Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	St. Joseph's Centre
Name of provider:	Saint John of God Hospital Company Limited by Guarantee
Address of centre:	Crinken Lane, Shankill, Co. Dublin
Type of inspection:	Announced
Date of inspection:	25 June 2019
Centre ID:	OSV-0000102
Fieldwork ID:	MON-0022717

About the designated centre

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

St Joseph's centre provides holistic dementia care and palliative care to persons living with dementia. The philosophy of the Hospitaller Order of St John of God guides the work in the centre, and this philosophy means that residents are viewed as having intrinsic values and inherent dignity. The building is purpose built, and consists of a single storey and is divided into 6 houses, with capacity for 62 residents. The centre has 2 beds for respite residents, and provides day care for members of the community. The centre provides 24-hour care to men and women with dementia over 18 years of age.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	62

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
25 June 2019	08:15hrs to 18:00hrs	Sarah Carter	Lead
25 June 2019	08:15hrs to 18:00hrs	Deirdre O'Hara	Support

Views of people who use the service

This was an inspection that was announced in advance, and a small number of questionnaires were received indicating residents and/ or their relatives' views on the service. Some were left completed in the centre, and others were sent to the office of the chief inspector.

The feedback received was entirely positive, and all reported that they were satisfied with the staff and facilities on offer. All singled out the potential to be active, and to "do what you would do at home" was of tremendous benefit to the residents.

Residents spoken with on the day appeared content, and while they may not have been able to clearly articulate their views, their words used were positive and their demeanours indicated they were calm and content.

Inspectors observed many residents moving around throughout the centre. On several different occasions both inspectors observed residents engaged in activity groups, which were running in the different units (which the centre calls lodges) at the same time.

The weekly gathering of the community Living Well with Dementia Sweet Memories Choir took place on the day of inspection, and resdients were encouraged to attend in addition to any visitors and anybody who was attending the on-site day care services.

Residents indicated they liked the food and the facilities they had, and were content in their rooms.

Relatives spoken with said they felt their loved-one was respected, well cared for and felt safe in the centre.

Capacity and capability

The centre was well managed by an established management team who were focused on improving resident's wellbeing. There were effective management structures in place that ensured care was provided in a safe and sustainable way. This inspection was announced a month in advance, and took place to assist the office of the chief inspector to grant a renewal of the centres registration.

The service offered in the centre was clearly outlined in the statement of purpose

(SOP). The SOP contained the detail required by the regulation, however some sections required expansion and further information to ensure the registration the centre is seeking can be granted. This was discussed with the person in charge (PIC) during the inspection. The centre is part of the St John of Gods Hospital clg, and had both its own internal governance structures, as well as clearly defined links and relationships with the management structures of the main hospital. The governance systems in the centre included daily handover meetings and separate house and staff meetings (the centre calls each of its 6 units, lodges). In addition there were various management meetings and committees including a risk, health and safety committee which met regularly.

The service was led by a person in charge, who was suitably experienced and qualified for the role. She was available full time in the centre, and was maintaining her own professional development through attendance at relevant courses and conferences. Audits were completed routinely by different staff, some were completed by the staff in the centres, some by staff from the main hospital. There was a schedule of audits in place. Results of audits were discussed at different staff meetings, and translated out to staff in email format; they were also discussed at floor meetings on units to ensure staff were informed. The suite of audits completed was comprehensive, however some action was required to ensure audit results were fully actioned and monitored. Inspectors noted an outcome of an audit in the early part of the year, that had indicated a need for improvements in the facilities and cleanliness of sluice rooms, and inspectors found many of the same findings on the day of inspection.

As the centre ran its service with a specific model of care which focused on person centred dementia care, staff had been trained in this technique and approach, and specific person centred dementia care audits were also carried out annually to monitor how the service was meeting resident's needs. An annual review had been completed and included evidence of consultation with residents.

Staffing was sufficient to meet the residents' needs. The nurse managers were supernumerary to staffing levels and oversaw the quality and safety of care for residents. The day care centre on site was staffed separately from the staffing in the centre. There were qualified nursing staff available at all times. Staff were supervised in their work, and there was a system of performance appraisal in place. As part of the model of care in use in the centre, all staff were expected to provide and engage in one-to-one activities with residents if the residents wished. Several examples of this were seen throughout the day. Staff were available in each dining and sitting room area to assist residents as needed. Staff were knowledgeable regarding the needs of residents.

The staff work was supported by a large selection of volunteers. The centre had up to 70 volunteers on its records, and in the sample of volunteer files seen, all held the required documentation; including role descriptions and Garda vetting disclosures. There was a staff member appointed to supervise volunteers, and a schedule of their planned activities was also seen. In addition staff records were also reviewed, and contained all the required information and documentation. All staff

and volunteers had received Garda vetting disclosures.

Staff had access to a wide variety of training, and were supervised in their roles. Weekly education sessions took place. Staff were aware of the lines of accountability and authority in the centre. Staff who spoke with inspectors reported that they felt supported in their role and were clear about the standards that were expected of them in their work. There were some staff who were overdue training in the required areas, however this will be reflected in the specific regulations on infection control and fire precautions in the next section of the report.

Insurance was in place and its certificate displayed in the centre. The insurance policy detailed both the insurance obligations and cover for the main hospital as the governing body, and also detailed appropriate and centre-specific information and cover.

Schedule 5 policies were reviewed, and all were present and available to staff. A small number of policies were overdue for their 3 yearly review. In policies seen, they were evidence based, and referenced national guidelines where appropriate.

A directory of residents was maintained and contained all the required information about each resident who had lived or was currently living in the centre. Contracts of care were seen, that indicated residents had signed. Fees and costs associated with care in the centre were clear however the occupancy of bedroom the resident was admitted to was not clear. Recent guidelines on nursing home contracts published by the Competition and Consumer Protection Commission (CCPC) was discussed with the person in charge and other management present at the feedback meeting at the end of the inspection.

A staff member was appointed to the role of complaints officer, and where possible complaints were managed locally on each unit by the nurse in charge, if this wasn't possible the complaints officer was involved and sought a resolution. Complaints records seen were accurate and captured the satisfaction levels of the complainant. The complaints officer met the person in charge regularly to keep her up-to-date and was also part of committee through the main hospital, where complaints had senior management oversight.

Registration Regulation 4: Application for registration or renewal of registration

The floor plans, which form part of the information required by the Chief Inspector to renew registration were incorrect. Rooms were incorrectly described and illustrated; for example a toilet was a store room, and a store room was in use as an office. Unit (lodge) names and room numbers were not clearly listed. The statement of purpose will require further amendment to reflect the changes made to the floor plan.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge was experienced and qualified to complete her role, worked full time in the centre and maintained her own expertise through continuous professional development.

Judgment: Compliant

Regulation 15: Staffing

The numbers and skill mix was staff were appropriate to the needs of residents and the layout of the units (lodges). There was a clear allocation of staff to the different lodges. Staffing of the day care centre on-site was maintained on a separate roster.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were supervised in their work, and each lodge had its own team leader. Staff had access to adequate and appropriate training on-site and through the main hospital. Gaps in training are recorded in regulation 27 and regulation 28 below. Staff were knowledgeable about the office of the chief inspector and the standards expected of them.

Judgment: Compliant

Regulation 19: Directory of residents

A directory was established and maintained and available for inspectors. It listed all the required information for each resident who has lived or was living in the centre.

Judgment: Compliant

Regulation 21: Records

Records were available for review and included; appropriate and correct staff records, rosters, the complaints records, records in relation to fire prevention practices. Resident records were clear and included all necessary and required information.

Judgment: Compliant

Regulation 22: Insurance

There was an in-date insurance policy which detailed the insurance available against injury to residents and damage or loss to their property.

Judgment: Compliant

Regulation 23: Governance and management

There were sufficient resources in place to ensure the service offered and delivered to residents was in accordance with what was described in the statement of purpose. The management structure in the centre, and its part in the wider hospital management structure was clear. There were effective systems in place to monitor the service. An annual review had been completed which included resident and relative consultations.

Judgment: Compliant

Regulation 24: Contract for the provision of services

There were written and signed contracts of care in place for residents. The contracts outlined the fees and costs involved in the service. The occupancy of the bedroom being offered to the resident was not clear in the contracts seen.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a written statement of purpose that contained al the information as set out in the regulations. The changes required to ensure the SOP described what was on the floor plan is judged under registration regulation 4, above.

Judgment: Compliant

Regulation 30: Volunteers

The roles and responsibilities of volunteers had been set out in writing, and they were supervised by a member of staff appointed to co-ordinate their activities. All volunteers had received Garda vetting disclosures.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an accessible and effective complaints process in the centre. A member of staff was nominated to manage complaints, and a separate member of staff from the main hospital was appointed to review the process. The complaints policy was known to any relatives spoken to on the day, and it was advertised in the centre. Clear records were maintained of any complaints.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had prepared policies to meet the requirements of schedule 5 of the regulations. Most policies had been reviewed and updated in line with evidence based practice or new guidelines. However a small number of policies required review as they had not been reviewed within 3 years.

Judgment: Substantially compliant

Quality and safety

Residents wellbeing was maintained, and in some cases improved since their

admission, through evidence based care and good risk management processes. Gaps in staff training in specific areas has resulted in some substantial compliance judgements, however staff knowledge and practice was good on the day of inspection.

Comprehensive assessments were carried out to meet the needs of the residents. The inspectors reviewed a sample of care plans and these were found to be person centred. They had been updated at four monthly intervals in line with the requirements of the regulations. Where residents were assessed by specialists, their recommendations were reflected in the care plans or daily notes.

Each resident had a pre-admission assessment prior to their admission. The assessments were comprehensive and looked at both the health and social needs of the potential resident immediately before the admission in order to ensure that their ongoing needs for care and support could be met. There was clear evidence in the care plan records that residents and families, where appropriate, were involved and consulted in care planning.

Residents had access to a medical practitioner provided two days a week. The service had access to a behavioural psychologist once a month to discuss residents care needs and assist with care planning. There was access to other specialists available on referral, including physiotherapy, tissue viability, occupational therapy, speech and language therapy, dietician, chiropody, dental services and optical services.

Behavioural support plans were in place for residents who required additional support. These plans guided staff and enabled them to identify the triggers and recommend responses to behaviours that were challenging. Of the behaviour logs that were viewed by inspectors it was clear that specific tools were used to review behaviours afterwards to identify any possible cause. Risk assessments were reviewed at regular intervals and kept updated. Observations on the day of inspection showed that there were no restrictive practices in use in the centre.

Residents rights were safeguarded in the centre. All staff had received training in safeguarding vulnerable adults; the policy in the centre was clear and based on national guidelines. The centre had a pension agency arrangement in place, and the process in place protected the residents interests. The Health Service Executive and the Department of Social Protection had been consulted, and statements available were clear and indicated the residents rights were being upheld.

Resident's rights were further promoted in the centre, through a combination of the model of care in use, staff practices, and the environment of smaller units (lodges). In each lodge there was a large sitting room and dining area, which provided the facilities for recreation, all lodges had access to an outdoor area, and there was also further large communal recreational area in the building that all residents could access. Radios, televisions, newspapers and magazines were plentiful in the centre and various consultation processes were in place to gather both residents' views and relatives' views about the service. Advocacy services were available and residents were facilitated to vote in elections if they wished.

The premises of the centre was in good condition. The 6 units (lodges) flowed from one to another, across two separate H- shaped areas. Fire doors which had been decorated in tasteful murals, divided the lodges from each other. Bedrooms were a mix of single and twin rooms, and some were ensuite with a toilet and wash hand basin, some had showers and others did not have ensuite facilities. Bedrooms appeared to have sufficient space for resident's belongings and were well maintained, with emergency call bells and good ventilation. There was a sufficient number of baths and showers for the number of residents to use. The decor of the lodges had a general "homely" feel. The communal areas of the centre - used for larger activities for example a choir or mass - were by comparison, more clinical in their appearance. This was due to the paint colour, their layout and their size. Some room's had been converted to store rooms on units, and the centres floor plans were required to be updated to reflect these changes.

The resident's wellbeing was further enhanced by good risk management practices in the centre. A risk registry was maintained, and a clear policy in place to guide staff. The policy included all the aspects that the regulation requires. Inspector's identified some environmental hazards on the day, which were immediately addressed.

Adequate precautions were being taken to prevent fire. Fire drills were practiced regularly, and records showed the learning from each one. Residents had their own emergency evacuation plans, and staff knowledge about these was good. Fire prevention equipment was serviced regularly. However staff records indicated that 19% of staff required training in line with the policy of training staff annually.

Measures were in place to assist staff to minimise the spread of infection. In each of the lodges there was a supply of protective equipment and hand sanitizer as well as a policy to guide staff practice. However just over 25% of staff required training in hand hygiene and infection control standard precautions. There was also evidence that improvements were required in the centres sluice rooms, and this had been identified in the centre audit in February 2019.

Regulation 17: Premises

The layout and decoration of the building was appropriate for residents and the model of care used in the centre. There was sufficient space in bedrooms for residents personal possessions and sufficient number of bathrooms and showering facilities. There was access to pleasant outdoor spaces.

Judgment: Compliant

Regulation 26: Risk management

There was an effective risk management policy in place, that included hazard identification and the specific measures in place to control identified risks. There were arrangements in place to continuously assess risk and oversight of the process through a specific management committee. There was a plan in place to respond to major incidents and emergencies.

Judgment: Compliant

Regulation 27: Infection control

Infection control measures included hand sanitisation and personal protective equipment available on units (lodges). There was evidence that sluice rooms required oversight to ensure full standard precautions were being followed and monitored. Not all staff had received training in hand hygiene. However staff practices observed on the day indicated good adherence to infection control principles.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were sufficient fire prevention measures in place in the centre, and equipment was monitored and serviced regularly. Staff knowledge was satisfactory on the day and followed information contained in the fire prevention policy. However not all staff had received annual fire training. Regular drills were being conducted and recorded appropriately.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents were comprehensively assessed before admission and at regular intervals once resident in the centre. Their care needs were described in person-centred care plans which were routinely updated and reviewed. If their needs changed there was evidence they were assessed by specialists and care plans were subsequently changed. There was also evidence that residents and their relatives where appropriate were consulted in the development of the care plans.

Judgment: Compliant

Regulation 6: Health care

General practitioners were available to the residents in the centre. Other specialists were available as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Evidence showed that residents' needs were met in the least restrictive way. There were no bedrails in use in the centre and residents had clear care plans guiding staff to respond in the least restrictive way to any behaviours that were challenging.

Judgment: Compliant

Regulation 8: Protection

Residents were safe and well protected in the centre. Staff were knowledgeable about upholding residents rights and protecting vulnerable residents. There was a clear policy to guide staff to respond to any allegations or suspicions of abuse, and all staff had received training in the area.

Judgment: Compliant

Regulation 9: Residents' rights

Residents rights to privacy and dignity was upheld by staff and in an environment where residents made their own choices and maintained their preferred routines. Residents were consulted to seek their views and ideas on the services, and where it was difficult for a resident to communicate their relatives were also consulted, if appropriate. Advocacy services and voting was available in the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. Joseph's Centre OSV-0000102

Inspection ID: MON-0022717

Date of inspection: 25/06/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Registration Regulation 4: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 4: Application for registration or renewal of registration: A review of current floor plans will be carried out and the plans will be amended to reflect current function of all areas and rooms. The Statement of Purpose will be updated to reflect the changes made to the floor plan.	
Regulation 24: Contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services: The Contract of Care will be updated to include a section which must be completed upon admission indicating the occupancy of the room in which the resident will be residing.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies	

and procedures:
A review of Saint Joseph's existing policies and policies listed in Schedule 5 of the regulations will be undertaken and all policies that require review or that have exceeded 3 years will be reviewed and updated.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Infection Control Training will be scheduled for all outstanding staff.

Cleaning schedules will be reviewed to ensure cleanliness and monitoring of sluice rooms is maintained.

A review of sluice room facilities will be undertaken and any improvements identified will be implemented.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire training will be scheduled for all staff who have not completed their annual basic fire awareness.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Not Compliant	Orange	31/08/2019
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other	Substantially Compliant	Yellow	26/07/2019

	occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/09/2019
Regulation 28(1)(d)	The registered provider shall 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.	Not Compliant	Orange	30/09/2019
Regulation 04(3)	The registered	Substantially	Yellow	31/10/2019

	provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Compliant		