Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St Joseph's Hospital
Name of provider:	Bon Secours Health System CLG
Address of centre:	Bon Secours Care Village, Mount Desert, Lee Road, Cork
Type of inspection:	Unannounced
Date of inspection:	17 January 2023
Centre ID:	OSV-0000284
Fieldwork ID:	MON-0038177

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

St Joseph's Hospital, Mt. Desert is a purpose-built designated centre situated in the rural setting of the Lee Road, Cork city, a short distance from Cork and Ballincollig. It is registered to accommodate a maximum of 103 residents. There is a large comfortable seating area and main 'Village Green' restaurant dining room at the main entrance. Communal areas include the Beech room which facilitates functions, the large activities room and Chapel, and occasional resting areas along corridors for residents' relaxation. Bedrooms accommodation comprises five twin bedrooms and the remainder are single occupancy; all with full en suite facilities of shower, toilet and wash-hand basin, with additional toilet facilities throughout the centre. Accommodation is set out in four wings: 1) Daffodil: 26 bedded unit with two living rooms and seating areas with direct access to the secure garden, and the Patel room dedicated private family room 2) Bluebell: 26 bedded unit with a living room and glass seating area 3) Lee View: 26 bedded unit with living room, two glass seating areas with direct access to the secure garden 4) Woodlands: 25 bedded unit with two living room. St Joseph's Hospital, Mt. Desert provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, respite, convalescence and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	97

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 17 January 2023	09:00hrs to 18:30hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

Overall, the inspector found that staff promoted a person-centred approach to care, and actively and positively engaged with residents to promote individualised care which supported residents' independence and autonomy. The inspector met with many residents during the inspection and spoke with eleven residents in more detail. Residents spoken with gave positive feedback about the staff, their kindness and consideration, and this was observed on inspection.

There were 97 residents residing in St Joseph's Hospital Mt Desert at the time of inspection. On arrival for this unannounced inspection, the inspector was guided through the centre's infection prevention and control (IPC) procedures, which included a signing in process, hand hygiene, face covering, and temperature check.

There was an opening meeting with the person in charge and the assistant person in charge, which was followed by a walk-about the centre with the person in charge.

St Joseph's Hospital Mt Desert was a single-storey building with basement that accommodated laundry, storage, offices and staff facilities. The main entrance was wheelchair accessible and led to an expansive foyer with reception, seating area and main dining room; the main fire alarm system, registration certification, suggestion box and complaints procedure were also located here. The activities room and church were located beyond the main foyer to the right. The centre was set out in 4 wings namely Daffodil, Bluebell, Woodland and Lee View which radiated off the main foyer. Each wing had day rooms, a dining area and comfortable seating areas along wide corridors. Corridors and seating areas had lovely photographs, paintings and art decorating the walls. As part of their end-of-life care facilities they were two Potel rooms for families which comprised comfortable seating and kitchenette facilities.

Bedrooms were seen to be spacious with good room for bedside chair, locker, storage facilities for residents' belongings, and use of assistive equipment if required. All rooms were en suite with shower, toilet and wash-hand basin facilities. Many of the bedrooms were decorated in accordance with the resident's preference with book shelves, photographs and other memorabilia. While some bedrooms had been recently painted, others were seen to require painting and decorating as paintwork on walls, window and door frames, and skirtings were scuffed and damaged; some wardrobe doors were not aligned properly and sagged; some flooring in bedrooms and corridors were marked and worn; all of which looked unsightly. Some equipment was broken such as a wall-mounted hand gel dispenser and a holder of a shower head so the shower head was left on the ground.

Gardens were seen to be well maintained with shrubbery beds, beautiful walkways, seating and statuettes. Even though it was a cold day, residents were seen walking in the gardens as per their daily routine. Several residents spoken with commented on how well the gardens were maintained, and how they loved to look out in the

morning and see all the rabbits scurrying around as well as the variety of birds visiting the gardens. There were seating areas along corridors with views of either the enclosed gardens or the avenue leading into the centre; residents were observed enjoying their morning cup of coffee in these spaces. The inspector joined residents in different locations and they reported they found them relaxing while at the same time other residents and staff stopped to chat and spend some time with them.

While orientation signage continued to be minimal throughout the centre, the person in charge showed the inspector a sample of the new orientation signage they were awaiting to be delivered. This will provide good orientation for residents throughout the centre. Nonetheless, some communal rooms remained without signage to indicate what they were; in addition, while doors to these communal rooms were fire safety doors they did not have the open mechanism of bedroom doors, so these doors remained closed and residents would not realise that they were communal rooms for their use.

The activities schedule was displayed on each unit and a large coloured schedule was displayed outside the activities room for residents to see what was happening during the day and evening times. The schedule had activities over six days of the week, Monday to Saturday. The inspector saw that residents gathered in the activities room or in the seating area on the corridor outside the activities room before mass at 11 o clock. Mass was celebrated Tuesdays to Saturdays and a service was facilitated on Mondays. Rosary was held in the chapel every afternoon after dinner. Staff were seen to assist residents when taking them to the chapel for mass and bring them back to the activities room; staff chatted and positively engaged with residents when escorting them around the centre. One resident spoken with explained that she enjoyed using the exercise bike; the staff helped her and once she was seated appropriately she operated the bike herself. She said she spent an hour on it and increased and decrease the pace and difficulty as it suited her.

A variety of activities were facilitated each day ranging from arts and crafts, news paper reading, music, bingo, exercise programmes, and movie evenings. The therapy dog was on site in the afternoon. Some residents were seen to enjoy the radio or television in their bedrooms throughout the day; other residents walked around the centre to help improve their mobility. While minutes of residents meetings were displayed on the notice board outside the activities room for residents to read, these were minutes of the meeting in June 2022 and had not been updated with the minutes of the December meeting.

Dinner and tea times were observed and the findings of the dining experience were mixed. While the main dining room had re-opened, the inspector saw three people having their dinner there; one of whom was from the apartments alongside the centre, so two residents dined there. Most residents remained in their units and dined in their bedroom or in the smaller dining room on the unit. Meals were well presented and residents gave positive feedback about the quality and choice for their meals. While assistance was seen to be provided in a dignified manner and residents' independence was encouraged, due to staff shortages on one unit, the

dinner time meal was unsupervised for a period. This was while staff assisted other residents in their bedrooms. Plated meals, cutlery and drinking glasses were not removed from trays when residents were served in the dining room, and residents were served their main course and desert together, which was not in keeping with a normal dining experience. On another unit, where there were no staff shortages, the inspector observed that the dining experience was much more social and positive. Tables were appropriately set before residents came for their meal here. The inspector sat with residents during their tea and was offered a cup of tea. All residents here were served with their own tea pot, and each resident had a different tea in accordance with their choice; one had an omelette, another had a grill, chips, ham sandwiches, cake and scones. All residents actively engaged with each other and the inspector. They were very complimentary of all the staff on their unit, they knew staff by name and staff were seen to positively and actively engage with residents in a friendly and respectful manner. Allergy information was displayed alongside the kitchenette on each unit providing information of foods, allergy potential and calorific details.

Hand gel dispensers were available with advisory signage indicating how to perform hand hygiene. Most of the centre was visibly clean, however, there were some areas and one bedroom that was unclean. Most staff were seen to wear their protective masks appropriately, but other staff did not ensure their nose was covered; some staff wore bracelets and rings with stones.

The foyer and some residents' bedrooms had been re-decorated as they became vacated. Residents had specialist mattresses, profiling and low low bed, crash mattresses, and equipment such as specialist hoists. Catheter bags were seen to be appropriately secured to beds and maintained off the floor to prevent contamination.

The household cleaners' room was neat and tidy with items appropriately stored on shelves. There was a separate hand-wash sink here along with additional sink for cleaning waste. Laundry was segregated at source and each unit had their designated laundry trolleys. There were separate trolleys for clean linen for comfort rounds. Clinical rooms had hand-wash sinks with hands-free taps.

There was swipe-card access to many rooms requiring security such as clinical rooms. While all sluice rooms had keypad access, one door could not close due to the keypad fixture which was not removed when the fob access was installed following the last inspection. This was brought to their attention and the keypad was removed to enable the magnet mechanism to be effective. Two further rooms were not secured and contained electrical equipment and boiler; these were made secure on inspection to ensure the safety of residents. Broken equipment was seen in two sluice rooms along with several clinical bins, recycling bins and laundry bins so the bedpan washer was inaccessible.

Emergency evacuation floor plans were updated since the last inspection and were displayed on each unit; they were orientated to reflect their relative position in the centre, had room numbers and unit name and a point of reference' You are Here'.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, the findings on this inspection demonstrated that a review of the governance and management of the centre was necessary to be assured that the service provided was in alignment with the ethos espoused in their statement of purpose, and that the management systems in place ensured that the service provided was safe, appropriate, consistent and effectively monitored. Other areas for improvement identified included their complaints procedure, issues relating to infection control and restrictive practice assessment; these were repeat findings.

St Joseph's Hospital was operated by the Bon Secours Health System Limited. The designated centre formed part of the Bon Secours Care Village. The governance structure comprised the board of management (BOM), the chief executive officer (CEO) and senior management team. The CEO was the person nominated by the registered provider to represent them. On site, the structure comprised the person in charge, assistant director of nursing (ADON), clinical nurse managers (CNMs x 5), care team, human resources (HR) and finance departments. The post of ADON was filled since the last inspection to enhance the governance structure and ensured appropriate deputising arrangements for times when the person in charge was absent from the centre. CNMs were appointed to each unit and one CNM rotated on duty each weekend to provide management oversight and support the service.

The service had access to the Bon Secours health safety and well-being officer and the national quality manager, both of whom were on site on a regular basis. The consultant geriatrician was clinical director for the service and provided support and direction for residents and staff.

A schedule of audit for 2023 was being finalised at the time of inspection. The previous inspection acknowledged that a programme of audit had commenced which would take time to embed, however, the scope of the audits in place was not sufficiently robust to ensure the service was effectively monitored to drive improvement. A new clinical audit committee was set up and was facilitated by the ADON, and CNMs attended these meetings; monthly meetings were scheduled until such time as it became established. Minutes of these meetings showed good discussion and information sharing to inform the audit process. The household manage completed audits for cleaning regimes; catering had responsibility for kitchen audits, the health safety and well-being officer completed audits of the environment from the view of fire safety. However, other audits such as environmental audits were not completed to facilitate a programme of works for environmental maintenance and upkeep.

Minutes of the monthly clinical governance meetings showed some oversight of the service with results of audits, key performance indicators (KPIs) informing the meetings, with actions, time-lines and responsibilities assigned for remedial actions identified. Matters were seen to be followed up on subsequent meetings. Quality and safety meetings were convened every six weeks with set agenda of clinical and non clinical matters including fire safety.

The health safety and well-being officer was on site during the inspection for scheduled fire training and drill exercise. He outlined that following the last inspection, monthly fire safety drills were completed on each unit on a rotational basis, that is, a drill every four months per unit. Following the health safety and well-being meeting the day before the inspection, it was decided that the monthly training and drill sessions would continue, and a weekly drill would be scheduled on each unit going forward. This was to be welcomed as drill records showed that improvement was required to be assured that staff could evacuate residents in a timely and safe manner. This was also significant as there was a noteworthy staff turn-over in the last number of months.

Additional fees to be charged, as detailed in the contract of care, required review as some of the additional fees included would be covered under the Nursing Home Support Scheme. This was further discussed under Regulation 24: Contract for Provision of Services.

The policy relating to volunteers was updated at the time of inspection to ensure it reflected regulatory requirements, and that it was in date.

During the inspection it was observed that staffing levels were inadequate to ensure the assessed needs of residents could be met in a timely and safe manner. Evidence of inadequate staffing levels were discussed throughout the report and detailed in the observation section at the start of this report. A review of staffing rosters confirmed ongoing shortfalls in worked staff rosters. Several entries into the organisational risk registered detailed risk associated with deficits in staffing levels on both day and night duty. Due to staff shortages, the CNM was not supernumery on one unit as she had to take up the nursing duties such as medication rounds and dressings, this resulted in little or no staff support or supervision at different times during the day. Staffing levels on night duty were inadequate with one nurse and one HCA for each unit.

Overall, while staff were observed to promote a person-centred approach to care, inadequate staffing resulted in shortfalls in outcomes for residents.

Regulation 14: Persons in charge

The person in charge was full time in post and had the necessary experience and qualifications as required in the regulations. She was involved in the governance, operational management and administration of the service.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the staffing levels were not appropriate having regard for the assessed needs of residents. The duty roster was examined and over a four week period for example, there were staff shortages on a daily basis for both day and night duty shifts. The staff complement rostered per unit included a CNM, nurse and four health care assistants (HCAs), but the worked roster showed that this roster was not maintained, for example, some days there were three HCAs and other days two HCAs and no nurse.

On night duty, one nurse and one HCA were rostered on each unit. Cognisant that all units had maximum and high dependency residents who could require two staff for comfort rounds, and the nurse had responsibility for medication rounds along with attending to sick residents, accidents or incidents, leaving the comfort rounds to be completed by the HCA. One night, the roster showed that there was one nurse and one HCA for two units (50 residents); another night there was one nurse and no HCA for 25 residents.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector acknowledged the efforts made by the registered provider to strengthen the governance and management of the centre with the recent appointment of an assistant person in charge with the necessary experience and qualifications. Nonetheless, inadequate staffing levels and deficits in the audit programme did not assure that the service was either adequately resourced or effectively monitored.

The organisational risk register detailed the risk associated with staff shortages such as poor manual handling techniques, interrupted medication rounds with the associated potential risk of medication errors, and delays in care delivery.

While a programme of audit was in place and the results of audits completed showed thorough understanding and awareness of the matter being audited, the rage of audit was inadequate. An example of this was evidenced under Regulation 17: Premises, as the physical environment was not include in the schedule. This would provide oversight to enable a programme of works regarding ongoing upkeep and maintenance of the centre.

The additional fees being charged to residents did not provide assurances that the service was in keeping with the ethos and mission of their Statement of Purpose.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Complaints records were examined. Overall, these were not maintained in line with specified regulatory requirements as:

- the outcome of the complaint or the satisfaction of the complainant was not routinely recorded
- the complaints policy and complaints procedure did not correlate and while there was an independent appeals process as part of the procedure, it was not detailed in the policy
- the policy would benefit from more detail to inform and support staff regarding complaints procedure time lines
- the procedure mentioned a complaint about a member of staff, but did not expand to direct staff on how this type of a complaint was to be managed,
- complaints were not followed up to ensure that similar incidents would not recur, for example, a staff member gave incorrect food consistency to a resident, however, actions taken or control measures put in place to mitigate recurrence were not detailed; a further example detailed that often, residents menu choices were not served to residents.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Following the last inspection, Schedule 5 policies and procedures were made available to all staff on line as part of their suite of documents available to staff. The policy supporting volunteers was updated at the time of inspection to reflect current legislation and best practice guidelines.

Judgment: Compliant

Regulation 30: Volunteers

Volunteers had recommenced in the centre, and while there was vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons)

Act 2012, other documentation as specified in the regulations was not in place for volunteers.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A review of additional fees to be charged by the registered provider to residents seen on the day of the inspection was necessary as some of the items included in the additional fees would be covered under the Nursing Homes Support scheme, and did not align with the ethos and mission of the Bon Secours Sisters: these included the following

- maintenance and upkeep of the Chapel
- provision of pastoral care rooms
- restaurant dining experience
- tissue viability nurse, speech and language therapy and dietician (some residents were entitled to these services as part of their medical card; in addition, dietician services were provided to St Joseph's Hospital free of charge by the company supplying food supplements)
- organising and facilitating in-house optician and dental consultation (some residents were entitled to these services as part of their GMS)
- palliative care and dementia care training for staff
- investment infrastructure, quality of the facility, architectural design, generous seating areas and additional day room.

Judgment: Substantially compliant

Quality and safety

Throughout the inspection the inspector observed that the care and support given to residents was respectful. Staff were kind and those spoken with were familiar with residents' preferences and choices.

In relation to care planning, the inspector found that while staff were knowledgeable regarding residents' preferences and their care needs, this level of knowledge was not reflected in the assessments and care plans documentation. End-of-life care plans were not routinely completed when a resident was well and able to make these decisions for themselves in the sample viewed by the inspector. The restrictive practice assessment did not enable risk to be quantified to inform the decision-making process.

The health care needs of residents were supported. The clinical director was a consultant geriatrician who provided additional support to residents and staff. Documentation demonstrated that residents had access to a range of health care professional with regular reviews by the physiotherapist, occupational therapist (OT), podiatry, tissue viability nurse (TVN), dietitian and the speech and language therapist (SALT). Occupational therapy access was increased since the last inspection whereby the occupational therapist was on site once a fortnight.

Emergency evacuation floor plans were upgraded since the last inspection to accurately reflect the primary and secondary escape routes available. The health safety and wellbeing officer had responsibility for fire safety in the centre. He attended the centre on a regular basis and was on site providing fire safety training on the day of inspection. Following the health safety and wellbeing meeting the day prior to the inspection, it was decided that the monthly training and drill sessions would continue, and a weekly drill would be scheduled on each unit going forward to ensure evacuations could be completed in a timely and safe manner.

Regulation 11: Visits

The inspector found that the visiting protocol was in line with the current visiting guidelines. Relevant HPSC information notices were displayed at the entrance to the centre providing details to visitors of necessary precautions on entering the building.

Visitors were seen visiting throughout the day, mostly in residents' bedrooms. Staff were seen to welcome them and socially engage with visitors and it was apparent that there was an open and friendly atmosphere.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had access to good personal storage space in their bedrooms such as double wardrobes, bedside locker, and some had chest of drawers and book shelves.

Judgment: Compliant

Regulation 17: Premises

Action was required to ensure the premises met the requirements as set out in Schedule 6 of the regulations as follows:

- some bedrooms required painting and decorating as paintwork on walls, skirting boards, window and door frames were scuffed and damaged
- some wardrobe doors were not aligned properly and sagged
- flooring in some bedrooms and corridors were marked and worn; all of which looked unsightly,
- the general store room was top-heavy with assistive equipment of residents that had passed away and had not been de-cluttered in some time to provide space for storage in the unit. This was de-cluttered on inspection to enable additional storage space for assistive equipment,
- two rooms were not secured and contained electrical equipment and boiler [these were made secure on inspection to ensure the safety of residents].
- the light was broken in a sluice room so it was difficult to see in there

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents generally gave positive feedback about their meals and the quality of the food served. However, due to staff shortages on one unit, plated meals, cutlery and drinking glasses were not removed from trays when residents were served in the dining room; residents were served their main course and desert together, which was not in keeping with a normal dining experience.

Judgment: Substantially compliant

Regulation 26: Risk management

The policy relating to risk management was available as part of the risk management folder. The policy had been updated since the last inspection to include the specified risks as detailed in the regulations.

Judgment: Compliant

Regulation 27: Infection control

Previously there was an infection control lead for the centre, however, an overall lead was no longer in place for the service.

Issues relating to infection control that required action to ensure regulatory compliance included:

- oversight of maintenance and environmental audits were not completed
- the tap to the hand-wash sink in one sluice room was corroded so effective cleaning could not be assured
- broken equipment was seen in two sluice rooms along with several clinical bins, recycling bins and laundry bins so the bedpan washer was inaccessible
- residents' personal creams (sudocream and silcocks base) were on the shelf in one sluice room
- most of the centre was visibly clean, however, there were some areas and one bedroom that was visibly unclean
- some equipment was broken, such as a wall-mounted hand gel dispenser, and a holder of a shower head so the shower head was left on the ground
- a toilet seat enhancer was seen to be stored on the ground in one en suite
- most staff were seen to wear their protective masks appropriately, but other staff did not ensure their noses were covered; some staff wore bracelets and jewellery with stones which is not in line with good infection control guidelines
- a large sheet of heavy wood was seen on top of a clinical waste bin in one sluice room with signage from maintenance that it was not to be removed making it inaccessible for staff.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Drill records showed that there continued to be improvement and action necessary to be assured that staff could evacuate residents in a timely and safe manner. This was significant as there was a noteworthy staff turn-over in the previous number of months.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of assessments and care plans were reviewed and while they contained some information to inform individualised care, they were not comprehensive. Staff spoken with demonstrated comprehensive knowledge of residents and their care needs including behavioural support needs, however, this information was not

detailed in either their assessments or care plans seen. For example, staff reported on the interventions and supports provided to residents during times of additional communication needs along with comforts put in place to support residents, but these were not recorded.

Other valuable information staff detailed include resident's social history, and while there was a good care plan to support the resident, the associated assessment or 'It's All About Me' document did not have this information. The cognition and depression care plan did not reflect the care needs of the resident and the supports necessary to enable best outcomes for the resident.

One resident's end-of-life assessment and care plan had not been discussed with them. The inspector spoke with this resident and they were in a position to articulate their choice and preference should they become acutely unwell and decide whether they would like to be transferred to acute care or not.

Judgment: Substantially compliant

Regulation 6: Health care

GPs attended the centre on a weekly basis and when required. Residents had access to allied health professionals. The clinical director was a consultant geriatrician who provided ongoing support to residents and staff in the care of residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The on-line resident record system had two restrictive practice templates available to staff, one was the 'restraint' assessment and the second the 'bed-rail' assessment, however, neither had a risk matrix to enable staff quantify the risk and help in the decision-making process associated with individual residents. Consequently decisions made regarding restraint, including bed rail restraint, was subjective and not evidence-based.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While the statement of purpose detailed that residents' meetings were facilitated every two months, this had not occurred. This was discussed during the inspection

and clarification provided to staff regarding attendees at these meetings. Going forward, assurances were given that residents' meetings would be held every two months. The most recent meeting was held in December and this showed that issues were followed up from the meeting in June with good discussion and feedback given by residents.

While orientation signage continued to be minimal throughout the centre, the person in charge showed the inspector the new orientation signage awaited. This will provide good orientation for residents throughout the centre. Nonetheless, some communal rooms remained without signage to indicate what they were; in addition, while these doors were fire safety doors they did not have the open mechanism of bedroom doors, so these doors remained closed and residents would not realise that they were communal rooms for their use restricting residents choice.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Joseph's Hospital OSV-0000284

Inspection ID: MON-0038177

Date of inspection: 17/01/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Increase recruitment to increase staffing levels at night to ensure safe staffing levels meet the dependency levels of residents 2. Daily review of the roster by the manager on duty to ensure that any gaps in the roster are covered and safe staffing levels are maintained. 3. Ensure that open positions for all grades of staff are filled in a timely manner. Continue ongoing recruitment plan. A recruitment open day is planned for March 4. Formalise process to establish an internal "Bank" for nurse and HCA cover 5. Management of absenteeism by stringent adherence to the Sick Leave policy 6. Additional training and support for line managers in managing attendance and back to work interviews Action by: 1, 3, 4, 6. March 31st 2023 2, 5. Completed	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Review audit schedule and add regular audit of the physical environment. 2. From audit develop a programme of works for ongoing upkeep and maintenance. 3. Review and amend what is included under additional fees in Contracts of Care Action by: April 30th 2023	

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. Continue to audit complaints and increase the frequency to ensure compliance with the policy .
2. Conduct an audit of all complaints weekly to ensure the outcome and the satisfaction of the complainant is recorded accurately.
3. Review the complaints policy and the complaints procedure

Action by: March 31st 2023

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
1. Audit volunteer files to ensure that documentation specified in the regulations are in place.
2. Update volunteer policy to reflect references for National Standards for Residential Care Settings
3. Forward updated volunteer policy to inspector.

Action by: 1. February 28th 2023
2. Complete
3. Complete

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
1. Review and amend what is included under additional fees in Contracts of Care
2. Forward amended Contract template and Statement of Purpose to HIQA
3. Review and amend services included under additional fees in Contracts of Care

Action by:
1 & 2 Complete
3. March 30th 2023

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Review audit schedule and add regular audit of the physical environment.
2. From audit findings develop a programme of works for ongoing upkeep and maintenance

Action by: March 31st 2023

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
1. Increase the frequency of mealtime experience audits to monthly
2. Feedback the results of the audits to staff to ensure learning and improvements to the dining experience for the residents.

Action by: March 31st 2023

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. Identify individual with responsibility for oversight in Infection Control
2. Review audit schedule and add regular audit of the physical environment.
3. From audit develop a programme of works for ongoing upkeep and maintenance.

Action by: March 31st 2023

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Increase the frequency of the fire drills for each unit and monitoring of same to weekly.

Action by: February 28th 2023

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1. Review the Individual Assessment and Care Planning audit to assess the quality and personalization of Care Plans
2. Introduce the Epicare Electronic Health Record which will assist with the auditing of assessments and care plans for completeness

1. Action by: February 28th 2023
2. Action by: June 30th 2023

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
1. Introduction of a restraint risk balance tool to enable staff to quantify the risk associated with the restraint and assist in the decision-making process regarding use of the restraint

Action by: February 28th

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. A schedule is in place to ensure residents meetings are conducted every 2 months
2. Orientation signage to be erected in one of the units and designs are underway for the remaining units

1. Action by: Completed
2. Action by: April 28th 2023

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/03/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/03/2023
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food	Substantially Compliant	Yellow	31/03/2023

	and drink which are properly and safely prepared, cooked and served.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/04/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2023
Regulation 24(2)(c)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of where appropriate, the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme, including the arrangements for the payment or refund of monies.	Substantially Compliant	Yellow	30/03/2023

Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/03/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	28/02/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	28/02/2023
Regulation 30(a)	The person in charge shall ensure that people involved on a	Substantially Compliant	Yellow	28/02/2023

	voluntary basis with the designated centre have their roles and responsibilities set out in writing.			
Regulation 30(b)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre receive supervision and support.	Substantially Compliant	Yellow	28/02/2023
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/03/2023
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required	Substantially Compliant	Yellow	31/03/2023

	for improvement in response to a complaint.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	31/03/2023
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Substantially Compliant	Yellow	31/03/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident	Substantially Compliant	Yellow	28/02/2023

	immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	28/02/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	28/02/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	28/02/2023
Regulation 9(3)(c)(i)	A registered provider shall, in	Substantially Compliant	Yellow	16/02/2023

	so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to information about current affairs and local matters.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	28/04/2023