

**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
Provider Nominee:	Mary Fenton Morrissey
Lead inspector:	Gemma O'Flynn
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	38
Number of vacancies on the date of inspection:	13

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 December 2016 09:10	07 December 2016 18:10
08 December 2016 08:05	08 December 2016 14:15

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Non Compliant - Major
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This unannounced inspection took place over two days, the purpose of which was to monitor ongoing compliance with the regulations. The inspection also followed up on the actions that resulted following the centre's previous inspection in January 2015. Seven of the 14 action plans had been completed and seven remained an ongoing non-compliance.

St. Cathage's House is a voluntary centre that provides support to residents that have been assessed as having care needs that are low to medium dependency. Twenty four hour nursing care is not provided in the centre.

As part of the inspection process, the inspector met with residents, staff, the person in charge, the provider and members of the board of management. Residents' opinions were elicited and staff discussed the care delivered to residents in the centre. Care practices were observed and documentation was reviewed. The inspector found that there was evidence to demonstrate that residents had access to

health and social care that met their needs. The care was delivered by staff who demonstrated an in-depth knowledge of residents and their needs. Residents were very complimentary of the staff and the care that they received, with some stating that their fellow residents and staff were their family. Staff spoke of residents in a respectful, appropriate manner.

Recruitment procedures required review as there were a number of recently recruited staff working in the centre without the required Garda vetting disclosure. An immediate action plan and an associated warning letter was issued to the provider by the Health Information and Quality Authority (HIQA), requesting that immediate action be taken to bring the centre into compliance in this regard. The provider confirmed in writing that they had taken immediate action to ensure that no person recruited on or after 29 April 2016 (whether on a part-time, full-time, volunteer or other basis) is allowed to work at, or be involved with, the designated centre unless the registered provider has sought and received a vetting disclosure in respect of the person from the National Vetting Bureau of An Garda Síochána.

Improvements were required in the governance and management of the centre. Based on the available evidence, it was not clear that the centre was sufficiently resourced to complete action plans from the previous inspection and to ensure that matters relating to staffing, health and safety and general management were fulfilled. Improvements in documentation pertaining to care planning were required.

Given the nature of the identified non-compliances and the resources that would be required to address same, the provider was invited to attend a meeting at the HIQA offices to discuss their plans to bring the centre into compliance.

The inspector's judgments of compliance relating to each outcome inspected against are set out in the table above and discussed in detail in the body of the report and the associated action plan.

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 consisted of a statement of the aims, objectives and ethos of the designated centre and a statement as to the facilities and services which are to be provided for residents. The statement of purpose had not been reviewed on annual basis as required by the regulations. The date of the last review was January 2015.

The inspector found that the centre was operating outside of its statement of purpose and function which stated that care would be provided to residents of low to moderate dependency. The person in charge stated that there were exceptions to this provision in exceptional circumstances, however, this was not set out in the statement of purpose. It was evident on review of the centre's residents' dependency assessments that at least one resident's dependency levels was determined to be greater than moderate dependency.

Judgment:

Non Compliant - Major

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):

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

implemented.

Findings:

Some actions associated with the previous inspection in January 2015 had not been satisfactorily addressed and are restated in this outcome.

The centre is a voluntary organisation providing support with activities of daily living to residents with a low to moderate dependency. Residents pay a fee, an annual grant is allocated to the centre via statutory funding and additional monies are raised via fundraising. Residents and staff who spoke with the inspector confirmed that the centre was adequately heated, well maintained and residents were provided with adequate food and drink to meet their needs.

However, the inspector was not assured, based on the available evidence, that the centre was sufficiently resourced to ensure the effective delivery of care in accordance with the statement of purpose. The provider cited inadequate resources as the reason why action plans were not progressed or completed. For example, premises issues that had been identified on the previous inspection regarding the laundry room had not been addressed, the inspector was informed that this was due to insufficient funding.

The provider had invited an external fire safety expert to the centre to conduct a review of the centre's fire safety arrangements. Some action had been taken such as the purchasing of 13 automatic fire door releases of which the centre was awaiting delivery. However, the provider had undertaken to address this issue by April 2015 following the centre's previous inspection in January 2015. The provider and person in charge cited inadequate funding as the reason why this plan had not been implemented to date. The fire safety report had been issued in November 2016, however, when management were asked when the recommendations would be fully implemented, the inspector was informed that funding was an issue and hence there was no clear plan in place to ensure all matters would be attended to in a timely fashion.

The person in charge stated that due to changes in staff nurse availability, there were insufficient resources available to ensure that the hours required would be covered in the coming weeks or months. She anticipated that there would be a loss of four hours per week. Recruitment for additional nursing staff to cover planned leave had not commenced at the time of the inspection. The provider stated that the use of agency nurses was not an option due to limited funding.

On the second day of inspection, there were three health care assistants rostered until 14:00hrs despite the requirement being four health care assistants. The person in charge stated that this was due to lack of availability and cover for annual leave or sickness. Due to the non-compliances identified throughout the course of the inspection, the inspector formed the judgment that the person in charge was inadequately resourced to fully discharge the function of her role. The provider and board of management were asked at the feedback session at the close of the inspection, to review the supports available to the person in charge. The board of management stated that they would be meeting in January 2017 to commence a detailed overview of the service.

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 the first day of inspection, the person in charge, the provider and three members of the board of management made themselves available to the inspector. On the second day of the inspection, the provider, the person in charge and two members of the board of management made themselves available to the inspector.

The person in charge stated that she had daily informal meetings with the provider, these meetings did not have a set agenda and minutes were not maintained. The person in charge did not attend the board of management meetings. The person in charge said that she prepared an update which was forwarded to the board of management prior to their meeting. The last meeting records of the board of management available in the centre were for April 2016. On the agenda were matters such as finance, fire door releases and building maintenance.

The person in charge identified that four members of staff had been recruited since 29 April 2016 and confirmed that these staff members did not have the required vetting disclosure as required under the 2013 Regulations and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016. The posting of new staff without a valid vetting also contravened the centre's recruitment policy. This is discussed further and actioned under outcome seven, safeguarding and safety.

There was an audit schedule in place and audits completed in 2016 included medication audits, a kitchen safety audit and a health and safety audit. The inspector found that the audit process could be enhanced to provide comprehensive feedback on all aspects of the service such as risk management, consultation with residents and documentation review. These are areas in which non-compliances were identified on inspection.

The centre's 2015 annual review was available for inspection. This was a one page document that set out the improvements that had taken place and listed plans for 2016. The review stated that funding would be available to address the laundry area and some aspects of the fire safety issues by May 2016, however, these matters had not been fully addressed at the time of the inspection in December 2016.

Judgment:
Non Compliant - Major

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 was a suitably qualified nurse with the required experience in nursing of the older adult. She worked in the centre Monday to Friday, 40 hours per week. She demonstrated excellent clinical knowledge of the residents' needs and an awareness of her regulatory responsibilities.

Staff and residents were supportive of her as a manager and stated that she was approachable and responsive.

The person in charge stated that she had attended training in safeguarding in 2016. She stated that there were no definitive plans in place to attend further training in 2017.

She was engaged in the governance of the centre on a regular basis however, she was also a rostered nurse for 24 hours of the 40 she was rostered to work. She stated that this had an impact on her ability to discharge the administration function of her role. This matter is discussed under outcome two, governance and management.

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

Findings:
Elements of this outcome were examined on this inspection.

In the sample of residents' files reviewed, medical notes were not securely stored in any the files examined by the inspector. Medical notes were not secured to the files in which they were contained and therefore were at risk of being misplaced or lost.

Not all requirements of schedule two of the regulations were held in the staff files reviewed. For example, a copy of a valid form of identification was not in all files, nor was evidence of qualifications or a history of employment.

Judgment:
Substantially 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:

There was a policy on, and procedures in place for, the prevention, detection and response to abuse dated July 2016. The majority of staff had received training on elder abuse prevention and the majority of staff had received training in the safeguarding of vulnerable adults in September 2016. New staff that had recently been recruited had not received this training. Staff who spoke with the inspector were knowledgeable in regards to what constituted abuse and what to do in the event of an allegation or witnessing abuse.

The person in charge said that she met with residents regularly on an individual basis to ensure they were happy in the centre. The person in charge said that all care assistants rotated between day and night duty to ensure adequate supervision. Staff who spoke with the inspector confirmed that they worked shift rotation. Residents told the inspector that they would approach the person in charge if they had any concerns. All residents who spoke with the inspector gave very positive feedback about the staff. Some residents said they were like family. Residents said that they felt safe.

As discussed in outcome two, 'governance and management', the person in charge confirmed that four staff members employed on or after April 29, 2016 did not have the required vetting disclosure. The person in charge and board of management were reminded of their regulatory responsibilities in this regard. The person in charge stated that the issue had arisen due to the unexpected departure of four long-term staff. An immediate action and warning letter were issued to the provider requesting immediate action be taken to ensure compliance in this regard. On the day after the inspection, the provider submitted written assurances that only staff with the required vetting were rostered on duty.

There were systems in place to safeguard residents' money. The person in charge said that money was not stored in the centre on behalf of the residents, the management of which had been an action in the previous report. The provider was a pension agent for eight residents. Records were kept of monies returned to residents and signatures were in place for same. The role of the agent was clarified for the provider in regards to ensure monies are returned to residents prior to any billing being applied.

There was no restraint in use in the centre. There were no residents who required support for responsive behaviour.

Judgment:
Non Compliant - Major

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:
Improvements were required in health, safety and risk management. Undertakings by the provider in response to the centre's previous action plan in January 2015 had not been addressed in the timeframe given to HIQA. Some proactive measures had been taken by the provider in that they had commissioned a review by a fire safety expert to ensure fire issues were identified, however, a formal plan had not been developed to address such issues.

The centre had policies and procedures relating to health and safety. There was a comprehensive risk management policy dated July 2016. There was an emergency plan also dated July 2016. There was a list of identified hazards in the centre. Risk assessments were done in the format of audit that listed the control measures in place but the level of risk was not assessed to determine its likelihood and severity. Some hazards had not been formally identified although controls were in place, such as no nurse being present in the centre at designated times and the on call arrangements and protocols for same.

There was an infection control policy dated July 2016 and it was evident from previous notifications to HIQA that the appropriate links were in place with external agencies for expert advice when required. Overall there were satisfactory procedures in place for the prevention and control of healthcare associated infections and the relevant staff who spoke with the inspector were knowledgeable of the procedures in place. However, some chairs in communal areas were seen to be torn, therefore preventing effective decontamination. A refuse holder in the laundry room was covered in significant rust again preventing effective decontamination. The layout of the laundry room did not provide segregated areas for soiled or clean clothing. The person in charge stated that there were plans in place to relocate the laundry area to an outside building and this was awaiting sanctioning of funding.

There were arrangements in place for recording serious incidents and adverse events

involving residents. These were documented and managed well on an individual basis. However, as referred to in outcome two, such incidents were not subject to audit or management review or analysis to provide learning opportunities to improve future practices in risk management.

Training records provided to the inspector indicated that staff had received training in safe moving and handling practices.

The provider and person in charge had invited a specialist in fire safety to review the fire safety arrangements in the centre in November 2016. A number of non-compliances had been identified such as door wedges propping open fire doors. This practice had been identified on the previous HIQA inspection in January 2015 and again on this inspection. There was no fire evacuation procedures displayed in a prominent location. Not all bedding, furniture and mattresses were to the required standard of fire resistance as identified in the specialist's report. The person in charge and provider informed the inspector that 13 automatic release fire door closures had been ordered and that the additional door closures would be ordered before the year end. There was no formal plan in place to address the remaining outstanding issues of non-compliance relating to fire safety. Residents who smoked were required to do so in a designated area, however, individual risk assessments for smoking safety were not carried out to ensure that all appropriate safety controls were in place. Hence, the controls listed in the centre's general smoking risk assessment were not being fully implemented.

Staff were knowledgeable about what to do in the event of the fire alarm sounding as were some residents who spoke with the inspector. The person in charge carried out a weekly information refresher to enhance staff knowledge. However, annual fire training had not been provided by a suitably qualified person. Fire drills were not being carried out on a regular basis to ensure that the arrangements for evacuation of residents were sufficient. In the absence of these additional drills, there was no evidence, documentary or otherwise, to demonstrate that the plans and practices in place were sufficient to ensure a timely evacuation if the need arose. There were no details as to the length of time it would take to evacuate all residents from a specific zone if needed. This was discussed with the provider and person in charge over the course of the inspection.

Judgment:
Non Compliant - Major

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

Findings:

There were written policies relating to medication management in the centre. There were processes in place for the handling of medicines, including controlled drugs. Since the previous HIQA inspection in January 2015, two staff were involved in the checks and documenting checks of controlled medications in the centre, however the documentation required review as it had not been appropriately adapted to clearly state what staff were signing to confirm. This was discussed with the person in charge who commenced amendments to the form prior to the close of inspection.

A medication refrigerator was in place, however, daily checks of the refrigerator temperature were not taking place. The medication fridge did not have a lock but was stored in an area accessible to all grades of staff, hence, medications were not always stored securely.

A medication round was observed. Overall, practices were in line with current guidance for nurses, however, medications were verified prior to administration by referring to the medication administration record as opposed to the registered prescriber's prescription.

A record was maintained of all medications returned to the pharmacy including medication name, amount and which resident the medication belonged to. This record was signed by the pharmacist and the returning person.

Residents were facilitated to self administer if they so wished and a suitable individual assessment was completed for such residents.

Medication practices has been subject to audit in 2016 and no findings of non-compliance had been elicited.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

Overall, there was evidence to demonstrate that residents' health and social care needs were met, however, improvements were required in documentation practices.

Residents had access to appropriate medical treatment. A comprehensive log was maintained in the sample of residents' files reviewed that demonstrated suitable interventions and referral systems were in place. For example, the record showed that residents had access to podiatry, out-patient appointments, optical services, physiotherapy and pharmacy review. Referrals for allied health services such as speech and language therapy, occupational therapy and physiotherapy were made via the public community services. It was noted that at times the wait could be lengthy, nursing staff confirmed that if they so wished, residents could access private care.

Residents weights and vital signs were recorded three monthly. It was evident from speaking with staff that they knew the needs and life history of the residents in great detail. On observation of care interventions, staff were seen to anticipate residents' needs in a timely and sensitive manner. Residents were at ease with staff who were assisting them. Residents told the inspector that the staff looked after them very well and that there was never a delay in accessing care should they require it.

Improvements were required in the documentation of health and social care needs. Assessments were carried out three monthly and included dependency level assessments, mental test scores and falls risk. There was scope to enhance the assessment process to ensure that the changing needs of residents were formally identified in a timely manner. For example, routine assessments did not include nutritional status or assessment of skin integrity despite some residents having existing nutritional concerns or compromised skin integrity as discussed at the morning handover on the second day of the inspection.

It was evident on review of the centre's residents' dependency assessments that not all residents were assessed as being low to moderate dependency. Some had needs that were greater. The care delivered in the centre was intended to be delivered to those residents with low to medium dependency. The person in charge was asked by the inspector to complete a comprehensive assessment of residents falling outside this criteria and submit assurances to HIQA within a designated timeframe, that the centre was in a position to meet those assessed needs given that 24 hour nursing care was not available.

Where a specific issue had been identified such as admission to the centre for symptom management or wound care, there was no specific care plan in place to direct care. Instead, care plans were a narrative note that explained care given. For example, there was no wound assessment completed for wound dressing changes just a note to say wound redressed. There was no record of the materials used to confirm that specialists' advice had been implemented nor was there a record of the progress of the wound.

Where a resident had an identified area of concern regarding skin integrity, a validated risk assessment tool had not been implemented. There was no documented care plan that outlined appropriate interventions. Upon review of narrative notes, there was evidence that a pressure relieving device was in place.

Where a resident had a history of requiring support for their mental health or an illness such as diabetes, it was evident that they had access to the appropriate specialist

services and suitable interventions were implemented, however, care in the centre was not guided by a specific care plan outlining how to appropriately support the resident.

Where a resident's dependency levels increased and their care needs could no longer be met in the centre, there was no formal discharge care plan in place.

The person in charge stated that all residents' needs were known to the staff and whilst this was clear during discussions with staff, there was no documentation to demonstrate that the care provided was based on the assessed needs of residents. A four monthly narrative update was completed and gave an overview of the current status of residents but did not plan or direct future care. The inspector discussed these issues with the person in charge and nursing staff. Prior to the close of the inspection, action had been taken to address these issues.

Since the centre's previous inspection, a dietician had reviewed the centre's menu to ascertain it was nutritionally balanced.

Judgment:

Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The person in charge had issued ten residents' surveys at the end of 2015 and all ten were completed. Overall, feedback was positive with some comments stating that entertainment could be improved upon. There was no documented review of the surveys to provide analysis of the responses and to ensure an action plan for that feedback was developed to improve the quality of service in the centre.

Residents' meeting had been held in the centre in previous years, however, these had not been conducted in 2016. Therefore, it was not evident that all residents had the opportunity to raise concerns or put forward suggestions about the running of the centre. This was discussed at the close of the inspection.

Residents who spoke with the inspector stated that they would have no hesitation in approaching the person in charge if they had any concerns. These residents indicated

that overall they were satisfied with how the centre was operated. Some feedback was elicited which indicated some dissatisfaction with some aspects of the running of the centre, this was relayed to management at the close of the inspection.

Residents had the freedom to exercise choice and personal freedom. Some residents retained the use of their car and left the centre on a regular basis. Residents told the inspector that they were facilitated to vote. Mass was celebrated in the centre on Tuesdays and there was arrangements for residents to receive visitors in private if they so wished.

There was no restriction on visiting. Visitors were asked to sign in and out and were seen to come and go over the course of the inspection. Residents had access to the centre's cordless telephone as confirmed by the person in charge.

Staff were courteous, friendly and patient with residents and demonstrated an awareness of the communication needs of residents that they interacted with.

Residents had access to activities. Over the course of the unannounced inspection, residents were seen to partake in a music session in which some residents played musical instruments whilst other residents sang along. Chair exercises were carried out and a Christmas party was scheduled to take place on the second day of the inspection and residents who spoke with the inspector told of how much they were looking forward to it.

Judgment:

Substantially 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:

Over the course of the inspection, staffing levels differed. For example, on day one of the inspection there were four care assistants scheduled until 14:00hrs. On day two of the inspection, there were three care assistants scheduled until 14:00hrs. Staff told the inspector that this had a minimal impact on the care of the residents as on day two, the

person in charge was assisted by a nurse from 08:00hrs to 13:00hrs. The person in charge stated that ideally there should be four care assistants rostered daily until 14:00hrs but lack of resources to cover annual leave and sick leave had an impact on the roster.

The person in charge stated that a lack of resources impacted on her ability to discharge the administration function of her role. As stated in outcome two, the board of management were requested to review this and make appropriate resources available to support the person in charge.

Training was available to staff. However, mandatory training for elder abuse prevention and fire safety was not complete for all staff. This has been actioned under outcomes seven and eight respectively.

Up to date registration was seen for all relevant member so staff. Appraisals were completed in the sample of staff files reviewed, these appraisals did not take the opportunity to identify areas of training that would be of benefit to staff. Staff were rotated between day and night duty to ensure adequate supervision for all staff.

Written agreements with volunteers were not on file. Evidence of a vetting disclosure for volunteers was not available on inspection. The provider stated that she had received same but it was not in the centre on the day of inspection (this is actioned in outcome seven).

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St Carthage's House Limited
Centre ID:	OSV-0000687
Date of inspection:	07/12/2016
Date of response:	20/02/2017

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 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The statement of purpose was not reviewed on an annual basis.

1. Action Required:

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

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

Please state the actions you have taken or are planning to take:
The statement of purpose will be reviewed by March 31st each year from here out.

Proposed Timescale: 31/03/2017

Theme:
Governance, Leadership and Management

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

The centre was operating outside its statement of purpose as not all residents were assessed as being low to moderate in their dependency levels.

2. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The Board will modify the statement of purpose accordingly

Proposed Timescale: 31/03/2017

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

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

Based on the available evidence, it was not clear that the centre was sufficiently resourced to ensure the effective delivery of care in accordance with the statement of purpose.

3. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

The Board recognise that they are not adequately resourced and that many of the issues raised in this report could be solved if we had a full-time manager. He/she would relieve the PIC of her non-nursing duties making more nursing time available. These issues are currently being discussed with the relevant authority and the Board is hopeful that the necessary funds will be made available.

Proposed Timescale: 30/09/2017

Theme:

Governance, Leadership and Management

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

It was not evident that there were adequate resources available in the centre at all times.

For example:

- premises issues that had been identified on the previous inspection regarding the laundry room had not been addressed.
- Recommendations regarding fire safety following an external review had not been addressed and there was no clear plan in place to ensure all matters would be attended to in a timely fashion.
- The person in charge stated that due to changes in staff nurse availability, there were insufficient resources available to ensure that the hours required would be covered in the coming weeks or months.
- Due to the non-compliances identified throughout the course of the inspection, the inspector formed the judgment that the person in charge was inadequately resourced to fully discharge the function of her role.
- The audit process required review to ensure it was comprehensive and informed continuous improvement in the quality and safety of the service.

4. Action Required:

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

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

The issues with the laundry room require refurbishment and significant funding and the Board have applied to the relevant authority for a grant to address them. They are hopeful of a positive outcome Time scale: refurbishment completed by December 15th 2017.

The fire safety issues are currently being addressed. In November 2016 the Board commissioned a comprehensive report from the Waterford Fire Service. Since then the Board have employed a retired fire officer to develop an extensive fire prevention and evacuation strategy (see below for further details).

Time scale: ongoing

Regarding staff nurse availability, the Board have advertised for an extra nurse to work part-time. It is hoped that this position would be filled in a few weeks.

Time scale: March 25 2017

Non compliance and audit issues: up to now the PIC has been doing this. The Board have realised that the PIC workload is too much. The Board have applied to the relevant authority for funds to employ a manager who would, in addition to managing the centre take over these functions from the PIC. The Board expect a positive outcome to their application. In the meantime the board will endeavour to carry out audits to the

best of its ability.
Time scale: manager in place before September 30th 2017.

Proposed Timescale: 15/12/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

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

Not all staff files held the requirements of schedule 2.

5. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All staff files will have required documentation by 28th February 2017.

Proposed Timescale: 28/02/2017

Theme:
Governance, Leadership and Management

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

Medical notes were loosely stored in residents' files.

6. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

All notes are now being securely filed

Proposed Timescale: 20/02/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

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

Four staff members did not have the required Garda vetting disclosure.

7. Action Required:

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

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

The four staff members have now been Garda vetted

Proposed Timescale: 20/02/2017

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

Safe care and support

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

Not all hazards in the centre were formally identified.

The level of risk was not assessed to determine its likelihood and severity.

Controls associated with specific risk assessments were not being fully implemented at all times, for example, the risk assessment for residents who smoked.

8. 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:

One of the new Board members has experience of health and safety issues and he, together with the retired fire officer, have taken responsibility for the non-medical aspects of this issue. Hazards and the risks associated with them are currently being identified.

Proposed Timescale: 01/07/2017

Theme:

Safe care and support

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

Incidents in the centre were not subject to audit or review to provide a learning opportunity and inform future practices in the centre.

9. Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The incidents with residents have been reviewed by a Board member and mainly involve falls. In the future, the Board will review all incidents every 6 months and will

endeavour to put in place systems which would help to reduce these incidents, if this proves necessary.

Proposed Timescale: 20/02/2017

Theme:

Safe care and support

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

Not all matters in the centre were in line with the standards for the prevention and control of healthcare associated infections published by the Authority. For example: The layout of the laundry room did not provide segregated areas for soiled or clean clothing.

Some chairs in communal areas were seen to be torn, therefore preventing effective decontamination.

A refuse holder in the laundry room was covered in significant rust again preventing effective decontamination.

10. 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:

The segregation of soiled and clean clothing will be addressed as soon as the funding to improve the laundry becomes available. The washing machines and driers are housed in separate buildings. In the meantime, soiled clothing is placed in sealed plastic bags and washed clothes are taken to the drying room before the soiled clothes are brought into the washing machine room for washing.

Time scale: 15 Dec 2017.

The relevant chairs are currently being upholstered.

Time scale: completed

The refuse holder in the laundry room has been replaced.

Proposed Timescale: 15/12/2017

Theme:

Safe care and support

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

Fire drills were not taking place.

11. Action Required:

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

of fire.

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

Fire drills will be carried out every 6 months starting in March 2017

Proposed Timescale: 31/03/2017

Theme:

Safe care and support

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

Annual training was not provided by a suitably qualified individual.

12. 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 retired fire officer is being employed to implement this regulatory requirement. He will institute all of the actions under this regulation plus the additional ones identified in the Fire Officer's report, dated 21 Nov 2016, a copy of which HIQA have. It is envisaged that fire drills would be held every 6 months and that fire-fighting equipment would be inspected annually. This will begin immediately. In addition, fire door controls will be installed in the last remaining rooms rooms by 28 February 2017.

Proposed Timescale: 30/06/2018

Theme:

Safe care and support

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

Not all furniture, bedding and equipment were not to the required fire resistance. Fire doors were propped open with door wedges throughout the centre.

13. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Fire resistant bedding: quotations are being sought from three suppliers for the bedding
Timescale: replaced by 1 September 2017.

All door wedges will be removed by February 28th when automatic fire releases will have been installed in all residents rooms.
Time scale: 28th Feb 2017.

Proposed Timescale: 01/09/2017

Outcome 09: Medication Management

Theme:

Safe care and support

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

Medications were verified prior to administration by referring to the medication administration record as opposed to the registered prescriber's prescription.

14. Action Required:

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

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

All medications are now being checked against each resident's prescription

Proposed Timescale: 20/02/2017

Theme:

Safe care and support

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

Not all medication was stored securely in the centre. For example, all grades of staff had access to the unlocked medication fridge.

Daily refrigerator temperatures were not recorded.

15. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

Medications are now stored in a locked fridge and fridge temperatures are recorded daily

Proposed Timescale: 20/02/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Assessments were not sufficiently comprehensive to ensure that all residents' needs were formally identified in a timely manner.

Care plans were not in place where specific issues pertaining to residents' care had been identified, for example, wound care, discharge from the centre or symptom management.

Care plans for residents whose needs were outside the centre's scope of care as per their statement of purpose were not in place.

16. Action Required:

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

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

Care plans for all residents are currently being updated regarding wound care, discharge from the Centre and symptom management.

Proposed Timescale: 01/05/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

It was not evident that all residents had the opportunity to raise concerns or put forward suggestions about the running of the centre.

17. Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

The Chairman and some members of the Board have consulted the residents on whether a formal consultative system should be put in place. The overwhelming response was that the present system, where any problems are brought to the attention of the person in charge, was quite adequate. The Board respects the wishes of the residents in this regard. An annual meeting of the residents and the board will be held and the findings will be documented.

Proposed Timescale: 05/05/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

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

There were insufficient staffing resources to cover annual and sick leave.

18. Action Required:

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

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

Currently annual and sick leave are covered by asking staff members who are not on annual or sick leave to work additional hours to provide the necessary cover. The Board are also going to advertise for another carer.

Proposed Timescale: 20/02/2017

Theme:
Workforce

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

Written agreements with volunteers were not on file.

19. Action Required:

Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

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

Any volunteers who come in to the centre do so in a communal setting with most of the residents present and are supervised by staff at all times. The Board are trying to get written agreements from all volunteers.

Proposed Timescale: 30/06/2017