person in charge explained that after the last inspection, additional staff were rostered for the evenings but they were reassigned to earlier shifts because they were required to facilitate activities during the day. Staffing arrangements required continuous review.

The inspectors found that at the time of inspection there were appropriate staff numbers and skill mix to meet the assessed health needs of residents for the size and layout of the centre. However staffing resources and staffing arrangements did not meet the social needs of residents especially the cohort of younger residents. This is discussed in detail and actioned under outcome 16. Inspectors examined the rosters and noted that there were fewer staff on duty in the evenings than during the day. Clinical nurse managers were not on duty at weekends to coordinate care in each of the three units at weekends. Staff residents and relatives who spoke with inspectors provided evidence that the impact of reduced staffing at weekends and in the evenings was not confined to younger residents.

Staff were very friendly and person centred. Residents and relatives spoke positively of the staff and the care they provided.

New staff were mentored and given a comprehensive induction. Staff appraisals were done annually and used to develop staff and inform training needs. The provider and person in charge promoted professional development for staff and were committed to providing on-going training to staff. A training matrix was maintained. Training records showed that extensive training had been undertaken and staff who spoke with inspectors confirmed this. Records confirmed all staff had completed mandatory training in areas such as safeguarding and prevention of abuse, fire safety, moving and handling, and managing aggression and potential aggression. All staff completed infection control training every two years. Nurses had undertaken specialist training to prevent unnecessary admissions to hospital. Some nurses were competent to undertake intravenous cannulation, administer intravenous medications, insert PEG tubes and

undertake male catheterization. Staff had received specialist training in palliative care and participated in the project 'Journey of Change' to support residents' end-of-life care. Since the previous inspection, 10 staff had completed training to facilitate sensory stimulation and exercise groups.

The inspectors reviewed four staff files and saw that all documents required by Schedule 2 of the regulations were on file with the exception of a vetting disclosure. Garda vetting disclosures were subsequently submitted by the provider.

Volunteers from a number of organizations attended the centre and provided very valuable social activities and services that residents said they enjoyed and appreciated. There was documentary evidence that volunteers had been vetted appropriate to their roles.

Judgment:

Non Compliant - Moderate

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:

Catherine Rose Connolly Gargan
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 report¹

Centre name:	St Joseph's Care Centre
Centre ID:	OSV-0000466
Date of inspection:	10/01/2018
Date of response:	09/02/2018

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The provider did not adequately resource the service to ensure that the changing needs of younger residents were met, to enable them to make choices in a way that reflects their diverse needs and rights.

1. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient

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

resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:

As requested Following the inspection, the provider is currently reviewing the needs of individual residents with acquired brain injury to put a plan in place to ensure that their social needs are adequately met.

A formal response will be submitted as requested outlining a long-term and interim plan by 28 Feb 2018.

The Management team wish to acknowledge that activity provision within the centre was an area that required improvement on last inspection and were pleased to see that inspectors saw evidence that this action had been satisfactorily completed and activities provision addressed the needs of our older residents and people with dementia.

However Management are committed to ensuring that staffing resources are kept under continuous review to determine what additional resources can be put in place to meet the changing needs of individual residents when their physical and health status improves.

Proposed Timescale: 30/06/2018

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Improvement was required in relation to documenting the rationale for the use of bedrails and the alternatives tried before full-length bed rails were put in place.

2. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:

1. Bed Rail Risk Assessment Documentation will be reviewed to support the documenting for the rationale for the use of bedrails and alternatives tried before full-length bed rails were put in place.

2. The Audit Tool currently in place to monitor use of physical restraint will also be reviewed in order to audit (in more detail) the compliance in relation to documenting the rationale for the use of bedrails and ensuring that all alternatives are tried before full-length bed rails are put in place.

Proposed Timescale: 31/03/2018

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Documentation of fire evacuation drill records did not provide sufficient assurances that timely evacuation of residents of residents from one compartment to another could be achieved within a reasonable timeframe.

3. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:

A discussion has taken place with Fire Officer for the region and a rehearsal fire evacuation is planned for 20/2/2018

A fire evacuation rehearsal scheduled for 20/2/2018 will identify time required to evacuate an entire compartment. From previous rehearsals we can confirm at this point in time, that we can achieve an evacuation of the immediate area or origin of fire within 2.5 minutes.

Proposed Timescale: 31/03/2018

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:

The centre held a small stock of medications for emergency use. The policy on the utilization and maintenance of the centralized drug press, stated that pharmacist was responsible for the monthly checking procedure and stock rotation. This had not been done since September 2017.

4. Action Required:

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:

As evidence in the inspection report the absence of an onsite pharmacist has resulted in

the policy on the utilization and maintenance of the centralized drug press not being adhered to.

The re-introduction of an on-site pharmacy support 2 days a week within the centre will ensure compliance in this area to ensure that there is a monthly checking procedure and stock rotation as required.

An induction meeting with the new pharmacist was held on 25/1/2018 and findings from the HIQA inspection were discussed with actions agreed.

Proposed Timescale: 31/03/2018

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Areas for improvement were identified in the prevention of pressure sores. Inspectors noted that some pressure relieving mattresses were set too high to provide effective pressure relief. Care plans did not state how frequently a resident should have their position changed and there were gaps in the turning charts.

Residents with diabetes were not provided with individual glucose monitors in line with best practice.

While recommendations made by dieticians and speech and language therapists were implemented in practice, they were not recorded in sufficient detail in residents' care plans.

5. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:

1 a. Actions have been taken to ensure that all mattress pressure is set correctly to ensure effective pressure relief. These actions include the introduction of a recording chart (dated and initialled) for each resident to reflect that mattresses are checked on a daily basis or in event that a resident's weight alters.

1. b Care plans, following assessment, will now include as appropriate how frequently a resident should have their position changed to relieve pressure on their skin.

1.c Our Care Plan audit tool will be revised to monitor turning / pressure relieving charts ensure there are no gaps in the recording of timing of a residents who require a change in position to relieve pressure on their skin.

2.Following the receipt of the HIQA Alert 005/2014 Risk Management of Blood Glucose

monitoring in Designated Centres, Nursing Management developed a Local policy SJCC 068 Procedure for the safe use of the Accu-Chek Performa Glucometer. This policy is in line with the Alert (005/2014: point 4.2) which supports that specifically designed blood glucose monitors can be used with multiple residents by appropriately trained staff.

Management wish to confirm that Blood Glucose Monitors currently in use within the Centre are specifically designed for use by multiple residents. However following the feedback from our HIQA Inspection, discussions have commenced with the Community Diabetic CNS in order to source individual glucose monitors for residents.

3.Care plan will include in sufficient detail recommendations made by dieticians and speech and language therapists as evidence through audit and review.

Proposed Timescale: 31/03/2018

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some care plans examined lacked sufficient detail to guide consistent care provision.

6. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:

1.As evidence in Inspection Report, Care Plans were in place to address identified needs and were reviewed regularly however as a result of action required all care plans will be examined by their allocated nurse to ensure all care plans have sufficient detail included to guide consistent care provision.

2.Care Plan allocations are continuously reviewed to ensure that all residents have an allocated Key Nurse responsible for updating and review of care plans on a three monthly basis.

3.Continuous audit of care plans and documentation will continue as evidenced during inspection, findings from same will be reviewed to ensure that recommendations and agreed actions are complete to ensure continuous quality improvement.

Proposed Timescale: 31/03/2018

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Inspectors observed and relatives commented that the paintwork in some areas was in need of attention. The person in charge confirmed that routine decorating had not been done in St. Therese's unit because the refurbishment works were imminent. The screening rails in large bedrooms had not been reconfigured to maximize the personal space for residents when beds had been removed.

7. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:

The next phase of the refurbishment plans for St Joseph's Care Centre includes the refurbishment of St Therese Unit however this is not due for completion until Dec 2021.

A painting schedule has been devised by the maintenance department and approval to proceed has been granted. In the interests of the Residents Privacy and Dignity painting will be carried out on a phased basis to minimise any disruption to the Residents.

Proposed Timescale: 31/07/2018

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Resources were not put in place to meet the changing needs of residents when their physical and health status improved. The service did not have the resources to support some younger residents to exercise choice in their daily lives in a way that reflected their diverse needs and rights. The resources were not in place to support younger residents to participate in activities in accordance with their interests and capacities.

8. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:

1.As requested following the inspection, the provider is currently reviewing the needs of younger individual residents with acquired brain injury and putting a plan in place in collaboration with the Disability services to ensure that their social needs are adequately met.

A formal response will be submitted as requested outlining a long-term and interim plan by 28 Feb 2018.

2 Management have been actively working on reducing the number of residents in the

multi occupancy rooms where possible and have created a more informal relaxed environment by the use of homely personalised furniture and lightening. A new television system had been installed in late 2017 in order for the residents to access more choice of T.V. channels. New televisions were purchased to facilitate the new upgraded system. Whilst a few wireless headphones were available for personal use more have been purchased in order for all residents to avail of this as they choose. All remaining multi occupancy rooms (4 bedded) have ensuite facilities. Each Unit has a family room available in the event residents wish to meet their visitors in private. In the event a family wish to have a family gathering/celebration/ tea outside of the unit there are rooms available to accommodate same. There is a Library facility in house for residents who have interest in reading and/or use of computers. A snoozelan room is also available to all residents to use at their leisure. Garden areas are easily accessed from each unit for those who have interest in gardening, or who wish to spend time outdoors. Each of these gardens have been fitted with outdoor fitness equipment. Another secure communal garden area is in the process of being developed.

Proposed Timescale: 1. February 28th 2018 2. Complete

Proposed Timescale: 28/02/2018

Theme:

Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

As discreet listening devices were not available, residents in multiple occupancy bedrooms could not listen to their television or radio without impacting on the others residents in the bedroom.

9. Action Required:

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

Please state the actions you have taken or are planning to take:

1. Discreet listening devices will be made available to all residents in multiple occupancy bedrooms to allow residents listen to their television or radio without impacting on the others.

The management wish to acknowledge that while discreet listening devises were made available on request from residents, this will now be reviewed to ensure that all residents will have access to same in multiple occupancy bedrooms

Proposed Timescale: 30/04/2018

Theme:

Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Screens were drawn to provide privacy but malodours and conversations were not contained behind screens.

10. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:

Plans for refurbishment to reduce multi-occupancy rooms have been submitted to HIQA as part of the centres re registration process in order to comply with requirements for 2021.

In addition all measures will continue to be taken by staff to ensure the dignity and privacy of all residents.

Currently all residents in multi occupancy room have access to ensuite bathroom facilities.

Proposed Timescale: 31/12/2021

Outcome 18: Suitable Staffing

Theme:

Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The staffing levels and shift patterns did not meet the needs of some residents with acquired brain injury.

Conversations with residents, relatives and staff evidenced that reduced staffing at weekends and in the evenings also impacted on other residents.

11. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

Management wish to acknowledge that at the time of inspection inspectors found on review of the rosters that there were appropriate staff numbers and skill mix to meet the assessed health needs of residents for the size and layout of the centre.

1.The report states that there are fewer staff on duty in the evenings and weekends.

The staff numbers for each of the units are as follows:

2.St. Therese's ward (16 Residents): 2 Nurses and 3 healthcare assistants, (Mornings) / 1 Nurse and 2 healthcare assistants after 5pm. There is also a kitchenette staff member on duty 8-8pm.

Padre Pio ward (25 Residents): There are 3 Nurses and 4 healthcare assistants in the mornings and 2 Nurses and 4 healthcare assistants in the evenings. There is also a kitchenette staff member on duty 8-8pm.

The Lodge (27 Residents): There are 3 nurses and 5 healthcare assistants in the mornings and 2 nurses and 4 healthcare assistants in the evenings as well as a kitchenette staff member 8-8pm.

All of the above staff numbers are the same 7 days per week.

A CNM2 is in place in each unit Monday to Friday.

Management cover at weekends is provided by either CNM2 or the ADON on a rotational basis.

3. Activity provision is incorporated by the staff in their duties. Individual activities are available to all residents as they wish. There are some residents who are regularly brought to local shops, library, post office and bank at their request. There is one resident who is accompanied to attend a local hairdresser as she wishes. There is ongoing discussion between residents and staff in relation to any activity they wish to attend/participate in. There are individualised activity careplans insitu for all residents. There is information and equipment provided in all units to facilitate various types of activities.

As requested following the inspection, the provider is currently reviewing the needs of individual residents with acquired brain injury and putting a plan in place to ensure that their social needs are adequately met. A formal response will be submitted as requested outlining a long-term and interim plan by 28 Feb 2018

The Management team will also use the Residents Forum meeting as a forum to talk to residents and their families to determine from their perspective the impact of the current staffing levels in the evenings and at weekends. The Resident Forum Meeting takes place quarterly, with the first meeting scheduled for 7th March 2018.

Proposed Timescale: 31/03/2018