

Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people



Centre name:	St Joseph's Community Nursing Unit
Centre ID:	0542
Centre address:	St Patrick Street
	Trim
	Co Meath
Telephone number:	046-9431229
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Type of centre:	<input type="checkbox"/> Private <input type="checkbox"/> Voluntary <input checked="" type="checkbox"/> Public
Registered provider:	Health Service Executive
Person in charge:	Karl Brogan
Date of inspection:	23 September 2009 and 24 September 2009
Time inspection took place:	Day-one start: 09:10hrs Completion: 18:05hrs Day-two start: 09:30hrs Completion: 17:00hrs
Lead inspector:	Brid McGoldrick
Support inspector(s):	Nuala Rafferty Leone Ewings (day-one only) Sheila McKevitt
Type of inspection:	<input type="checkbox"/> Registration <input checked="" type="checkbox"/> Scheduled <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced

About inspection

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

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.

Acknowledgements

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

About the centre

Description of services and premises

St Joseph's Community Nursing Unit in Trim, Co Meath, is run by the Health Service Executive (HSE).

The service is divided into five units on the ground floor with 24 to 33 residents living in each unit. Two of the units are for women and one for men with the remaining two units accommodating both men and women. The centre provides continuing care, planned respite care, palliative care and day care. There is also a specific unit dedicated to the care of residents with dementia.

The five units share a common entrance leading to a small reception area. A long corridor extends from the reception area to where the five units are located. There is also a large dining room and chapel leading off this corridor.

The first floor consists of management offices, staff changing rooms and a conference room.

Location

The centre is located in Trim town, a short walk from the main shopping and business area of the town.

Date centre was first established:	1921
Number of residents on the date of inspection	147

Dependency level of current residents	Max	High	Medium	Low
Number of residents	75	35	28	9

Management structure

The Local Health Office (LHO) Manager, David Gaskin is the designated provider. Karl Brogan is the Person in Charge and is supported in this role by two assistant directors of nursing (ADON), one clinical practice facilitator and 11 clinical nurse managers (six at level-two and five at level-one).

Both assistant directors of nursing have devolved responsibility for supervising nursing and care staff, catering, laundry, chaplaincy and mortuary staff. Clerical, ground staff and other ancillary workers are supervised by a local administrator who reports to the General Manager.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on first day of inspection	1	22	15	10 catering and 2 chefs	5 cleaning and 1 laundry.	5.5 WTEs admin	1 ADON, 1 clinical practice facilitator, 1 activities nurse.

Summary of findings from this inspection

This was a scheduled announced inspection and was the first inspection of this centre undertaken by the Health Information and Quality Authority (the Authority).

Inspectors met residents, relatives, the person in charge, an assistant director of nursing, and staff on duty during both days of the inspection. They reviewed a range of documents that included resident care plans, medical administration records, staff files, training records, duty rotas, policies and the complaints record file.

Discussion with the nursing and care staff confirmed that they were familiar with individual resident's care needs. However, a review of care plans indicated that the information recorded by nurses in the daily evaluation records did not always reflect the individual care planned for residents.

Inspectors also noted that residents' medical care had not been routinely reviewed by their general practitioners (GPs).

The working patterns and rostering of staff did not always ensure continuity of care or maximise residents' safety and staffing levels were not always adequate to address residents' needs. There was also a lack of management supervision at night and an over-reliance on agency staff.

The Action Plan at the end of the report identifies areas where improvements were required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. These included issues around the design and layout of the centre, in particular the insufficient numbers of toilets and bathrooms to meet the individual needs of the residents, poor infection control, and inadequately maintained floor coverings.

On the week prior to the inspection visit, the Chief Inspector of Social Services had been notified of three allegations of abuse of residents in the centre. This notification was not given in the required timeframe. The actions of the person in charge in response to the allegations were fully explored during the inspection. Inspectors identified a number of shortcomings, particularly in relation to the failure by the person in charge to investigate the allegation in accordance with HSE policy. These failings were brought to the attention of the provider who was asked to review the actions taken by the person in charge and submit a report to the Authority within two weeks of the inspection. The provider was also required to submit an action plan addressing three issues that required urgent action, namely the protection of residents, end-of-life care and the management of complaints. This urgent action plan was not satisfactory in terms of protection of residents from abuse in that the nurse in question remained on duty. The nurse concerned was not placed on administrative leave until 5 November 2009 following two further incidents of alleged abuse that the Authority was not notified about as per requirements of the regulations.

Residents' and relatives' comments

The inspectors obtained the views of 26 residents and 10 relatives by reviewing the completed pre-inspection questionnaires and by speaking to a number of them during the inspection. Their views in general were positive in all aspects, with residents being complimentary of the support and assistance provided. Residents also praised staff for their commitment and kindness to them, and this commitment was also observed by inspectors.

Many relatives told inspectors that they visited daily and felt that their input into the care of residents was welcomed. While relatives were satisfied with the level of care provided, eight shared their concerns about the low numbers of staff on night duty. Relatives also said that it was difficult for residents and visitors to speak in private and were dissatisfied with the current laundry arrangements in that clothes at times were misplaced or lost. A number of relatives also commented on the poor quality of windows throughout the centre which were found by inspectors to be draughty.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

A residents' and representatives' committee meeting took place on a six-weekly basis. A resident-member of the committee told inspectors that the committee had been successful at implementing change within the centre. The resident described how, following recent consultation, the designation of units had been changed from numbers to names that had significance to the residents and the locality.

Some improvements required

While there was a full-time clinical facilitator who provided mentorship and guidance to student nurses and new staff, these details did not appear on the organisational chart.

Inspectors were told by the person in charge that contracts of care were not in place for residents.

While a financial file had been maintained, residents were not routinely issued with statements. Inspectors were informed that this was due to the lack of lockable storage. Residents confirmed that they had no lockable storage space in their rooms to store private possessions.

Significant improvements required

Inspectors found that there was poor leadership and management in the centre which directly impacted on the care provided to the residents.

Allegations of abuse:

Three allegations of elder abuse had been notified to the Authority by the person in charge in the week prior to the inspection. These notifications were outside the timeframes required to ensure safeguarding of residents. A review of the documentation and discussion with the person in charge confirmed serious shortcomings in how the allegations had been progressed.

The person in charge failed to investigate the allegations in accordance with the HSE policy document, "Responding to Allegations of Elder Abuse." The investigation had not been initiated in a timely manner and there was a lack of robustness in the approach. Relatives had not been informed and the only persons interviewed were the person making the allegation and the staff member named. No immediate protection measures for residents had been introduced.

The provider was required to submit an immediate action plan. This action plan was not satisfactory in terms of protection of residents from abuse in that the nurse in question remained on duty. The nurse concerned was not placed on administrative leave until 5 November 2009 following two further incidents of alleged abuse which the Authority was not notified about as per requirements of the regulations.

The Authority has initiated a complaint with An Bord Altranais around the fitness to practice of the nurse and elevated the need to ensure effective response to abuse of residents to a higher level within the HSE. These actions, and other actions which the Authority deems appropriate, will be followed through on with the HSE.

Discussion with staff and a review of the records confirmed that training on elder abuse had not been provided to all staff.

Management of complaints:

Inspectors reviewed a sample of a log of general complaints which are maintained within each unit and the central complaints register that was kept by the person in charge. Inspectors found that the management of complaints was unsatisfactory. Inspectors identified that a number of complaints had not been investigated. Where some had been investigated (according to the person in charge), there was no supporting documentation to evidence that investigations had taken place or that feedback had been given to the complainant. There was no documented evidence of any learning following the investigation of complaints or process in place for cascading the learning to staff.

Fire and safety:

A number of fire management practices within the centre did not meet fire regulations. Inspectors observed that a number of bedroom doors had been wedged open, and units 3, 4 and into the corridor of unit 5 could not be isolated to prevent a spread of fire. There was also insufficient space outside to remove residents from units 3 and 4 in the event of a fire. Staff had not attended fire drills in accordance with the statement of purpose and a number had not attended any fire drills during 2009. There was 10 staff on night duty (two in each unit) which was insufficient to meet the needs of all 147 residents if there was a need to evacuate in the event of a fire.

End-of-life care:

Inspectors were provided with a draft of the "Guidelines for the care of the deceased resident". However, these guidelines were not reflected in practice.

Health, safety and security:

There was no plan in place for the emergency evacuation of the centre. Inspectors observed practices that could potentially infringe on residents' health and safety. These practices included the storage of liquid chemicals in an unlocked cupboard.

Bank statements and resident registers were kept in an unlocked cupboard adjacent to an elevator which provided easy access to unauthorised persons.

A number of outer doors from the kitchen and laundry were left open throughout the day which provided ready access to unauthorised persons. There was also no log for visitors to sign when entering and leaving the centre.

Statement of purpose:

The statement of purpose and function submitted prior to the inspection did not comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009. Specifically it did not contain a statement of the maximum number of residents to be accommodated, the residents' age or gender.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

The choice, quality and presentation of meals were of a good standard. An inspector joined residents for lunch which was relaxed and unhurried. Residents confirmed meals to be enjoyable, social and relaxing occasions.

Feedback, comments and views obtained from residents by the inspectors during the inspection were positive overall. The person in charge told the inspectors that work was in progress to provide an advocacy service for residents and inspectors noted a poster on a notice board seeking volunteers for the programme. Some residents were facilitated to attend a weekly "active retirement" group.

Risk assessments had been carried out on residents prior to the use of bed rails as a form of restraint, and restraint consultation forms had been completed and signed by the residents and / or their relatives where appropriate.

Some improvements required

There was no dining room available for residents in unit 1. Inspectors saw that residents remained in bed and were assisted by staff with their meals. The table settings in the main dining room did not include drinking glasses, saucers, tea spoons or napkins. Cold milk was the only cold drink offered to residents at lunch in the main dining room.

On review of the staff allocation book, and from discussions with staff, it was evident that a key worker / named nurse system had been implemented. However, this allocation to residents did not always occur when they were on duty thereby minimising continuity of care.

Inspectors observed that locks were not provided on the main bathroom doors in certain units and this infringed on the privacy of residents.

There were no intervention strategies identified to ensure that staff could respond to behaviour that challenges. The care plans reviewed indicated medication was

prescribed and administered by staff to control behaviour that challenges. There was no evidence that residents or their relatives had been consulted with or had agreed the plan to prescribe and administer medication for behaviour that challenges.

Inspectors reviewed records of incidents and accidents and noted that behaviour that challenges was a recurring theme. While there was documented evidence of training provided to staff on the management of behaviour that challenges there was no evidence that incidents had been audited to inform learning and future practice or included in individual care plans.

Significant improvements required

There was evidence of institutionalised care practices, for example, residents remaining in bed routinely, showers being based on routine rather than individual preferences, and laxatives being routinely administered. These practices, observed by inspectors and confirmed by staff, did not reflect a person-centred approach to care.

Residents in unit 2 had not been involved in any activities. The inspector observed the residents either in bed or sitting for long periods.

Residents were not risk assessed in the event that they would go missing. Staff confirmed that, while there was a HSE policy on missing persons, they had not conducted a drill to see if procedures would enable them to locate a missing person quickly.

Relatives said that, at times, clothing became misplaced or lost while been laundered and inspectors noted that a number of complaints related to missing or lost clothing.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process, which is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

Good leadership by clinical nurse managers at unit level was evident and inspectors observed high levels of supervision and their involvement with staff, in all aspects of care delivery.

Care plans reviewed by inspectors had risk assessments for lifting and moving, pressure sores, nutrition and falls. Evidence-based tools had been used to inform these assessments. A nurse had been assigned to falls management two days per week and had provided education and training on this aspect to all staff.

An inspector interviewed and accompanied a staff nurse who was administering medication. Safe practice was observed and staff demonstrated good knowledge and understanding of An Bord Altranais guidelines for safe medication management.

Significant improvements required

All residents had a care plan and a number of these were reviewed by the inspectors. New care plans had been introduced earlier this year. There was evidence that care plans had not been fully implemented in each of the units and they did not reflect a multidisciplinary approach. Some care plans did not address all the residents' needs identified on assessment and were not sufficiently detailed to ensure that residents' needs were being adequately met. There was no direct link between the residents care plan and the daily nursing evaluation of care given.

Inspectors observed residents sitting in the one spot for long periods. The person in charge advised inspectors that there was no occupational therapist officially assigned to the centre.

Seating assessment had not been undertaken on a number of residents. The person in charge told inspectors that that the occupational therapist assigned to the day-hospital is consulted and offers advice on seating as requested.

Minor issues to be addressed

While each resident had been assigned a GP, they were not afforded choice in this matter.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

A number of quiet seating areas with large comfortable couches or armchairs had been provided at intervals on the main corridors and at main exit areas for residents and visitors use.

A closed circuit television (CCTV) security system was in place with cameras strategically placed at all main entrance and exits and along the corridors throughout the centre and was monitored from 09:00hrs to 21:55hrs Monday to Sunday.

A private shop facility for residents had been provided for two hours every morning and residents were observed availing of this facility.

A number of areas had been upgraded to meet infection prevention and control standards. All sluice rooms have been fitted with stainless steel fittings and equipment. The kitchenette in unit 1 and the main kitchen had been fitted with stainless steel fixtures and fittings. The inspectors observed these areas to be clean and hygienic.

Some improvements required

The surface of the floor covering on the main corridor, in the main kitchen, the chapel and on the staircase was chipped and worn. Inspectors observed that these areas had not been adequately cleaned. Adjacent to the entrance to the chapel, a tile was missing which made the surface uneven and created a trip hazard for residents and visitors.

A small part of the floor covering on unit 5 had been repaired with adhesive tape and was found on the day to be uneven underfoot. Some of the walls on the corridor and in the bedroom areas had areas of paint missing. There was a loose tile on the ceiling over the entrance to the lift on the first floor, which was also stained. A damp odour was also noted in this area.

Significant improvements required

Design and layout:

The entry to the visitors' room from the main corridor had been locked. Staff informed the inspector that it was normally locked. There was a second door into the visitors' room from the kitchen which was open. Kitchen staff were observed using it for their breaks. Relatives had commented that there was a lack of private areas in the centre.

Infection control:

There was a potential risk of cross infection for residents and staff due to the poor layout of the units and the sharing of facilities between units, for example, the sharing of the kitchenette and clinical rooms. There were insufficient toilets and washing facilities throughout the centre.

The main female staff changing area did not have adequate facilities for the number of female staff employed to store their clothing and personal belongings. Staff were observed at lunchtime leaving the premises wearing their uniforms.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

"Life story books" consisting of photographs and headings were in place for a number of residents, particularly residents with cognitive impairment. These books charted the social history of the resident and significant family events. While not all relatives had been involved, inspectors were told that staff had worked closely with residents to develop the books and provided any assistance necessary.

Information and details of the recent referendum were available to both residents and relatives in the form of written leaflets, and the inspectors were informed that the centre was to act as a polling centre on the day of the referendum.

Televisions were placed in each of the units and in the single room. Inspectors saw that residents switched on the televisions and watched programmes of their choice. Notice boards were a source of information to residents. Inspectors saw notices in relation to the menu and the activities schedule. All notices were laminated. The menu displayed and the activities listed corresponded to what the inspectors saw on the day of the inspection.

Local newspapers and magazines were available throughout the centre.

Significant improvements required

The centre did not have all of the relevant policies required by regulations available. The staff involved in developing the policies told the inspectors that they were currently awaiting feedback on draft policies from the management of the centre.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

Staff told inspectors that they enjoyed their work and the training opportunities afforded to them.

25 out of the 40 carers are trained to Further Education and Training Awards Council (FETAC) level-5, with a further 5 in training in the current academic year, 2009 / 2010.

There was a clinical practice facilitator employed full-time. All new staff were booked on a two-day HSE induction programme. However, there was a waiting list for attending this course. Each of those who had started working in the centre had been allocated a staff member to shadow and was given an induction booklet for completion within the first week. The clinical facilitator met all new staff on a three-monthly basis for their first year of employment to ensure they were settling in and that their learning needs had been met.

All agency staff were interviewed by an assistant director of nursing and prior to starting work had been introduced to relevant staff. They were given a tour of the centre and had completed induction prior to commencing work.

Student nurses have regularly undertaken placements in the centre. A staff preceptor and associate staff preceptor were allocated to them on commencement of their placement. Inspectors observed that comprehensive induction packs had been developed for student nurses which contained copies of core care plans and a reflective diary.

Professional development plans had just been introduced for all staff members. There was evidence from staff files that staff had received mandatory training on fire safety, minimal handling practices and cardiopulmonary resuscitation (CPR). There was an automated external defibrillator available in the centre.

Some improvements required

While the assistant director of nursing informed inspectors that three references had been obtained, and Garda Síochána vetting had been carried out prior to staff commencing employment, this could not be confirmed, as the records were not kept on site.

Significant improvements required

The layout of the building, the current high dependencies of residents, the regular use of agency staff and the lack of management structure at night, limited the ability of staff to manage unforeseen circumstances, provide continuity of care, and ensure that residents' needs were appropriately addressed. Inspectors examined the rotas for all staff working in the centre. Ten staff had worked seven continuous nights on, seven off. In addition, relief staff had been allocated on a task-oriented basis and no consideration was given to the areas they previously worked in or their understanding of the particular needs of residents. From 8pm to 8am there was only one nurse and one attendant on duty in each unit, and there was no formal on-call arrangements in place.

Report compiled by

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

5 November 2009

Provider's response to inspection report

Centre:	St Joseph's Community Nursing Unit, Trim, Co Meath
Centre ID:	542
Date of inspection:	23 September 2009 and 24 September 2009
Date of response:	17 December 2009

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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

All reasonable measures had not been taken to protect residents from abuse.

Action required:

Ensure that allegations of abuse are managed in accordance with regulations, best practice standards and local policies and procedures.

Reference:

Health Act 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

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

Timescale:

<p>Provider's response:</p> <p>The staff and management take all allegations of abuse seriously and all allegations of abuse are managed under Trust in Care and Elder Abuse Policies.</p> <p>The three allegations of abuse which have arisen relate to one staff member who was investigated under Trust in Care. The inspectors' concerns in relation to the supervision of this staff member and the informing of residents' relatives during the investigation have been immediately taken on board by management and rectified.</p> <p>Training on Elder Abuse for all Senior Nurse Managers and Clinical Nurse Managers occurred on the 15th October 2009.</p> <p>Refresher training on Trust in Care will be provided for all managers in 2010.</p> <p>Elder Abuse Training is currently provided for all staff having commenced on 4th November '09 and will be completed on 18th December '09. Thereafter Elder Abuse Training will be included in the Induction Programme for new staff.</p>	<p>Immediate</p> <p>October 2009</p> <p>October 2009</p> <p>February 2010</p> <p>4th November to 18th December '09</p>
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<p>2 The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The person in charge failed to handle and investigate complaints in accordance with regulations and local policy.</p>	
<p>Action required:</p> <p>Written operational policies and procedures should be in place in relation to the making, handling and investigation of complaints in accordance with regulations.</p> <p>All complaints should be handled and investigated in accordance with regulations.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 39: Complaints Procedures Standard 6: Complaints</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>

<p>Provider's response:</p> <p>The existing HSE Polices on the making, handling and investigations of complaints are in place in St Joseph's.</p> <p>The Person in Charge developed a local policy, which the Quality & Safety Committee, adopted on the 11th of November. This Policy is now in operation and ensures that complaints are recorded, addressed, actioned and reviewed for learning by the management team.</p> <p>A revised Consumer Feedback Log has been developed and implemented to facilitate and demonstrate evidence that complaints, issues and compliments are addressed and managed appropriately. The Person in Charge ensures that reviews occur on a monthly basis.</p> <p>The flow chart on display at Suite level since August 2009 outlines the process and contact details for independent appeals and this is stated in the policy</p>	<p>11th November 2009</p> <p>November 2009</p>
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<p>3. The provider has failed to comply with a regulatory requirement in the following respect:</p> <p>Care of deceased residents required improvement.</p>	
<p>Action required:</p> <p>Guidelines for the care of the deceased resident should be introduced and the procedure for the removal of remains to the mortuary should be revised to maximise the dignity and respect of all residents within the centre.</p>	
<p>Reference:</p> <p>Heath Act 2007 Regulation 14: End of Life Care Standard 16: End of life Care.</p>	
<p>Please state the actions you have taken or are planning to take following the inspection with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>New arrangements have been introduced which no longer involve the removal of the deceased resident's remains through the centre. The remains are now removed from a side room via the nearest exit on that Suite to the chosen area of rest (Mortuary, Home, and Chapel of Rest). The removal of the deceased residents' remains is</p>	<p>Immediate.</p>

<p>managed by a Funeral Director and consequently the use of the mortuary trolley has ceased.</p> <p>A detailed guideline has been developed for care of deceased residents, which includes the use of a side room on each of the five Suites. Further feedback on this will be sought before the Hospice Friendly Hospital Committee sign off this guideline.</p> <p>Training and roll out of the new guideline will occur in March 2010.</p>	<p>February 2010.</p> <p>March 2010</p>
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<p>4. The provider has failed to comply with a regulatory requirement in the following respect:</p> <p>Adequate precautions had not been taken against the risk of fire.</p>	
<p>Action required:</p> <p>Ensure adequate precautions are in place against the risk of fire which includes an effective means of evacuation and an emergency plan.</p> <p>Ensure that all staff regularly attend fire drills.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Doors that were left open to assist residents to have free access and egress have now been fitted with magnetic locks.</p> <p>The concerns raised by the inspection team regarding the Fire Orders and Policy were under review at the time of the visit. A more user-friendly signage system to assist the fire evacuation process will be developed with the HSE Fire Prevention Officer and displayed appropriately.</p> <p>A revised Fire Policy to support the above will be signed off at next Quality & Safety meeting on the 10th of December.</p> <p>A comprehensive emergency evacuation plan will be developed with the HSE Fire Prevention Officer, the Chief Fire Officer for the county and other key stakeholders.</p>	<p>November 2009</p> <p>December 2009</p> <p>December 2009</p> <p>February 2010</p>

The number and frequency of fire drills will be increased to facilitate the mandatory attendance of all staff to same.	December 2009
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<p>5. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The numbers of staff and skill mix were not always appropriate to meet the assessed needs of the residents and the size and layout of the centre.</p>	
<p>Action required:</p> <p>Using appropriate evidence-based tools, review the staffing levels on night duty, taking into account the size and layout of the centre, the number of residents and dependencies.</p> <p>Ensure formal on-call arrangements are in place out of hours.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Senior Management has arranged to undertake a review of the staffing levels on night duty utilising an evidence based tool to be completed by the 12th February 2010</p> <p>The current on-call polices / arrangements cover the following: Fire, Missing Persons, Personal Alarm (unexpected event / challenging behaviour), Maintenance, Doc on Call, Intruder alarms, Hospital Watch. Local procedures are in place for staff shortages at night. Senior nurse managers are contactable and available. The Director of Nursing has a HSE mobile phone and is contactable out of hours.</p> <p>The Management Team will review existing and additional formal on-call arrangements.</p> <p>St. Joseph's is very much aware of the need to reduce bed numbers to meet the assessed needs of the residents and the size and layout of the centre and has been making progress with this as is evident by the following bed reductions: -</p> <ul style="list-style-type: none"> - 2003 – 2006 - 18 beds reduced. - 2008 – 2009 - 17 beds reduced. 	<p>February 2010</p> <p>In place</p> <p>January 2010</p> <p>May 2010</p> <p>May 2010</p>

<p>A further bed reduction plan has been commenced which will give a reduction of 12 beds by the 30th April 2010. Further reductions of bed numbers and required staffing levels and skill mix will be informed by the review of staffing levels using the evidence-based tool.</p> <p>At this time there is a need to employ agency staff to meet roster requirements. Every effort is made to ensure continuity of care by assigning the same agency staff to the same Suites. The inspectors did note that the agency staff were all screened and inducted to the service.</p>	
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<p>6. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Adequate personal and communal space had not been provided for all residents throughout the centre.</p>	
<p>Action required:</p> <p>Provide adequate personal and communal space for all residents throughout the centre to meet the regulations and standards.</p>	
<p>Reference:</p> <p>Heath Act 2007 Regulation 19: Premises Standard 25: Physical Environment</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>It is recognised that the ongoing updating and modernisation of a facility which was built-in 1841 has its challenges. Management strive to develop areas and space which can cater for the needs of the residents that comply with the Standards and Regulations of 2009. The Management Team is very much aware of the challenges that the building presents to meet the adequate personal and communal space requirements for residents. To enhance the residents personal space the following bed reductions have taken place: -</p> <ul style="list-style-type: none"> - 2003 – 2006 - 18 beds reduced. - 2008 – 2009 - 17 beds reduced. 	<p>May 2010</p>
<p>A further reduction of 12 beds is planned by 30th April 2010.</p>	<p>December 2009</p>

A newly decorated day room/dinning room has been opened on Lackanash Suite.	January 2010
The day room / dining room in St Camilius Suite will be decorated in January 2010.	September 2009
The visitors' room is now openly available at all times.	December 2009
The main residents' dining room has being redecorated and new seating was purchased for this area.	February 2010
A newly developed dining / living space for Butterstream Suite will be completed in February 2010.	March 2010
Funding has been sought to address a maintenance programme for 2010.	

7. The provider is failing to comply with a regulatory requirement in the following respect:	
There were insufficient toilets and bathrooms having regard to the number of dependent persons in the centre.	
Action required:	
Provide adequate toilet and bathroom facilities.	
Reference:	
Health Act 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 25: Physical environment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The planned reduction of beds by 30 th April 2010 will achieve the following ratio of Toilets/ Bathrooms for residents. <u>Toilets</u> <ul style="list-style-type: none"> - Tara Suite – 1:7 - Lackanash Suite – 1:6 - St Camilius Suite – 1:6 - Sycamore Suite – 1:6 - Butterstream Suite – 1:5 	30 th April 2010

<p><u>Bathroom/shower facilities</u></p> <ul style="list-style-type: none"> - Tara Suite – 1:9 - Lackanash Suite – 1:14 - St. Camilius – 1:14 - Sycamore Suite – 1:14 - Butterstream Suite – 1:13. <p>This will be subject to ongoing review to comply with HIQA's standards.</p>	
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<p>8. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The provider did not ensure that each resident was supported on an individual basis to achieve optimum levels of health.</p>	
<p>Action required:</p> <p>Ensure that residents have access to occupational therapy.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 9: Health Care Standard 13: Healthcare.</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>The Senior Occupational Therapist for the Day Hospital provides as required consultation and advice on environment issues and seating and Mini-Mental assessments are conducted as requested.</p> <p>With the establishment of a Primary Care Team for Trim the provider will explore options for increasing this level of service within St. Joseph's.</p>	<p>September 2009 & Ongoing</p> <p>March 2010</p>

<p>9. The provider is failing to comply with a regulatory requirement in the following respect:</p>	
<p>There was no suitable lockable storage space available for use by residents in their bedrooms.</p>	

Action required:	
Provide a suitable lockable storage space for each resident.	
Reference: Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All residents will be offered a lockable space, which they will be provided with it, by end of first quarter of 2010.	April 2010

10. The provider has failed or is failing to comply with a regulatory requirement in the following respect:	
Staff files were not maintained at the centre.	
Action required:	
Ensure that staff files are maintained at the centre and contain all the requirements listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009	
Reference: Health Act 2007 Regulation 18: Recruitment Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The practice to date is that all recruitment and selection of staff was centrally managed via the corporate Human Resource Department located off site. Central files are held off site which complies with legal requirements. In recognition of the new legislation that files now must be stored on site, work on this will commence in January 2010 with completion in the first quarter of 2010.	Historical April 2010

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

There was no formal system of evaluating care plans.

Action required:

Ensure that residents' care plans are kept under formal review and at no less than three-monthly intervals.

Reference:

- Health Act 2007
- Regulation 6: General Welfare and Protection
- Regulation 8: Assessment and Care Plan
- Regulation 17: Training and Staff Development
- Standard 13: Healthcare
- Standard 10: Assessment

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

Timescale:

Provider's response:

The system within St Joseph's is that the primary nurse is responsible for reviewing their allocated residents' care plan on a three monthly basis. This is a new system that is under continuous review by the Nursing Practice Development Committee.

September 2009

The layout of the care plan has now been modified to demonstrate when it was reviewed, by whom, with whom and what the outcome was.

October 2009

Senior Management will amend the evaluation sheet to demonstrate daily reviews and MDT approach to care planning. The Clinical Practice Facilitator will audit the nursing care plans with the appropriate Clinical Nurse Manager in December and January and action findings.

December 2009 / January 2010

The Medical Officer reviews residents every six months and as required. The manner in which these reviews were documented will be changed to ensure resident's medical notes reflect this practice.

December 2009

<p>12. The provider has failed or is failing to comply with a regulatory requirement in the following respect:</p> <p>A range of nursing and care practices were based on routine rather than being person centred.</p>	
<p>Action required:</p> <p>Ensure all nursing and care practices are evidence based and reflect a person-centred approach to care.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation: 6 General Welfare and Protection Standard: 17 Autonomy and Independence Standard: 18 Routines and Expectations</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>St Joseph's was part of the national two-year project addressing person centred care for residential care settings in Ireland and management continue to strive to ensure a culture of person centeredness is embedded within the service provided.</p> <p>The primary nurse under the direction of the Clinical Nurse Managers review residents with reduced mobility and risk assess needs and develop a care plan in consultation with the resident and/or their family.</p> <p>With the development of more communal living spaces residents and staff will have additional alternatives to choose from.</p> <p>Laxatives are administered only if prescribed by the Medical Officer, and all Drug Kardex are reviewed at six-monthly intervals and rewritten. Residents on laxatives are managed and kept under review by the Primary Nurse and the Clinical Nurse Managers. Prescription and care plans are updated as required.</p> <p>The showering of residents is undertaken in accordance with care plans. All personal care is recorded in the resident's notes. In addition shower lists were held by some Clinical Nurse Managers which were for reference purposes only and not used as an allocation system. This practice has ceased.</p>	<p>June 2007</p> <p>Immediate</p> <p>January 2010</p> <p>Immediate</p> <p>December 2009</p>

<p>13. The provider has failed or is failing to comply with a regulatory requirement in the following respect:</p> <p>The current recreational facilities were not meeting the residents' needs.</p>		
<p>Action required:</p> <p>Provide facilities to ensure residents receive recreational activities to meet their individual needs.</p>		
<p>Reference:</p> <p>Health Act 2007 Regulation 6: General Welfare and Protection Standard 18: Routines and Expectations</p>		
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>	
<p>Provider's response:</p> <p>Management are aware that the current structure of the Community Nursing Unit does not lend itself to recreational activities but within the confines of the infrastructure the following developments are in place or planned.</p> <p><u>Butterstream Suite</u> Newly developed enclosed smoking area provided for the residents of Butterstream Suite.</p> <p>Architectural opinion is currently been sought for the existing dining room/sitting room and the sun lounge to be redesigned on the home from home model of care for the residents.</p> <p>It is planned that this redesign will commence in early 2010.</p> <p><u>Sycamore Suite</u> Enhance the utilisation of Sycamore Suite's sunroom, the main dining room and the small seated area off the corridor by staff encouraging and enabling residents to move from the bedside to these areas at some stage throughout the day.</p> <p><u>Main Dining Room</u> To encourage, enable and assist more residents to attend the main dining room for main meals. The dining experience for residents has improved in the main dining room by ensuring that tables are appropriately set, including napkins, glasses and a variety of drinks etc..</p>		<p>December 2009</p> <p>February 2010</p> <p>December 2009</p> <p>September 2009</p>

<p>A communal seating and entertainment area has been developed in part of the existing main dining room.</p> <p><u>Smoking Facilities</u> Combined male/female smoking area exists off the corridor from main entrance to Sycamore Suite.</p> <p><u>Lackanash Suite</u> Smoking room in Lackanash Suite has been decommissioned and smokers have now been re-directed to the combined smoking area on Sycamore Suite.</p> <p>Lackanash Suite now has a newly renovated and redecorated activities, day room / dining room.</p> <p><u>St Camillus Suite</u> Existing day room in St Camillus Suite to be a ward area for residents and the dayroom to be relocated to the centre of St Camillus Suite to allow greater accessibility. Both these areas for renovation and redecoration in February 2010.</p> <p>Approval from the Fire Officer was received on the 4th December 2009 for the re-designation of existing day room.</p> <p><u>Gardens</u> Joint project with the Friends of St. Joseph's to develop a garden for the residents of Tara Suite. National Lottery funding will also be sought to assist with completion of this project.</p> <p><u>Transport</u> Bus available to take residents on external outings such as local variety shows, art exhibitions and concerts.</p> <p><u>Activities</u> The planned reduction in beds will enhance staff time to devote to activities and enhance the person-centred care programme.</p> <p><u>Volunteers</u> A guideline to support the introduction of volunteers in St Joseph's is in draft format for ratification in February 2010.</p>	<p>December 2009</p> <p>October 2009</p> <p>October 2009</p> <p>February 2010</p> <p>December 2009</p> <p>June 2010</p> <p>September 2009</p> <p>May 2010</p> <p>February 2010</p>
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14. The provider has failed or is failing to comply with a regulatory requirement in the following respect:

Staff had not been provided with adequate facilities for the purposes of changing and storing their personal belongings.

Action required:	
Provide adequate facilities for staff to change and store personal belongings.	
Reference:	
Health Act 2007 Regulation 19: Premises Standard 26: Health and Safety Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: There are facilities on the 1 st floor for staff to change when coming and going off duty. These facilities will be reviewed and additional lockers will be purchased for the staff. Within each suite there are sufficient smaller lockers for staff to store personal items if they wish. All staff are aware of the inspectors findings and informed not to go off site in their uniforms. As part of ongoing work of the local partnership forum for 2010 the development of a staff uniform policy will be undertaken.	January 2010 December 2010 March 2010

15. The provider has failed or is failing to comply with a regulatory requirement in the following respect:
The range of policies, procedures and guidelines available in the centre was not in compliance with Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.
Action required:
Put in place written policies and procedures on all items listed in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.
Reference:
Health Act 2007 Regulation 11: Communication Regulation 22: Maintenance of Records Regulation 27: Operating Policies and Procedures Standard 14: Medication Management Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>The Local Quality Risk and Safety Committee has responsibility for developing and reviewing policies and procedures. Since the introduction of the Regulations in 2009, the Committee has been developing additional policies required, see chart below.</p>	September 2009

	Ref	Title	Type of Document	Developed	Comment	Lead	Status
1	1.1	Function and Purpose	Statement	YES	First Version signed off	DON	Completed Sept 09
2	2.5	Satisfaction Survey	Questionnaire	No	CPF has some examples and discuss with the Quality and safety Committee	CPF / DON	Work in progress
3	3.2	Policy on Consent	PGPP	WIP	Local Consent Policy on intimate examination to be developed	DON	Feedback obtained – 3 rd draft circulated Oct 09.
4	3.5	Communication	PGPP	Yes		DON	3rd Draft Returned for feedback Completed. to be formatted and signed off by Q+S committee
5	3.1	Consent Forms Psychotropics Medication	Document	Bed Rails reviewed 2009	See 3.2		New Form on Psychotropics medication to be developed
6	5.1	Rights of Residents	PGPP	No		CPF	2nd draft to be circulated Jan 2010
7	6.1	Complaint Procedure	Information	Yes HSE	Draft under development, Flow charts to be circulated.	DON and CPF	Completed.
8	6.5	Register of complaints	Document	Yes June 09	New Format Sept 09	CPF and ADON	Completed.
9	7.1	Contract of Care	Document	No	None	LHM and DON	Work in progress
10	7.2	Abscension/ Missing Persons	PGPP	Yes 2007			Completed.
11	8.1	Elder Abuse	PGPP	Yes HSE	Require local policy and flow chart in interim.	Quality & Safety Com.	Local Policy under development plan to sign off Dec 09

12	8.3	Whistle Blowing Policy	PGPP	Yes HSE 09			Completed.
13	9.1	Residents Accounts	PGPP	Yes			Completed.
14	9.1	Residents Personal Property	PGPP	Yes	ADON currently reviewing	ADON	Work in progress
15	10	Admission Policy	PGPP	Yes 2009		DON	To be reviewed in light of Fair Deal.
16	10	Discharge Policy	PGPP	Yes 2009			Completed.
17	12.1	Health Promotion Policy	PGPP	Yes	CPF is working on this with Health Promotion Dept	CPF	Work in progress
18	14.3	Medication Management Policy	PGPP	Yes			Completed.
19	17.2	Policy that promotes maintains and maximises independence.	PGPP	No	Consider philosophy of care.	Quality and Safety Comm	Philosophy of care to support vision statement deemed sufficient.
20	21.1	Challenging behaviour	PGPP	Yes			Completed.
21	21.14	Policy physical restraint	PGPP	Yes	HSE developing new policy		Awaiting sign off.
22	24.17	Staff Development and Appraisal Policy	PGPP	Yes 2008			Completed.
23	25.25	Provision, management, maintenance, cleaning, decontamination , and repair of medical devices and equipment.	PGPP	No	We have procurement, maintenance requests, SARI, and local cleaning SOP.	Administrator	Completed – Administrator to ensure these are present in all areas.
24	25.31	Smoking Policy	PGPP	Yes 2008	Version 2 under review.	DON	Completed.
25	26.11	Incident Report Policy.	PGPP	Yes HSE			Completed
27	32.4	Retention and destruction of records	PGPP	No	Administrator will follow up	Administrator	Partial completion
28		Recruitment, selection and vetting of staff;	PGPP	HSE Policy in place	Discussions on going with HR Central re files on site		Plan to have work progressed in first quarter 2010
29		Monitoring and documentation	PGPP	Essence of Care group	Last Draft circulated for	ADON	Plan for Sign off in Feb 2010

		of nutritional intake;		have drafted guidelines	feedback		
30		Provision of information to residents;	PGPP	Information folders on all units.	New induction programme for residents under development	DON	Plan to have completed in Feb 2010
31		Health and safety, including food safety, of residents, staff and visitors;	PGPP	H&S Act in place.			Completed.
32		Health and safety, including food safety, of residents, staff and visitors;	PGPP	H&S Act in place		Completed.	
33		The handling and disposal of unused or out of date medicines	PGPP	Flow chart for Units & return envelopes developed.	To be included in medication management policy.	Pharmacist and CPF	Completed Oct 09
34		Temporary absence and discharge of residents	PGPP		Section in Admissions and Discharge Policy	DON	Completed July 09
35		Emergencies	PGPP	Need to look at Major incident plan	ADON taking lead	Quality and Safety Committee	Work in progress plan draft Jan 2010

Abbreviations used: PGPP - Policies Guidelines Procedures Protocols, CPF – Clinical Practice Facilitator
DON - Director of Nursing, ADON – Assistant Director of Nursing, LHM – Local Health Manager,
SOP – Standard Operating Procedures, H&S - Health and Safety.

Work in Progress

Completed

To be Developed

16. The provider has failed or is failing to comply with a regulatory requirement in the following respect:

Staff were not provided with access to education and training in the areas of elder abuse and the management of challenging behaviour to enable them to provide care in accordance with contemporary based evidence.

Action required:

Provide staff with training that maintains skills and ensures they are competent to carry out their role.

Reference:

Health Act 2007
Regulation 17: Training and Staff Development
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Since the HIQA inspection all Nurse Managers were trained in Elder Abuse on the 15th of October 2009.</p> <p>Elder abuse training is currently being provided for all staff. This training programme commenced on the 4th November 2009 and will be completed by the 18th December 2009. This training will be included in the induction programme for new staff.</p> <p>Training has been provided to all staff in the 5 Suites on the Management of Violence and Aggression since April 2008 and this is a continuing programme of education as we recognise, from reviewing our incident reporting statistics, that this is a significant issue for the service. The recognised training provided on site is the Professional Management of Aggression and Violence (PMAV). To date there are 102 staff trained. The Person in Charge secured funding via the National Council of Nursing and Midwifery in August 2009 to support the release of the Clinical Nurse Manager 1 who is trained at level 8 as a PMAV instructor. This CNM 1 is released from their post 1 day a fortnight to support the management of challenging behaviour.</p> <p>The instructor reviews and supports staff at Suite level to provide evidence-based care and will undertake to review the residents' care and management strategies. If residents have a tendency to demonstrate violent or aggressive behaviour this is discussed with them and / or their next of kin if available.</p> <p>A tool will be developed by management to demonstrate written evidence that the review and consultation has occurred.</p>	<p>15th October 2009</p> <p>4 November to 18 December 2009 inclusive</p> <p>April 2008</p> <p>November 2009</p> <p>January 2010</p>

<p>17. The provider has failed or is failing to comply with a regulatory requirement in the following respect:</p> <p>Adequate arrangements were not in place for the laundering of residents' clothes.</p>
<p>Action required:</p> <p>Review laundry arrangements to ensure that systems are in place to minimise the loss of residents' clothing.</p>

Reference: Health Act 2007 Regulation 13: Clothing Regulation 7: Residents' Personal Property and Possessions Standard 17: Autonomy and Independence.	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All residents' clothing will be checked for personal identification and marking will be renewed if necessary. Items that are not clearly marked will be stored in a secure area until they are identified. Progress will be tracked via the Consumer Feedback Log's at Suite level and in consultation with the residents' committee.	December 2009 December 2009

18. The provider is failing to comply with a regulatory requirement in the following respect: The risk management policy was not sufficiently comprehensive and the missing person policy required further development.	
Action required: Ensure that a comprehensive risk management policy is in place and that the missing person policy [as per Schedule 5] is further developed in the area of risk assessment.	
Reference: Health Act 2007 Regulation 31: Risk Management Procedures Standard 17: Autonomy and independence	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Currently in the nursing assessment all residents are assessed for risk of going missing and if deemed a risk the local policy is implemented, i.e. a plan of care is commenced, an identification profile form is completed and the multidisciplinary team is informed of the potential risk.	September 2009

An audit of nursing records will be undertaken in December 2009 to identify compliance with this policy and action outcomes.	December 2009
A drill on missing persons will be introduced from 2010 in support of this policy.	February 2010
A Visitors' Log will be introduced.	Early 2010

19. The provider is failing to comply with a regulatory requirement in the following respect:	
Residents' records were not kept in a sufficiently secure place.	
Action required:	
Ensure that resident's records including financial statements are kept in a safe and secure place and in accordance with data protection legislation.	
Reference:	
Health Act 2007 Regulation 22: Maintenance of Records Standard 32: Register and Residents' Records.	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
The records found pre-date 1997 and this cabinet has now been securely locked.	September 2009

20. The provider is failing to comply with a regulatory requirement in the following respect:	
The centre had not been maintained in a good state of repair.	
Action required:	
Put in place a maintenance programme to maintain the centre in good repair.	
Reference:	
Health act 2007 Regulation 19: Premises Standard 25: Physical Environment.	

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Management recognise that the ongoing development of a facility which was built in 1841 has its challenges and we strive to develop areas and space which can cater for the needs of the residents that comply with the Standards and Regulations of 2009. A comprehensive maintenance programme has been in place since 2006 to address priority maintenance works including the upgrading of toilet, bathroom and recreational facilities and this programme will continue in 2010. The matters identified within this report will be prioritised within this programme. Each year the Management Team submit a plan for minor capital monies and a submission has been made for 2010</p> <p>Smaller issues, which are identified by Suite/Department Managers, are addressed from within the local maintenance budget.</p> <p>The issue of floor coverings is being addressed and will be completed by January 2010</p>	<p>January – December 2010</p> <p>January – December 2010</p> <p>January 2010</p>

<p>21. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>There was no system in place to review accidents and incidents and ensure that any learning was shared with staff.</p>	
<p>Action required:</p> <p>Implement a system to review accidents and incidents. Provide for consultation with residents and representatives specifically in relation to incidents of challenging behaviour.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life. Standard 21: Responding to Behaviour that is Challenging.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>St Joseph's has an Incident Reporting Policy and Framework which supports best practice and HSE policy has been implemented. This includes a:</p>	

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 4: Privacy and Dignity	Provide locks on all communal bathrooms. Provider's response: Locks will be provided immediately
Standard 5: Civil, Political and Religious Rights	Residents should be afforded a choice of GP. Provider's response: The feasibility of this recommendation will be assessed. Residents will be consulted in relation to their preference, the results of which will be used to inform appropriate changes of national policy. In contracts of care for residents, provision is made for a second medical opinion.
Standard 19: Meals and Mealtimes	Enhance the social element of mealtimes for dependent residents and consider making improvements to the setting of dining tables. Provider's response: Dining room redecorated and table setting addressed and improved.
Standard 23: Staffing Levels and Qualifications	Revise the allocation of named nurses to ensure that they work with identified residents when on duty. Provider's response: The primary nurse allocation is currently under review at present to resolve this issue. The reduction in bed numbers is a key component to the implementation of this, along with a review of duty rosters.

Any comments the provider may wish to make:

Provider's response:

The management and staff welcome any feedback received, as it will help to enhance the quality of service provided to the resident in the future.

The publication of the Health Act and the National Standards for Residential Care of Older People is welcomed as it assists in focusing our service in the objective of providing quality care and a good living experience for residents in St. Joseph's. It is welcomed that residents and relatives expressed positive views on all aspects of the service and complimented the kindness and commitment of the staff. The findings of the report have been taken on board by senior management and HIQA's input and support in developing and benchmarking the service moving forward will be welcomed.

In the past number of years the service has been undergoing a transformation as it moves from the medical model towards the social model of care, which was embedded in the culture of the service whose historical origins have moved from a workhouse when established in 1841 to a Nursing Community Unit in 2009.

This transformation can only be achieved by strong management and leadership and by committed qualified staff that are dedicated to work and the service they provide. Some of the milestones achieved to support this transformation were the introduction of decentralised management structures, which has empowered the managers to manage their specific areas more effectively. The separation of duties was implemented and all staff have specific roles and functions, which assist in introducing and maintaining change. The ongoing reduction in bed numbers is assisting in moving to a social model of care as the environment is providing greater opportunities to develop social spaces for living, and time for the staff to devote to activities and quality of life issues.

Management continually strive to provide quality care taking into consideration the personal needs, values, beliefs and choices of individual residents, staff and family. The ongoing upgrading of the environment assists in promoting wellbeing and quality of life for residents in a safe and stress free environment.

It is recognised that there have been many improvements in the unit management structure and development of service within St Joseph's over recent years.

As the provider, I will support senior management to enhance the quality of service provided in St. Joseph's Community Nursing Unit based on a social model of care.

Provider's name: David Gaskin

Date: 17 December 2009