Health Information and Quality Authority
Regulation Directorate

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

Centre name:	St Carthage's House Limited
Centre ID:	OSV-0000687
Centre address:	Lismore, Waterford.
Telephone number:	058 54309
Email address:	stcarthageshouse@gmail.com
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St. Carthage's House Limited
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	42
Number of vacancies on the date of inspection:	9

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
09 January 2018 07:30	09 January 2018 17:30
10 January 2018 07:30	10 January 2018 17:00

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

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

Summary of findings from this inspection

This was an announced inspection following an application by St Carthage's House, in accordance with statutory requirements, for renewal registration of a designated centre. St Carthage's House was set up by local people to provide support with activities of daily living to residents with a low to moderate dependency. It is owned and managed by a voluntary organisation with charitable status through a voluntary board of directors. Twenty four hour nursing care is not required in the center. The

center was purpose built and opened in its current location in 1994. Residents are charged a weekly fee, an annual grant is allocated to the center via statutory funding and additional funds are raised through on-going local fundraising.

As part of the inspection process the inspector met with residents, the provider representative, the person in charge, members of the board of management and other staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Residents spoken with expressed a high level of satisfaction with the service they experienced at the centre and this satisfaction was also evident from residents satisfaction questionnaires viewed by the inspector. Other documents reviewed included training records, residents' care plans and minutes of meetings.

On the previous unannounced inspection was on 24 and 25 May 2017, considerable non compliance was identified with only 10 of the 19 compliance plans from the previous inspection had been completed. In addition, the center was not sufficiently resourced to ensure the effective delivery of care in accordance with the statement of purpose. The inspector found significant improvements on this inspection with evidence that the service was moving towards compliance. All the actions from the previous inspection had been either completed or progressed toward completion. The provider had obtained additional funding and there was evidence of improved governance and management including the implementation of a quality management system. In addition, the provider representative outlined how the centre was now applying for the renewal registration of a reduced number of beds from 51 beds to 42 beds in order to improve the quality of life for residents and meet HIQA standards.

The centers' statement of purpose states that "all applicants must have low to medium dependency levels and not require full time nursing care". The care provided to residents was seen to be adequate with 41 of the 42 residents living in the center were assessed as having low dependency support needs and one resident considered to have medium support needs. The person in charge confirmed that the ethos in the center was to provide a relaxed, homely and supportive environment for residents with low to medium support needs. The inspector noted that there was a respectful, supportive and positive atmosphere in the center. Residents to whom the inspector spoke commented on the kindness and attentiveness of staff, the social interactions and opportunities to meet friends and the good quality of the food provided. Residents were also very complementary about the care, attention and support they received from staff. Residents described the center as “home from home” and a number said “that it was wonderful”. Residents stated that they felt safe in the center and residents and visitors described the staff as "very caring".

There were 18 outcomes monitored on this inspection, 15 of the 18 outcomes were compliant or substantially compliant with the regulations. However, the following three outcomes were deemed to be moderately non-compliant; health and safety and risk management, suitable premises and residents' rights, dignity and consultation. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in

Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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

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

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose and function which was most recently reviewed by the provider representative in January 2018 and it described the service and facilities provided in the centre. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided support to residents.

The statement of purpose included the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007. There was evidence that the statement of purpose was kept under review and readily available for residents and staff to read. The statement of purpose was found to meet the requirements of legislation.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The centre was owned and managed by a voluntary organisation through a voluntary board of directors. It was set up by local people to provide support with activities of daily living to residents with a low to moderate dependency. The centre was purpose built and opened in it's current location in 1994. Residents were charged a weekly fee, an annual grant was allocated to the centre via statutory funding and additional funds were raised through on-going local fundraising. Residents and staff who spoke with the inspector confirmed that the centre was adequately heated, maintained and residents were provided with adequate food and drink to meet their needs. On the previous inspection of May 2017 it was identified that the centre was not sufficiently resourced to ensure the effective delivery of care in accordance with the statement of purpose. However, on this inspection there had been a number of improvements, for example the provider representative had obtained additional funding, there was evidence of improved governance and management including the implementation of a quality management system and all actions from the previous inspection had been either completed or were in the process of being completed. In addition, the provider representative outlined how the centre had now reduced it's total number of bed numbers from 51 beds to 42 beds in order to improve the quality of life for residents and meet HIQA standards.

The inspector met the provider representative and spoke to five members of the governing board including the chairperson. The provider representative and board members outlined a number of changes in the center since the previous inspection. For example, the provider representative had obtained additional (for specific purposes) funding for 2017 and 2018. A new person in charge had been appointed on October 2017. The person in charge had worked in the centre as a staff nurse since December 2015 and was very familiar with the residents and the centre. In addition, there was a recently appointed center administrator and new systems of quality, management and governance had been established. The provider representative stated that he and the board members had become more actively involved in the on going management of the center. They were supporting the person in charge and staff in the implementation of a ''Quality Management System'' (QMS) within the centre. For example, a number of members of the board had been visiting/monitoring the center frequently each week. They spent time in the centre, speaking with residents and staff and also met with the person in charge during each visit. They had attended meetings with the staff and QMS meetings. They had also attended a residents' forum meeting in December 2017 which was attended by 32 residents. The provider representative stated that due to the changes that the board have made, ''the board members believed that they would not get any surprises'', in relation to the centre and that they felt fully informed in relation to all operational and governance matters. The person in charge outlined how she had embraced this quality management approach, for example, through the systematic approach towards the management of incidents such as falls, the analysis of clinical audits and facilitating focused meetings with the provider representative.

The provider representative confirmed that the centre had adequate resources available to ensure the effective delivery of care in accordance with the statement of purpose.

This was evidenced by speaking to residents, visitors, the person in charge and staff, from a review of available records and from the identified improvements as outlined in this report.

The person in charge informed the inspector that she was adequately resourced to fully discharge the function of her role. For example, the person in charge stated that she felt supported by the provider representative and board members that were always contactable and were regularly on site. The person in charge stated that she had adequate time to attend to specific areas under her regulatory remit and enough staff to ensure that residents support needs were being met. The provider representative also identified that a number of additional health care staff and nurses had been recruited since the last inspection. He also confirmed that all staff including those recently recruited had the required vetting disclosure as required under the 2013 Regulations and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016.

There was a clearly defined management structure. Staff and residents were able to identify who was in charge and what the lines of accountability were. On both days of this inspection the person in charge, the provider representative and a number of members of the board of management made themselves available to the inspector and attended the feedback meeting at the end of the inspection.

The person in charge stated that she had regular informal and formal meetings with the provider representative, and minutes were maintained for the formal meetings which had focused on issues such as on-going developments, risk management and quality improvements. In addition, the person in charge had also attended board of management meetings. The inspector was provided with copies of the minutes of the most recent board meetings and noted that they were focused on a number of issues including matters such as sourcing additional funding, finance, staffing, health and safety issues, and building renovation/maintenance.

On the last inspection there was an issue in relation to fire safety and the installation of automatic fire door releases. On this inspection, the provider representative confirmed that automatic fire-door releases had been installed on all residents' bedroom doors. In addition, the person in charge stated that all other doors had automatic fire door releases installed.

The centre's 2017 annual review was available for inspection. It set out the improvements that had occurred and improvement plans due to take place for 2018. However, the review did not record how the quality and safety of care was delivered to residents in the centre to ensure that such care was in accordance with relevant standards.

Overall the provider representative, the person in charge and the staff team displayed a good knowledge of the regulatory requirements and they were found to be committed to providing person-centred, evidence-based care for the residents. They were proactive in responding to the actions required from previous inspection and the inspector viewed a number of improvements throughout the centre, including the aforementioned improvements in governance arrangements, policy development, premises and fire safety arrangements.

The provider representative, person in charge and staff demonstrated a commitment to on-going improvement and quality assurance. There was evidence of quality improvement strategies and monitoring of the service. There was an across-the-board system of audit in place, capturing many areas, to review and monitor the quality and safety of care and the quality of life of residents. For example, there were audits in relation to medication management, safeguarding and safety, residents rights, privacy and dignity, wound care and care planning.

There was evidence of good on-going consultation with resident's and relative's. Satisfaction surveys had been recently carried out. Resident's and relatives' questionnaires reflected a high level of satisfaction with support received in the centre. Policies had been updated and were in the process of being rolled out through on-going training meetings with staff.

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
A sample of residents' contracts of care was viewed by the inspector. The inspector found that contracts had been signed by the residents/relatives and found that the contract was clear, user-friendly and outlined all of the services and responsibilities of the provider to the resident and most of the fees to be paid. However, not all contracts of care reviewed were adequate as they did not contain details of all fees including for example, fees for occasional items such as hairdressing, newspapers or dry cleaning. In addition, not all contracts of care reviewed contained the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, ''after'' the terms, as required by regulation.

A Residents' Guide was also available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge had worked in the centre as a staff nurse since December 2015 and had been appointed to this post of person in charge in 24 October 2017. The person in charge displayed a good knowledge of the standards and regulatory requirements and was found to be committed to providing quality person-centred care to the residents.

The person in charge had many years of care of the older person experience and was fully aware of residents and their support needs and knew all staff well. She was on site in the centre each morning from 8am until 5pm five days a week and attended the morning handover each morning. The inspector interacted with the person in charge throughout the inspection process over the two days. There was evidence that the person in charge was actively engaged in the governance, operational management and administration of the centre on a day-to-day basis. The inspector was satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. She had a commitment to her own continued professional development and she had regularly attended relevant education and training sessions which was confirmed by training records. The person in charge stated that she had enrolled in a post graduate management training course due to commence this year.

Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service and said she was very approachable and supportive. It was clear that she always made herself available to them whenever they needed to discuss anything with her.

There were arrangements for the staff nurse on duty to replace the person in charge for short periods including the evenings, weekends and during annual leave periods.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and

ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
The inspector viewed the insurance policy and saw that the centre was adequately insured against accidents or injury to residents, staff and visitors.

Residents' records were reviewed by the inspector who found that they generally complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. However, some improvement was required as not all residents' care plans contained a nursing record of the person's health and condition and treatment
given, completed on a daily basis and signed and dated by the nurse on duty in accordance with any relevant professional guidelines. This issue was actioned under outcome 11 of this report.

The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspector.

The inspector reviewed the centre's operating policies and procedures and noted that the centre had policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and noted that all these policies had been reviewed and completely updated in 2016 and 2017. The centre-specific policies reflected the care given in the centre and informed staff with regard to up-to-date evidenced best practice or guidelines. Staff spoken to were knowledgeable in relation to these policies and on going policy awareness was being provided.

The inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

The inspector was satisfied that the records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Overall records were seen to be maintained and stored in line with best practice and legislative requirements.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
There had been no instances since the last inspection whereby the person in charge was absent for 28 days or more and the person in charge was aware of the responsibility to notify HIQA of any absence or proposed absence.

There were suitable deputising arrangements in place to cover for the person in charge when she was on leave. The staff nurse on duty was in charge in the absence of the person in charge along with the administrator provided on-going non-clinical support in the running of the centre.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff spoken to demonstrated a good understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. Many staff had been working in the centre for many years and the inspector was informed that some staff had been working in the centre for over 30 years. Safeguarding training was provided on an on-going basis in-house. From a review of the staff training records all

staff had received up-to-date training in a programme specific to protection of older persons. This training was supported by a policy document on elder abuse which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise.

The centre maintained day to day expenses for a small number of residents and the inspector saw evidence that adequate financial records were maintained. The inspector reviewed the system in place to safeguard residents' finances which included a review of a sample of records of monies handed in for safekeeping. A small amount of money was kept in a locked area in the center. All lodgments and withdrawals were documented and were signed for by staff members. The provider representative was a pension agent for a small number of residents. In relation to these pension accounts the provider representative informed the inspector that they did not hold any monies in any residents' bank accounts on residents behalf and there were transparent arrangements in place to safeguard residents' finances and financial transactions.

There was a policy on restraint which was updated since the last inspection. However, there was no restraint in use in the centre.

There was a policy on behaviours that challenged and the inspector noted that two of the 42 residents were assessed as having behaviours that challenged. There was evidence that for residents who presented with behaviours that challenge they were reviewed by their General Practitioner (GP) or other professionals for full review and follow up as required. Staff spoken to were clear on the support needs for residents exhibiting behaviours that challenge including the use of positive behavioural strategies. However, not all staff had not received training in the management of behaviours that challenge.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
There was a risk management policy as set out in schedule 5 of the regulations and included all of the requirements of regulation 26(1). The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. There was a risk register available in the centre which covered for example, risks such

as residents' falls, road safety risks and fire safety risks. There was a centre specific safety statement was dated as being most recently reviewed in October 2017. The inspector was informed that as part of the recently introduced QMS the provider representative and the person in charge met each month to review health and safety issues including any incidents, accidents or near misses in the centre. This meeting also reviewed procedures and practices including risk management and fire safety in the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency and assessments for pressure ulcer formation. The inspector noted that there had been a small number of accidents and incidents recorded on incident forms. All were reviewed by the person in charge and there was evidence of action in response to individual incidents. There was recorded information/communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any learning/changes required to prevent reoccurrence. The person in charge outlined a number of improvements implemented in relation to enhancing the health and safety since the previous inspection. These included new raised toilet seats fitted to all toilets, key pads locks placed on the doors into the staff changing room and sluice room, new call bells installed in toilets and in the sitting rooms. The inspector reviewed all notifications made to HIQA and crossed referenced them against the recorded accidents in the centre. The inspector noted that suitable notifications had been made in relation to all accidents in the centre. However, the hazard identification process required improvement as a number of potential hazards were identified by the inspector that required action including:

● the intermittent unrestricted access to the staff changing room required risk assessing as there may have been items potentially hazardous to residents with a cognitive impairment stored in this room

● the arrangement for storing all garden chemicals including weed killer, required risk assessing as access to the garden shed area was not always unrestricted

● the intermittent unrestricted access to the sluice/laundry room required risk assessing as there may have been items potentially hazardous to residents with a cognitive impairment stored in this room.

Latex gloves and plastic aprons were located throughout the centre and staff confirmed that they used personal protective equipment such as latex gloves and plastic aprons as appropriate. Overall there were systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. The communal areas and bedrooms were found to be clean and there was good standard of general hygiene in the centre. The cleaning practices as described by staff to the inspector were in keeping with the centres' cleaning policy and with best practice. The inspector noted that since the previous inspection all staff had received training in hand hygiene. Staff that were spoken to demonstrated knowledge of the infection prevention and control procedures to be followed or demonstrated suitable hand hygiene practices. All hand-washing facilities had liquid soap. Since the previous inspection the majority of the laundry requirements had been outsourced and most of the remaining laundry equipment had been moved away from the sluice room to an outside area. There were centre specific policies and procedures in place on infection prevention and control. However, there were a number of infection control issues including:

● the floor/wall covering/plaster in some parts of the sluice room and the laundry room was damaged and required repair/replacement

● the water taps of the wash hand sinks in the centres' sluice facilities were not adequate as they were domestic in design and did not promote good hygiene and infection control practices
● the lack of storage racks in the sluice room potentially compromised the prevention of cross contamination practices in the management of urinals
● there was no wash hand sink/soap/dryer in the sluice room for staff use therefore potentially compromising the prevention of cross contamination practices
● the floor covering in some areas required repair/replacement for example the linoleum floor covering was cracked/stained on the corridor/some toilets and could not be appropriately cleaned.

The provider representative informed the inspector that the remaining fire safety works including the installation of door closers and replacement of fire exit door handles to fire exit doors had been completed. There was fire safety training provided by an outside fire safety instructor and the inspector saw that fire training was provided to staff on dates in 2017 with the most recent training recorded as provided in October 2017. All staff spoken to demonstrate an appropriate knowledge and understanding of what to do in the event of fire and most staff had up to date fire training as required by legislation. However, five recently recruited part time staff had yet to receive fire safety training specific to this centre. The inspector did note that further training was scheduled for staff the following week. There were fire policies and procedures that were centre-specific. The fire safety plan was viewed by the inspector and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. There was one resident who smoked tobacco in the centre and there was a smoking area provided for residents' who smoked tobacco. There were adequate arrangements in place including records of a risk assessment completed for this resident. This record also referenced their capacity to smoke safely including any monitoring/observations requirements. The inspector examined the fire safety register which detailed services and fire safety tests carried out. Fire fighting and safety equipment had been regularly tested, the fire alarm and the emergency lighting was last tested in July 2017. All staff spoken to stated that they had participated in a fire evacuation drill in the centre. Records viewed evidenced that fire evacuation drills were practiced regularly in the centre with the most recent completed in October 2017. However, five recently recruited part time staff had yet to attend a fire evacuation drill and the provider representative informed the inspector that further training was scheduled for staff the following week. Most residents to whom the inspector spoke were knowledgeable about the fire safety arrangements in the centre including the fire evacuation drills and stated that they would recognize the sound of the fire alarm. Staff spoken to knew the evacuation requirements for each resident and many residents had good levels of mobility. The inspector reviewed residents' personal emergency evacuation plans (PEEP's) were had been completed for each resident living in the centre. However, these PEEP's required updating to include details of the supervision requirements of each resident in the event of an evacuation. The person in charge told the inspector and records confirmed that fire drills were undertaken regularly during the year. However, the records of fire drills required improvement to include details of the fire scenario being simulated or any problems identified during the fire drill practice so that learning from the drill and any improvements could be implemented as a result. All fire door exits were unobstructed and fire fighting and safety equipment had been tested and the fire alarm was last tested in July 2017. In addition, there were records of

weekly fire alarm and emergency lighting and daily monitoring of fire exits.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Residents had a choice of pharmacist from which to obtain their medications. The inspector noted that there were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were up-to-date. Nursing staff were observed adhering to appropriate medication management practices. The medication trolley was suitably secured and the medication keys were held by the person in charge or the staff nurse on duty. The inspector observed a nurse administering the morning time medications, and this was carried out in line with best practice. Medications were administered and disposed of appropriately in line with An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Controlled drugs were stored in accordance to best practice guidelines and two staff were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the person in charge which accorded with the documented records.

The inspector reviewed a number of medication prescription charts and noted that all included the resident's photo, date of birth, GP and details of any allergy. The person in charge outlined the system of ongoing audit and analysis in place for reviewing and monitoring safe medication management practices. The inspector noted that this system was also assisted by a recent audit completed by one of the supplying community retail pharmacists. Medication errors were recorded and there was evidence that appropriate action was taken as a result of same. Nursing staff undertook regular updates in medication management training as evidenced by training records.

Some residents self-medicated and this practice was supported by a centre specific policy and appropriate assessments. There was adequate and secure storage provided for the residents' medicinal products and access was limited to each individual resident. The person in charge outlined adequate evaluation (including on-going evaluation) of the residents' ability to self-administer as appropriate. There was also adequate recording and monitoring practices to facilitate the resident with self-administration.

There were appropriate procedures for the handling and disposal of unused and out of

date medicines and the documenting of same. The fridge containing medications was located in secure clinic room. There was evidence that the temperature of the fridge was monitored daily and that the fridges contained medications only.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
The inspector saw that there was a comprehensive log of all accidents and incidents that took place in the centre. Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 had been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents and incidents as required.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The inspector was satisfied that residents' healthcare requirements were met to an adequate standard. The centres' statement of purpose stated "the centre provided

supportive care for those who have been assessed as low to medium dependency and not requiring full time nursing care". The inspector noted that the overwhelming majority of residents were assessed as having low dependency needs with 41 out of the 42 residents assessed as having low support needs. These assessments had been completed by nursing staff using the activities of daily living assessments. Residents to whom the inspector spoke confirmed that they were well cared for and were very complimentary about the kindness and standard of care provided to them by all staff. The inspector noted many residents were very independent and in good health, with a number of residents had their own cars and regularly visited family, friends and went on social outings.

The person in charge stated that the centre did not admit any emergency admissions and that all admissions were planned with a pre admission assessment completed prior to residents admission to the center. On admission, each resident was reviewed by the person in charge and each resident's healthcare requirements were adequately and regularly assessed by nursing staff, as required. On admission residents were facilitated to retain access to their own General Practitioner (GP) of preference and the inspector noted that there were a number of GP's providing medical care to residents in the centre. There was documentary evidence that residents, as appropriate to their needs, had access to other healthcare professionals and services including dietetics, speech and language therapy, occupational therapy, physiotherapy and psychiatry. Residents also had access to ongoing GP services and out-of-hours medical cover was provided. Psychiatry of later life services were available including on going visits by the community psychiatric nurse that was provided to residents upon referral. Each resident had a nursing plan of care in place. The inspector reviewed a random sample of care plans and was satisfied that the system was clearly understood by staff. There was evidence that each care plan was informed by assessment and reassessment as required. There were few residents on modified diets and they were offered the same choices as people receiving normal diets. Each resident had suitable assessments and care plans completed in relation to their eating and drinking needs. The inspector noted that each resident had been most recently reviewed and assessed by a speech and language therapists in November 2015. However, there had been some changes in these residents support needs in the intervening period and these assessments therefore required review.

Each resident's vital signs were recorded regularly with action taken in response to any variations. Care plans were completed in consultation with the resident and/or their representative and were supported by validated assessment tools. In general care plans were person centred, clearly set out the arrangements to meet most of the identified needs as specific to each resident and incorporated interventions prescribed by other healthcare professionals. The inspector noted from speaking with staff that they knew the needs and life history of the residents in detail. On observation of care interventions, staff were seen to anticipate residents' needs in a timely and sensitive manner. The inspector observed that residents were at ease with staff who were assisting them. Many residents were well able to self advocate and told the inspector that the staff looked after them very well and all spoken to were complementary about the care and support provided by staff. Records reviewed recorded consultations with residents in relation to their care plans and residents confirmed that they felt that the staff informed them of their health care needs and any changes in their conditions. However, the

inspector noted from this sample of care plans reviewed that not all residents' care plans were adequately comprehensive for example, a number of care plans did not have adequate assessments/care plans in relation to each resident's social care needs. In addition, there was inadequate detail to guide staff practice in a care plan for a resident with behaviours' that challenge. The inspector noted that there was a flow chart record for each resident which did record some support that had been provided to residents each day. However, this was record was not adequate as this was not a nursing record of the resident's health and condition and treatment given, or signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

There was a low reported incidence of wounds. The inspector saw that the risk of wound development was regularly assessed. A validated assessment tool was used to establish for each resident at risk of falling and there was evidence of the routine implementation of falls and injury prevention strategies including close monitoring of residents. The residents right to refuse treatment was respected and recorded and brought to the attention of the relevant GP.

Judgment:
Substantially Compliant

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

Theme:
Effective care and support

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

Findings:
The centre comprised of a single storey building that had been purpose built and opened in 1994. It was located on a large site on the outskirts of Lismore town, Co Waterford. On the previous registration the centre had capacity for 51 residents however, on this renewal registration the provider representative was applying for 42 beds in order to improve the quality of life for residents in the centre and to meet HIQA standards. There was a large communal sitting room, two smaller sitting rooms in the main building along with a dining room and a small Oratory. Accommodation in the premises comprised of four ''Courts'', Court A, B, C and D. Court A accommodated 14 residents in single bed rooms and two residents in one twin bedroom. Court B accommodated 17 residents in single bed rooms. Court C contained one single bedroom. Court D consisted of eight en-suite self contained single bedroom flats conjoined by a

glass corridor at the rear of the building.

The provider representative outlined that since the previous inspection there had been a number of improvements in the premises including the footpaths around the premises have been made wider and more accessible for residents use. New traffic signs had been erected and a new designated set-down area with appropriate signage had been put in place. ''No parking signs'' had also been erected at the front of the premises. There was a new dedicated marked and signed walkway for any residents or visitors using the entrance road into the centre. The inspector observed that the redecorating programme had commenced with on going painting and decorating of a number of areas such as a redecorating of one of the small sitting rooms and painting of all bathroom doors. Some of the flooring had been replaced, there had been a new extraction system installed in kitchen and in the multi purpose room. The provider representative also outlined how staff have fund raised for the refurbishment of this sitting room and had donated a large T.V in multi purpose room. Residents informed the inspector that this TV was very popular particularly on movie nights and for watching sporting events.

Overall, the centre was adequately maintained, well organized and efforts had been made to make it homely. For example, the inspector noted that there were plants, pictures, fire places, and ornaments in communal rooms and handmade woollen throws on the backs of many of the chairs in the large sitting room. The overall design and layout of the centre fitted with the aims and objectives of the statement of purpose and the centre's resident profile. It promoted residents' independence and wellbeing and there was suitable storage for residents' belongings with many of the residents bedrooms had been personalized. Storage facilities for equipment were also adequate. There was a functioning call bell system in place and since the previous inspection new call bells had been put in all toilets and sitting rooms. However, the inspector noted that there was no call bell in the Oratory. The centre maintained a safe environment for resident mobility with hand-rails in circulation areas and corridors kept clean and tidy. There was appropriate lighting and colour schemes. The decoration was generally adequate with the aforementioned on-going redecoration programme was in place. However, as identified on the previous inspection there were still a number of tiles on bathroom floors that were stained and some cracked linoleum floor covering on corridors that required repair or replacement. The provider representative informed the inspector that these issues would be addressed as part of this redecoration programme.

Overall the centre met most of the requirements of the National Quality Standards for residential Care Settings for Older People in Ireland. Heating and ventilation was suitable. Water temperature was monitored and was at a suitable temperature. Pipe work and radiators were safe to touch. However, as identified previously and actioned in Outcome 8 of this report in some parts of the sluice room and the laundry room the floor/wall covering/plaster was damaged and required repair/replacement. There were sufficient number of toilets suitably located for residents convenience. The inspector noted that there were two assisted bathrooms available and a total of 12 shower units in the center. However, the inspector also noted that there were no radiators or fixed heaters in the assisted bathrooms. The person in charge informed the inspector that mobile heaters were used as an interim measure. The provider representative informed the inspector that the board had plans to renovate these assisted bathrooms to include

suitable heating and also install an additional separate new wet room in the center.

There was three sitting rooms available and each were homely, bright and had adequate space and there was a separate dining room adjacent to the kitchen. There was a small, quiet Oratory which was suitable for individual or groups of residents and or visitors to reflect or have small private meetings. There was a designated smoking area. Staff toilets, changing and storage space was adequate and well maintained. The kitchen was well maintained, well organised and had satisfactory environmental health office reports. Kitchen staff had received appropriate training and suitable staff facilities for changing and storage were provided. The provider representative informed the inspector that the vast majority of laundry was now outsourced to an external company and only a small amount of items were actually laundered in the center. However, as previously identified the laundry facilities were not fit for purpose and this issue is actioned under outcome 8 of this report.

The outside areas were well kept with some seating and a number of interesting attractions for residents including two inner court areas that the person in charge said were popular with residents in the summer time. The inspector noted that there was a large raised bed located at the main entrance and the person in charge outlined how staff had recently prepared this area for residents to be able to set spring/summer plants. A variety of comfortable seating was provided in the sitting rooms and in the entrance area. Secure storage was provided in each bedroom. In the one shared room suitable screening curtains had been provided to ensure privacy. However, the inspector noted that adjacent to the door of one bedroom there were three glass panels the length of the door and that these panels did not have any curtain or screening. Therefore these panels potentially compromised this residents privacy and this issue is actioned in outcome 16 of this report.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
Policies and procedures which complied with legislative requirements including an independent appeals process were in place for the management of complaints. Complaints could be made to any member of staff and the person in charge was the designated complaints officer. The provider representative was the second person as

required by regulation in relation to the monitoring and management of complaints. Residents were aware of the process which was on public display near the main entrance. On review of the complaints log there was evidence that complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcome of their complaint and records evidenced whether or not they were satisfied. All complaints were reviewed regularly as part of the QMS management system by the management group to identify any learning or changes that were required.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
The person in charge confirmed that there had been no death at the centre since it had been registered and that there had been no instances where end of life care had been provided. The statement of purpose and policy and procedures in place indicated that where the needs of a resident changed and end of life care provision became necessary, residents requiring such care were referred for assessment and transferred to an appropriate service provider accordingly.

The policy summarized the protocol in the event of a sudden or unexpected death and outlined a process whereby the relatives of residents were provided with advice and practical information on what to do in the event of a death. A policy on residents' personal property and a protocol for the return of personal possessions was also in place. Religious and cultural practices were facilitated and residents also had access to ministers of other religious denominations. Care plans reviewed contained provision for the assessment of needs around spirituality and dying from the sample reviewed had been recorded.

Judgment:
Compliant

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

discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
Residents were provided with food and drink at times and in quantities adequate for their needs. Assistance was observed and was offered to residents in a discreet and sensitive manner by staff. The dining experience was a social occasion and many residents were seen chatting with each other throughout their meal. Staff also used meal times as an opportunity to engage in a meaningful way with residents, particularly with residents to whom they gave assistance. The few residents on modified diets were offered the same choices as people receiving normal diets each resident had suitable assessments and care plans completed in relation to their eating and drinking needs. The inspector noted that each resident had been most recently reviewed and assessed by a speech and language therapists in November 2015. However, there had been some changes in these residents support needs in the intervening period and these assessments required review. This issue was actioned under outcome 11 of this report.

A two weekly rolling menu was in place to offer a variety of meals to residents. The inspector noted that most residents took their meals in the dining room and tables were appropriately set with cutlery, condiments and napkins. Residents spoken with agreed that the food provided was always tasty, hot and appetising. Overall residents were happy with the food provided in the centre and some residents stated that that ''the food was very good/excellent''. Food was served from the nearby kitchen by a team of staff and was well presented. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. The inspector spoke with the catering manager who outlined how she and the kitchen staff were knowledgeable about residents' dietary need and preferences. A list of all special diets required by residents was compiled on foot of the individual residents' reviews and copies were available in the kitchen.

Drinks such as water, milk, tea and coffee were available and following a recent residents' committee meeting there was an additional afternoon tea provided to residents around 3pm. Access to fresh drinking water was available at all times and jugs of water were observed in residents' rooms. There was a system in place to monitor the intake of residents identified as at risk of malnutrition which was found to be consistent/detailed enough to enable meaningful analysis as to the adequacy of intake for the few residents identified as at risk.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the

centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Residents were facilitated to exercise their civil, political and religious rights. The inspector observed that residents' choice was respected and control over their daily life was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal room. Respect for privacy and dignity was evidenced throughout both days of inspection. Staff were observed to knock on doors and get permission before entering bedrooms. Screening was provided in the multi-occupancy bedrooms to protect the residents privacy. Staff were observed communicating appropriately with residents who were cognitively impaired as well as those who did not have a cognitive impairment. It was clear to the inspector that residents were treated with respect and staff knew each resident's individual preferences. The inspector heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Resident's choose what they liked to wear and staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards residents. However, as discussed in outcome 12, the inspector noted that in one shared bedroom that was currently occupied by one resident contained three glass panels the length of the door. These panels did not have any curtain or screening and therefore potentially compromised this residents privacy.

Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Visitors told the inspector that they were always made welcome and that there were areas in the centre to visit in private if they wished to do so. They said that if they any concerns they could identify them to staff and/or the person in charge and were assured they would be resolved.

Residents had access to the daily national newspapers and weekly local newspapers, magazines, books and several residents were observed enjoying the newspapers on both mornings of the inspection. Residents had access to radio, television, and information on local events. Many residents frequently came and went to their home, or visiting families, friends and local shops and restaurants, some using their own cars for transport. The inspector observed other residents being collected by family and friends or taking taxi's or local transport to various outings and appointments. It was evident to

the inspector that residents had some opportunities to participate in activities that were meaningful and purposeful to them and that suited their needs. A range of activities were facilitated for example, some live music sessions, storytelling, social evenings, prayers/mass, games such as bingo and pongo. The inspector observed on the first day of inspection one resident playing their own accordion in the large sitting room to the obvious delight of residents. There were two transition year students seen playing pongo with a group of residents on the second day of inspection. In addition, some residents left the centre to attend a local day centre and maintained their links with these local community services. However, as identified on the previous inspection improvement was required in relation to providing opportunities for residents to participate in activities in accordance with their interests and capacities. This was evidenced from speaking to residents, a review of the residents' satisfaction surveys, from speaking to staff and the absence in residents care plans of suitable assessments of residents interests and capacities or life stories.

The provider representative outlined how the centre had long established links within the local community. The management and governance of the centre was provided by a voluntary board made up mainly of local people. The provider representative outlined that the centre was very well supported by the local community on an on-going basis, particularly in relation to fund raising activities. The person in charge stated that the provider representative or members of the board visited the centre on an almost daily basis and were available for consultations with any resident. The person in charge outlined how as the centre was relatively small, she was able to actively consult with residents and their representatives each day.

From speaking to residents it was clear that most residents were able to advocate for themselves and/or with the support of their representatives. The person in charge stated that the centre was looking into the provision of an independent advocacy service however, the person in charge confirmed that residents did not currently have access to an independent advocate.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:

There was a centre-specific policy on residents' personal property and possessions and from the sample of residents' records reviewed by the inspector; there were records in place of individual resident's clothing and personal items. The inspector noted that most bedrooms had been personalised in the center and residents were facilitated to have their own items, such as assisted equipment or furniture and personal memorabilia. Each resident had adequate furniture in their bedrooms to store clothing and personal items in their own bedside cabinets and wardrobes. Locked storage was provided and a further safe was available, if required.

The majority of laundry was done off-site either by an outside contractor unless the resident wished to send their laundry home. The inspector spoke to staff regarding laundry management and found that they were knowledgeable about appropriate procedures in regard to infection control. Residents and their relatives informed the inspector that clothing was well looked after. Residents laundry appeared well maintained and overall there were appropriate arrangements in place for the regular laundering of linen and clothing and procedures were in place for the safe return of residents' personal clothing items. However, the laundry room/area was not suitable in the design, size and layout and this issue was actioned under Outcome 12 of this report.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Residents and relatives spoke very positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care and support to residents. The inspector observed positive interactions between staff and residents over the course of the inspection and found staff to have good knowledge of residents' needs as well as their likes and dislikes.

An actual and planned roster was maintained in the centre. The inspector reviewed staff rosters which showed that the person in charge who was a nurse, was on duty 8am to 5pm Monday to Friday. Nurses were also on duty every evening from 8pm until 10pm. In addition, there was a nurse on duty from 8am to 1pm and again 8pm until 10pm at the weekends. The person in charge or a designated staff nurse were on call to the healthcare staff outside of these hours. Care staff including night staff spoken to gave examples of when this nurse/management supportive arrangement had worked well. For example, on the first morning of this inspection the inspector observed that the person in charge had arrived early to the centre following contact by night duty staff in relation to a resident who had become unwell. The person in charge confirmed that she along with other staff nurses were available for staff to contact outside of hours, if required.

The person in charge informed the inspector that copies of the regulations and HIQA standards had been made available to all staff. From a review of minutes of staff meetings the inspector noted that a number of issues such as care standards, HIQA inspections and notifications were discussed with staff.

Staff appraisals had been completed for all staff and from speaking to the person in charge, staff and a review of documentation; staff appeared to be supervised appropriate to their role and responsibilities. There was an education and training programme available to staff. The training matrix indicated that most mandatory training was provided and a number of staff had attended training in areas such as cardio pulmonary resuscitation (CPR) and infection control and hand hygiene. However, most but not all staff had completed site specific fire evacuation and fire safety training and responding to and manage behaviours that were challenging. These failings were discussed and actioned under Outcome 7 and 8 of this report.

The provider representative confirmed that all staff and volunteers had been suitably Garda vetted. The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were seen by the inspector.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Vincent Kearns
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	St Carthage's House Limited
Centre ID:	OSV-0000687
Date of inspection:	09/01/2018
Date of response:	09/02/2018

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

1. Action Required:

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

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
The Board are reviewing the quality ad safety of care of the residents at its meeting on February 7.

Proposed Timescale: 07/02/2018

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned including the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, ''after'' the terms, as required by regulation.

2. Action Required:
Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

Please state the actions you have taken or are planning to take:
We don't participate in the Home Support or the Fair Deal scheme. We will amend the agreement with the residents to include a statement that he/she will be accomodated in a single bedroom but that they may occasionally have to share with another person.

Proposed Timescale: 16/01/2018

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services including for example fees for occasional items such as hairdressing, newspapers or dry cleaning.

3. Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
The costs of various occasional items, e.g., hairdressing (€10-25), chiropody (€10), papers €10/week) have been added to our contract of care and will be given to all new residents.

Proposed Timescale: 19/01/2018

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

4. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
Half of our carers will attend a Behavioral Challenge Course in Dungarvan Hospital on Wed 14th February from 2-5pm and the remaining half on Wed 21st February.

Proposed Timescale: 24/02/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre including:
● the intermittent unrestricted access to the staff changing room required risk assessing as there may have been items potentially hazardous to residents with a cognitive impairment stored in this room
● the intermittent unrestricted access to the sluice/laundry room required risk assessing

as there may have been items potentially hazardous to residents with a cognitive impairment stored in this room
● the arrangement for storing all garden chemicals including weed killer, required risk assessing as access to the garden shed area was not always unrestricted.

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

Please state the actions you have taken or are planning to take:
Item 1. All staff have been informed that HIQA and the Board require that the door to the staff changing room be kept closed all times and that they must enter using the key pad.
Item 2. The sluice/ laundry room is going to be completely revamped over the next several months and a lockable cupboard will be included to keep hazardous items in will be included.
Item 3. A lockable steel press is being purchased to keep garden chemicals in and this will be located in the garage.

Proposed Timescale: Item 1, 01/02/2018; Item 2, 30/05/2018; Item 3, 01/02/2018

Proposed Timescale: 30/05/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff including:
● the floor/wall covering/plaster in some parts of the sluice room and the laundry room was damaged and required repair/replacement
● the water taps of the wash hand sinks in the center's sluice facilities were not adequate as they were domestic in design and did not promote good hygiene and infection control practices
● the lack of storage racks in the sluice room potentially compromised the prevention of cross contamination practices in the management of urinals
● there was no wash hand sink/soap/dryer in the sluice room for staff use therefore potentially compromising the prevention of cross contamination practices
● the floor covering in some areas required repair/replacement for example the linoleum floor covering was cracked/stained on the corridor/some toilets and could not be appropriately cleaned.

6. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the

standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
Items 1-4 will be included in the new revamped sluice/laundry room.
Item 5. We will replace all damaged floor coverings in the toilets and corridors.

Proposed Timescale: Items 1-4, 30/05/2018; Item 5, 31/03/2018

Proposed Timescale: 30/05/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

7. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
A fire drill is planned to take place on April 1st, 2018, during which staff will be trained in fire prevention, emergency procedures, etc. Simulation of a fire outbreak will be included as part of the drill.

Proposed Timescale: 01/04/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents including providing adequate PEEP's and records of fire drills.

8. Action Required:

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

Please state the actions you have taken or are planning to take:
The arrangements for evacuating residents will be included in the fire drill scheduled for April 1st.

Proposed Timescale: 01/04/2018

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2) including ensuring the following:
● that care plans are adequately comprehensive for example in relation to each resident's social care needs or to guide staff practice for a resident with behaviors' that challenge
● to ensure that there is a nursing record of the resident's health and condition and treatment given, or signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

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

Please state the actions you have taken or are planning to take:
Item 1. Suitable control plans have been added to the care plans of residents with behavioral challenges.
Item 2. As and from January 10, 2018, all care plans are written daily.

Proposed Timescale: 10/01/2018

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise including speech and language therapist.

10. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

Please state the actions you have taken or are planning to take:
A speech and language therapist will be engaged to advise the residents with swallowing difficulties.

Proposed Timescale: 26/01/2018

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre including the following identified issues:
● a number of tiles on bathroom floors were stained
● there was some cracked linoleum floor covering on corridors that required repair or replacement
● that there was no call bell in the Oratory
● there were no heating radiators in the assisted bathrooms

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

Please state the actions you have taken or are planning to take:
Item 1. We are going replace the stained tiles.
Item 2. Cracked linoleum is being replaced.
Item 3. A call bell has been ordered for the oratory
Item 4. We intend revamping one of the assisted bathrooms as an assisted wet room and will put a suitable radiator into it when that is being done. We will also put a suitable heater into the other assisted bathroom.

Proposed Timescale: Items 1 and 3. 31/03/2018. Item 3, 28/02/2018; Item 4, 31/05/2018

Proposed Timescale: 31/05/2018

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

Please state the actions you have taken or are planning to take:
An Activities Committee has been formed with a Chairman and two joint Secretaries. They have organised exercise classes on one day a week, movies on Thursday and Sunday of each week and a singer to come in with a guitar one day/week.

Proposed Timescale: 19/01/2018

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that each resident may undertake personal activities in private including residents living in any bedroom with glass paneling.

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

Please state the actions you have taken or are planning to take:
A blackout blind has been ordered to put over the pane of glass.

Proposed Timescale: 09/02/2018

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that each resident has access to independent advocacy services.

14. Action Required:
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

Please state the actions you have taken or are planning to take: We intend to employ a professional to act as an independent advocate for the residents and suggest she would talk to the residents at 3 monthly intervals.
Proposed Timescale: 02/02/2018