**Centre name:** Caritas Convalescent Centre  

**Centre ID:** OSV-0000020  

**Centre address:** Merrion Road, Dublin 4.  

**Telephone number:** 01 260 0609  

**Email address:** yvonne@caritas.ie  

**Type of centre:** Health Act 2004 Section 39 Assistance  

**Registered provider:** Caritas Convalescent Centre Limited  

**Provider Nominee:** Michael Lyons  

**Lead inspector:** Valerie McLoughlin  

**Support inspector(s):** Linda Moore;  

**Type of inspection** Unannounced  

**Number of residents on the date of inspection:** 48  

**Number of vacancies on the date of inspection:** 4
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.
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 Quality 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 1 day(s).

The inspection took place over the following dates and times
From: 01 April 2015 07:50  To: 01 April 2015 16:30

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

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Summary of findings from this inspection
This inspection report sets out the findings of an unannounced follow up inspection. The purpose of which was to monitor progress of the action plans required from the registration inspection in December 2014. This monitoring inspection was un-announced and took place over one day.

As part of the monitoring inspection, the inspectors met with residents and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical files and staff rosters.

Inspectors found that there continued to be a significant number of areas of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Caritas Convalescent Centre is a purpose built two storey building which has 52 places. The service provides short term convalescent and respite service with an average length of stay of 11 days. The main aim of the care provided is to focus on
the recovery of residents post surgery and maximise their potential in order for them to return home.

Caritas Convalescent Centre Ltd is the provider for this voluntary centre, its chairperson is the person nominated to act on behalf of the company. The centre is run by a board of directors who meet approximately four times per year.

Sr. Daly is the person in charge and is also the director of operations with responsibility for the overall daily operation of the centre including the coordination and administration of over 1400 admissions per year. Inspectors found that the person in charge had an excellent knowledge of each resident and had very hands on approach to care. However inspectors found that there was still a lack of clinical governance in the centre which could result in poor outcomes for some residents. There was still inadequate numbers of staff and skill mix to meet the needs of residents and the numbers of admissions and discharges each day impacted on the quality of assessment and care delivered. Care staff continued to carry out aspects of the role of the nurse and were not appropriately supervised or support in their role.

The management systems in place still did not ensure that services provided were safe, appropriate to residents needs, consistent and effectively monitored. Inspectors found that the provider and the person in charge had fully addressed ten of the 25 actions, partly addressed ten actions and five actions were not addressed that were identified on the previous inspection. While inspectors acknowledged that some actions were partly addressed, the action taken did not ensure that a consistent safe service was being delivered to residents.

Areas for improvement included:
- assessment and care planning
- medication management
- statement of purpose and residents’ guide
- risk management
- staff training
- developing policies
- developing a system for reviewing the quality and safety of care
- complaints management

These actions are detailed in the report and included in the Action Plan at the end of the report.
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 Quality 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):**

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

**Findings:**

Inspectors found that the statement of purpose had been revised to include the specific care needs that the centre intended to meet, the fire precautions and emergency procedures. While it contained a summary of the complaints procedure this did not meet the regulations. It did not specify who was responsible for ensuring that the complaint was managed and responded to.

A copy of the statement of purpose had not been provided to the residents.

The statement of purpose had not been implemented in practice. For example, the admission criteria stated that, 'all residents for admission must be lucid'. However, on the day of inspection one resident had a history of confusion and wandering. The statement of purpose also stated that a nurse would commence a comprehensive assessment for new admissions. Inspectors found that the care staff completed residents’ admission documentation which was outside of their scope of practice. See Outcome 11.

**Judgment:**
Non Compliant - Moderate

**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:
Inspectors found that while the provider had addressed some of the actions from the previous inspection, there was failure to provide sufficient oversight of key areas such as clinical governance, risk management and healthcare issues as discussed throughout this report. Inspectors found that clinical governance in the centre still remained weak and inspectors were concerned that this could result in poor outcomes for residents.

Inspectors identified non compliances in the areas of clinical leadership as outlined in Outcome 11, healthcare, risk management and insufficient staffing arrangements as outlined in Outcome 18. Inspectors found that the management systems in place still did not ensure that services provided were safe, appropriate to residents' needs, consistent and effectively monitored. The model of care delivery was not person-centred. For example, there was a task allocation approach to care, for example, one nurse allocated to do dressings, and a nurse allocated to do doctors rounds.

The person in charge had introduced clinical nurse meetings and inspectors found recorded evidence of discussions at these meetings about health and safety issues, staff training, and the Authority’s action plan from the previous inspection and ordering of some pressure relieving equipment. This was confirmed by staff on duty. Therefore this aspect of the action plan had been met.

The person in charge explained that she had commenced formal meetings with the provider and had requested two additional nursing staff to meet residents’ needs in light of the number of admissions and discharges of residents on a daily basis. There were no minutes of these meetings available in the centre on the day of inspection. The person in charge told inspectors that another meeting was scheduled for the end of April 2015.

While the role of clinical nurse managers and care staff were clearly set out in the job descriptions, they were still not being implemented in practice. For example, the job description of the clinical nurse manager stated that they would supervise care; however they explained that due to the number of admissions per day and their case load, they are still not carrying out their role as described in the job description.

There continued to be no clear lines of accountability for decision making and responsibility for the delivery of services to residents. For example, since the previous inspection, the care assistants were still completing admission assessments, manual handling assessments, monitoring vital signs of residents including residents following cardiac surgery, and monitoring blood glucose levels. Inspectors were concerned that the care staff were not supervised or supported at all times as the nursing staff were busy administering medications, carrying out dressings and doing doctors rounds. Care staff told inspectors that they were concerned that they were working outside their role.
as they were being asked to carry out nursing duties; inspectors were concerned that this could result in poor outcomes for residents.

While care staff were very dedicated and qualified to FETAC level 5, they did not have the qualifications, skills or knowledge to carry out the role of the nurse. While it was identified at the previous inspection there was still no system in place to review the safety and quality of care provided.

Judgment:
Non Compliant - Moderate

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

Findings:
Inspectors noted that the Residents' Guide had been made available to residents and was on display in the centre. However, it did not meet the requirements of the regulations. While the guide now provided a summary of the complaints procedure, the complaints process outlined did not meet the regulations. Therefore this aspect of the action plan has not been met.

Contracts of care were in place and found to be in line with the requirements of the Regulations. Inspector read a sample of completed contracts and saw that they had been agreed and signed by the resident. The contracts stated the services to be provided, the fee charged and any additional costs that may incur. This aspect of the action had been met.

Judgment:
Non Compliant - Moderate
**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The person in charge was a registered nurse and met the criteria set out in the Regulations. The person in charge demonstrated a commitment to delivering good quality care to residents and was aware of residents’ needs. Residents spoke highly of the person in charge. All documentation requested by inspectors was readily available.

While she worked full-time in the centre she still was not full-time in the post of person in charge as she also provided front line nursing duties at times. This had not changed since the previous inspection. As a result, inspectors remained concerned that she had not managed the service effectively.

The person in charge was supported by a clinical nurse manager (CNM) who deputised in the absence of the person in charge. However, the other CNM’s were unable to carry out their role of supervising and support care staff because they were acting as staff nurse’s because they were the only nurses on duty providing care to residents.

The person in charge had not kept herself suitably up to date to ensure the delivery of a consistent high standard of evidenced based practice. She was not familiar with risk assessments, care plans or quality improvement methodology.

Since the previous inspection, the person in charge had completed an update in medication management and training in risk management. However, she explained to inspectors that she had not attended any other training that had been scheduled as there was not enough staff to care for the residents.

The person in charge was not familiar with the regulations relating to her role. The provider failed to provide adequate resources to enable the person in charge to carry out her role as per the requirements of the Regulations.

**Judgment:**
Non Compliant - Moderate
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:
The designated centre did not have all of the written operational policies as required by Schedule 5 of the Regulations, for example residents’ personal property, personal finances and possessions and staff training and development.

However, since the previous inspection, the person in charge and provider had a number of policies in place such as the policy on the protection of vulnerable adults, wound care and nutrition. Inspectors were shown a copy of the policies, while they were evidenced based they were generic in nature, for example they had not been adapted to the centre.

While staff had received training in protection of older persons, wound care and nutrition they still did not have access to policies to guide practice.

While the risk management policy met the requirements of the regulations it had not been implemented and it was still not available to staff.

The risk management policy stated that a clinical governance committee was in place and a risk resister was in place. However, neither was in place and this was confirmed by the person in charge and the CNM.

The directory of residents had been updated to include if a resident was transferred to another hospital, the date on which the resident was transferred and the name of the organisation. Therefore this aspect of the action plan had been met.

Inspectors found that resident’s records were now completed in line with schedule 3 of the Regulations. For example the daily records completed by nursing staff now outlined a summary of care and treatment provided to residents. However, this information was not reflective of the care plans as outlined in Outcome 11.
Judgment:
Non Compliant - Moderate

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

Findings:
Inspectors found that this action had been partially addressed. Inspectors found that measures were not fully in place to protect residents from being harmed or abused.

Since the previous inspection, all staff had received training on identifying and responding to allegations of elder abuse. Additionally five staff had been trained to provide staff refresher training in protection of older people. While a policy had been developed it was not in line with current national guidelines.

The person in charge and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Residents spoken to and commented that they felt safe and secure in the centre. They attributed this to the fact that staff were approachable, and they could talk to any of the staff if they had an issue.

A review of incidents showed that there were no allegations of abuse in the centre.

Judgment:
Non Compliant - Minor
**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:**
Inspectors found that the provider had partially addressed the action plan from the previous inspection but there were still a number of areas that required improvement.

Inspectors were satisfied that the provider had ensured that all staff received training on fire safety and manual handling since the previous inspection. A review of training records indicated all staff had received training on fire management and manual handling.

Overall fire safety was well managed. Staff spoken with were knowledgeable about fire prevention and management. Additionally three members of staff received further training to facilitate new staff on induction and to oversee fire drills and to act as Fire Marshals. Two fire drills had been completed since the previous inspection and additional drills were scheduled. Therefore this aspect of the action plan had been addressed.

There were no risk assessments undertaken for the evacuation of residents who had reduced mobility and those who required a wheelchair to ensure their safety.

While manual handling assessments were in place they were still completed by staff that were not fully trained in this area and were not sufficiently detailed to guide staff in practice. This could pose a risk to residents. Therefore this aspect of the action plan had not been addressed fully.

The person in charge explained that an external consultant had provided education on risk management for all staff over two days. A review of training records indicated staff had attended this training and staff spoken with confirmed they had attended the training. Therefore this aspect of the action had been addressed, ahead of the agreed time scale of June 2015.

The risk management policy met the regulations but was not being implemented in practice.

Inspectors found there was no recorded learning or improvement in care from incidents and accidents although staff had received training on how to complete clinical incident reports.
There was no collective review of incidents and accidents to identify trends and implement quality improvement measures. Inspectors found that this was a missed opportunity for quality improvement in the centre and were concerned that this could result in poor outcomes from residents.

A review of incidents and accidents indicated that a resident sustained a fall and there was no record to state the cause or outcome of the fall. The person in charge said that a clinical nurse manager was scheduled to attend falls prevention and management training in April 2015.

The provider stated in the action plan that an expert assessment of risk strategy would be carried out on 23 January 2015. Inspectors found from speaking with the person in charge that while an external person engaged with the management team, a comprehensive assessment of risk in the centre had not been undertaken due to the resources required. The provider had obtained a proposal from the external consultant; however it was not available to inspectors on the day of inspection. Therefore this aspect of the action plan had not been addressed.

Residents who smoked did not have a risk assessment completed and there was no care plan in place to ensure their safety. This had also been identified at the previous inspection.

The Health and Safety Statement for 2014 was centre specific but it was not being implemented in practice. A health and safety committee was in place but it did not include a review of any clinical risks in the centre. There had been no meeting of this committee since the previous inspection. There were no minutes available.

The person in charge had plans in place to have a staff representative from each staff discipline on the health and safety committee by 31 June 2015 to manage potential risks in the centre, including clinical risks.

There was recorded evidence that the GP reviewed residents within twenty-four hours of a falls. While neurological observations were carried out they were not being recorded accurately.

**Judgment:**
Non Compliant - Moderate

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**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
Findings:
Inspectors found that there was some improvement made in the medication management process, however further improvement was required. Therefore this action had been partially met.

A medication management review had been carried out with input from the pharmacist. The medication management policy had been reviewed to include administration, transcribing medication, telephone orders, medication errors, withholding medication and competency assessment.

Inspectors observed medications being administered and found that staff read the prescription and signed the drug administration when the resident had taken the medication.

Inspectors reviewed a sample of medication management prescriptions and found medications were prescribed in line with the policy. The nursing staff no longer transcribed medications. The prescriptions included the generic and trade name of the drug which would reduce the likelihood of error occurring, the dosage and frequency of administration, the duration of the treatment and instructions on how to take the medication.

There was also an improved process put in place for the administration of a high alert medication. However, it required some improvement. The space to record the dosage and duration of the medication was too small to record the information clearly, and this could result in an error in drug administration.

There was a policy in place to guide safe practice with residents who choose to self medicate. However, this policy was not implemented in practice. There was no risk assessment in place to determine resident’s ability to self medicate safely. There was no system of checking that a resident was managing to self medicate safely according to the prescription. Inspectors were concerned that this could result in poor outcomes for residents. For example, for a resident self medicating, the procedure for insulin prescription had been altered and it was not clear who had made the alternations as there was no signature.

Inspectors were concerned that a resident’s medication was not stored safely as the key was left in the door of the bed side locker.

The person in charge told inspectors that the pharmacist had carried out a medication management audit. The results of the audit were not available on the day of inspection, and senior staff were not aware of the findings. As a result it was not possible to determine what learning had occurred following the audit.

All staff completed on-line medication management training. However, a competency assessment had not been completed following training, so it was not possible to determine if all staff were competent in medication management practices. This was not in line with the medication management competency based assessment in the
Since the previous inspection, the person in charge had implemented a regular checking of the contents of the resuscitation trolley to ensure medications were in date. However, records of monthly checks were poorly maintained, for example the previous monthly check on 02 March had not been recorded as checked.

Inspectors checked the medications in the trolley and found they were in date. The tagging/lock system in place was not been managed in accordance with international guidelines.

Since the previous inspection, a system had been put in place for the receipt and disposal of medication. Inspectors found that medication were checked when received in the centre and signed by the nurse and the pharmacy when medications were returned. Inspectors checked the fridge contents and found that there were no out of date medications in the fridge on the day of inspection.

**Judgment:**
Non Compliant - Moderate

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**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:**
Inspectors were concerned that residents still did not have a comprehensive assessment completed on admission, or risk assessments completed accurately to assist in the development of care plans. Care plans in place were pre printed, not consistently evidenced based and did not include all of the residents needs.

The care plans in place would not guide practice, for example, the care plan in place provided incorrect information, for example it stated to administer antihyperglycemics (tablets for diabetes management) However on review of the prescription the residents had been prescribed insulin, not antihyperglycemics.

There were no discharge plans in place, and some residents lived alone and required
assistance in the community. There was no evidence of residents’ involvement in the development of the care plans. While staff described the care they delivered, this was not consistently documented.

Falls prevention and management.
The management of falls and recurrent falls was in line with evidenced based guidelines. For example, there were no falls risk assessments completed to assist staff to formulate a specific care plan to meet the residents needs or to minimise the risk of recurrent falls. Incident reports had not been signed as reviewed by the person in charge there was no investigation of the cause of a fall.

Inspectors reviewed the records for residents and found that they had access to a general practitioner (GP) three days per week. Staff said the GP would provide a prescription for a resident over the weekend. Residents accessed other health professionals such as the chiropodist. Physiotherapy was available in the centre and their role was rehabilitative and included teaching residents to use the assistive equipment. They were not involved in falls prevention management, risk assessment or multidisciplinary care planning in falls management. Referrals to other services were made through the referring hospital.

Fluid Balance
Since the previous inspection, fluid balance charts had been implemented. However, the fluid balance charts were not being monitored to ensure accuracy or recording and adherence to GP’s instructions.

Wound care:
There was still an inconsistent approach to the management of wounds. While all staff received training in wound management since the previous inspection, inspectors were concerned about the lack of appropriate wound assessment. Several of the residents had recent orthopaedic or cardiac surgery; therefore wound management was a key element of the care. Respite was also provided to residents who had reduced mobility and may have been at risk of developing a pressure ulcer. Pressure ulcer risk assessment tools were completed incorrectly, indicating a lower risk of obtaining a pressure ulcer. Residents assessed as high risk of developing pressure ulcers did not have any pressure relieving devices in place such as alternating pressure relieving mattress. There were not enough alternating pressure relieving mattresses or pressure relieving cushions in place to meet the needs of residents identified as at risk. Wound charts had not been fully completed for residents with wounds, for example the size and grade of the wound.

Beds were unsuitable for some residents; staff were waiting to discharge one resident so that they could use the profile bed for one resident post surgery who required it.

There were gaps in residents’ documentation and staff could not explain this to inspectors. Therefore it could not be ascertained if appropriate wound care was being delivered. While nurses said they decided the dressing required based on their judgement, there was no documentation to support the rationale for the change. Staff were not knowledgeable on the classification of pressure ulcers and the use of pressure relieving equipment. Staff had not received training on pressure ulcer
prevention and management.

Nutrition:
Inspectors found improvement in the management of nutrition. Inspectors noted that residents were weighed on admission and a computerised malnutrition assessment screening tool (MUST) was completed. Where indicated, residents food intake was recorded and monitored. There was no system in place to track residents weigh over time, to determine if they were at risk of malnutrition. There was no policy on MUST to guide practice and to ensure consistent good practice.
Staff had attended training on modified consistency diets. Staff spoken with were knowledgeable in this area. There were no residents receiving altered consistency diets on the day of inspection.

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

Findings:
The complaints management policy did not meet the requirements of the Regulations. It did not state the person who was responsible for overseeing that the complaints were being managed.

Relatives and residents who spoke with inspectors knew the procedure if they wished to make a complaint.

Complaints and feedback from residents were viewed positively by the provider and the person in charge. A complaints log was maintained and inspectors found that it contained details of the complaints and the action taken to respond to the complaint. The satisfaction with the complaint was recorded.

Judgment:
Non Compliant - Moderate
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors noted since the previous inspection that both public and private residents now received the same choice and the same amount of food. Residents received a varied and nutritious diet that overall was tailored to meet individual preferences and requirements. Meal times were supervised by staff and the housekeeping supervisor.

All residents were offered a wide choice of main courses, including extra portions of food. Residents expressed satisfaction with their meals. Therefore this action has been met.

Inspectors saw residents being offered a variety of drinks and homemade cakes and snacks throughout the day.

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

Findings:
The privacy of residents was maintained. Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. Inspectors observed staff interacting with residents in a friendly and
courteous manner.

Due to the short term nature of the service, there was no residents committee established. Members of the pastoral care team visited daily and provided support to residents.

Residents religious needs were met, mass was celebrated weekly and prayers were held daily. There was access to other denominations as required.

Since the previous inspection, the person in charge said that open visiting hours were being facilitated. However, this was contrary to the signage on display in the centre outlining restrictions to visiting until the afternoon.

The person in charge had developed an activities schedule to include games and music evenings. Inspectors noted that the activities schedule was posted in a prominent area in the centre.

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:
Inspectors found that there was a very committed staff team with low turnover. Staff told inspectors they felt well supported by the person in charge.

The number of staff and skill mix was not sufficient to meet the needs of residents. The person in charge told inspectors she required two more nurses to meet residents’ needs and to enable the clinical nurse managers and the person in charge to carry out their role. Since the previous inspection, the provider had not supported the person in charge in providing additional staff. Therefore this aspect of the action plan has not been met.

Residents and staff stated that at times, there were inadequate levels of staff on duty.
and residents said they were often waiting for a long time for assistance.

Inspectors observed that due to the high rate of admissions and discharges each day (4 to 9) resulted in nursing staff still spending significant time on medications and had little time for assessments and care planning, risk management, training and the management of staff, residents or the care of other residents in the centre.

Individual performance reviews were carried out for staff and while they appeared comprehensive, they did not identify the training needs of staff.

Care staff performed roles outside their scope of practice without sufficient training which conflicted with their job descriptions.
The Health Act had been made available to the staff. Staff signed to say that they had read the document. Staff did not have any training on the Act or the Regulations and they were not knowledgeable of about the Regulations.

Training records outlined the training for all staff. Records showed that mandatory training was provided to all staff. There was now a system to identify those who had received any training and any deficit. Therefore this aspect of the action plan has been met.

<table>
<thead>
<tr>
<th>Staff attended the following training:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anticoagulants</td>
</tr>
<tr>
<td>• Risk Management</td>
</tr>
<tr>
<td>• Cavilon Cream</td>
</tr>
<tr>
<td>• Nutrition</td>
</tr>
<tr>
<td>• Pain</td>
</tr>
<tr>
<td>• CPR</td>
</tr>
<tr>
<td>• Wound Care</td>
</tr>
</tbody>
</table>

Staff did not have access to appropriate training on pressure ulcer prevention and management. While staff attended training on wound care there was no evidence to demonstrate that the training had been effective.
The person in charge explained that due to inadequate resources it was very difficult to ensure staff received the required training.

**Judgment:**
Non Compliant - Major
Closing the Visit

Feedback was provided.

Acknowledgements

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

Report Compiled by:

Valerie McLoughlin
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
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 had not been implemented in practice and did not meet all of the requirements of the Regulations.

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.

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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:
(a) Complaints policy now includes naming the person responsible for ensuring the complaints are managed and responded to.
(b) Copy of Statement of Purpose is now available in each of the rooms, in the reception area and sitting rooms. Due to high volume of patients, it was felt that it is better for the environment to curtail printing, but should anyone ask for a copy they could have one, and a note is placed on the information stand where the SOP is located.
(c) Staff nurses now completing the resident/patient comprehensive admission assessment
(d) A Pre Admission form is also being drafted with a view to assess risk of accepting patients that wander or have a risk of elopement to which Caritas is not suitable

Proposed Timescale: (a) Completed
(b) Completed
(c) Completed
(d) 31st July 15

Proposed Timescale: 31/07/2015

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:
Inspectors found that the management systems in place did not ensure that services provided are safe, appropriate to residents needs, consistent and effectively monitored.

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:
(a) Clinical governance: the management structure and lines of reporting is under review regarding long-term/future strategy and proposals have been discussed as to the way forward for Governance in Caritas. However, this will involve major reorganisation perhaps with a view to introducing a General Manager, and dividing up the clinical & non clinical responsibilities from the Directors of Services as it now stands, to Director of Nursing and introducing a CNM 3 to deputise and do “on call” when D.O.N is off duty. These changes have huge financial implications and may have to be done on a phased basis.
(b) Clinical governance meetings are now being held, the first one took place on 18th May, and regular (three monthly) meetings are planned. During this meeting, staff levels were discussed and from this, two more RGN’s were requested and a health care
assistant proposed to cover night duty. This was to be put forward at a meeting on 22nd May, at which these were sanctioned. The addition of these two new staff nurses will add to Caritas’ Skill mix and allow CNM 1’s to be freed up to carryout supervisory roles in line with their job descriptions, including supervising Health Care Assistants, who carry out roles covered in their Fetac level 5 training. This will ensure safety and quality care is being provided to our residents/patients.

Other issues such as falls, pressure areas, any other risk management issues were also discussed and a template is to be used as to the items discussed at these meetings.

Proposed Timescale: (a) Recruitment of two nurses-Mid August. (b) 20th May 2015

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**Proposed Timescale:** 15/08/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no clear lines of accountability for decision making and responsibility for the delivery of services to residents.

**Action Required:**
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
(a) Clinical governance: the management structure and lines of reporting is under review regarding long-term/future strategy and proposals have been discussed as to the way forward for Governance in Caritas. However, this will involve major re-organisation perhaps with a view to introducing a General Manager, and dividing up the clinical & non clinical responsibilities from the Directors of Services as it now stands, to Director of Nursing and introducing a CNM 3 to deputise and do “on call” when D.O.N is off duty. These changes have huge financial implications and may have to be done on a phased basis.

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<tr>
<th>Proposed Timescale:</th>
<th>(a) Recruitment of two nurses-Mid August.</th>
<th>(b) 20th May 2015</th>
</tr>
</thead>
</table>

See actions outlined above

Proposed Timescale: Dependent on outcome of Service Review

### Outcome 03: Information for residents

**Theme:** Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The residents guide did not meet the requirements of the regulations.

**Action Required:**
Under Regulation 20(2)(c) you are required to: Prepare a guide in respect of the designated centre which includes the procedure respecting complaints.

**Please state the actions you have taken or are planning to take:**
(a) Complaints process is now updated and every resident/patient has access to same
(b) Information regarding the future purchasing of electric beds also added to information section – one bed available and is used on a “clinical needs basis” more to be purchased in the future as fund raising allows.

**Proposed Timescale:** 03/06/2015

### 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:**
The designated centre did not have all of the written operational policies as required by Schedule 5 of the Regulations.

**Action Required:**
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
(A) Schedule 5 Policies such as Resident/Patients personal property/possessions now available
(B) Staff training and development policy now available
(C) Staff have now full access to all policies and have been asked to sign off when they have read them
(D) Risk management and risk register under review. Also CNM2 is to attend a series of education days – one on systems analysis for Incident/Complaints on 4th June, Risk Register on 9th and Risk management on June 16th which will allow us to update our risk register and review all incidents and complaints and learn from these, thus enhancing patient care by continuous quality improvement.
Full overview of risk assessment and quality improvement methodology is being undertaken by an outside consultant due to visit the Centre on the 11th June to assess our specific needs and to devise a risk management plan for the centre. This is envisaged to take place over a number of months with a completion date of end of December 2015.
(E) Clinical governance meetings now in place, as stated in outcome 2. Training Day that CNM2 is undertake will involve the collective review of incidents/accidents/complaints and opportunities for learning will arise from this, leading to better patient/resident outcomes.
(F) Falls prevention study way was attended on 16th April by member of staff and training for rest of staff is ongoing, and another one member is scheduled to go to another falls prevention day on 15th June
(G) Smoking assessment is carried out on all patients on admission and if they smoke a care plan is devised and two new smoking aprons have been sourced.
(H) Health and Safety committee now to merge with new risk management committee to include any clinical risks in Centre and minutes will be available, Meeting scheduled for 10th June 2015.

Proposed Timescale: (a) completed
(b) completed
(a) 30th June 2015
(b) On going with a view of completion end of 30 December 15
(c) On going
(d) Study days completed by 15/6/15 and ongoing education for staff
(e) Completed
(f) Study days completed by 15/6/15 and ongoing education for staff
(g) Completed
(h) 10th June 2015

Proposed Timescale: 30/12/2015
### 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:
The policy on protection would not in line with current national guidelines.

**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:**
Current policy in situ is based on National Guidelines and December 2014 guidelines also now available

**Proposed Timescale:** 03/06/2015

### 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:
The risk management policy was not being implemented in practice.

**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:**
a) New forms have been introduced to assess patients risk in event of evacuation, a “personal emergency evacuation plan” “peep” is now completed by RGN on admission and is placed in the patient/residents wardrobe door. In the event of evacuation being necessary, it is easily accessed by the responder. It clearly states how the resident/patient is to be evacuated in the event of an emergency

**Proposed Timescale:** 03/06/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no recorded learning or improvement in care from incidents and accidents
although staff had received training on how to complete clinical incident reports.

There was no collective review of incidents and accidents to identify trends and implement quality improvement measures.

**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:**
Risk management and clinical incidents are now discussed at all meetings i.e. multidisciplinary, staff nurses, CNM’s and care assistants as well as clinical governance and risk management and health and safety committee meetings.
With outside agency input staff education will be embedded.
All staff have been reminded to carry out neurological observations correctly and inline with falls policy

Proposed Timescale: ongoing

| **Proposed Timescale:** 03/06/2015 |
| **Theme:** Safe care and support |
| **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** |
| There were no risk assessments undertaken for the evacuation of residents who had reduced mobility and those who required a wheelchair to ensure their safety. Manual handling assessments were completed by staff that were not fully trained in this area, which could pose a risk to residents. Residents who smoked did not have a risk assessment completed and there was no care plan in place to ensure their safety. A health and safety committee was in place but it did not include a review of any clinical risks in the centre. |
| **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:** |
| Evacuation sheet has been devised – see (a) above Reference Outcome 5 (g) Reference Outcome 5 (h) |
| **Proposed Timescale:** 30/06/2015 |
### 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:**
All medication was not stored safely.

**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:**
(a) Any patient now wishing to self-medicate will have risk assessment done by RGN. Check sheet to ensure patient is managing to self medicate is now also operational.
(b) Patient/residents are informed of the importance of keeping their key safely and if they do not conform, safe medication will cease
(c) Medication audit results are now available and learning has occurred from same, some issues raised have been addressed e.g. dating bottles when opened Ensuring "allergies" is noted on Kardex and not just white Doctor’s sheets
(d) Competency tool is to be added to all new staff’s induction protocol and present staff will be audited/assessed on a phased basis, one senior staff nurse taking responsibility for overseeing this from 28th May 2015
(e) Resus trolley now checked on 1st Tuesday of every month and recorded accordingly. Tags that have been broken or removed to replace equipment or drugs are replaced and same noted

**Proposed Timescale:** 03/06/2015

### Theme:
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The system in place for self medicating was not in line with the policy.

**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:**
Assessment on admission of patient is now part of the comprehensive assessment and patients deemed suitable for self medication will be asked to complete forms as per medication policy

**Proposed Timescale:** 03/06/2015
## 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:**
A comprehensive assessment of residents health, personal and social care needs was not completed on admission.

**Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
(a) Comprehensive assessments are now being completed by admitting RGN. Risk assessments are also carried out based on these comprehensive assessments. Risk assessments such as falls, MUST, pressure area, smoking or challenging behaviour are carried out and care plans devised as indicated.

### Proposed Timescale: 03/06/2015

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care plans were not based on an assessment as referred to in the Regulations. Care plans did not meet the needs of residents.

**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:**
(a) Care plans are specific and patient orientated and patients are involved in their care plan,
(b) New discharge care plan is included in ALL resident/patient care plan and any issues indentified are followed up, leading to the safe timely discharge of patient/resident.
(c) Care plans also now in place and as discussed in outcome 5 incident forms will be discussed and seen as a learning opportunity. Our Physiotherapist are part of the H&S/Risk Management and multi-disciplinary team and have an input into falls management
(d) Fluid Balance sheets reviewed and monitored by Medical officer to guide care eg. In congestive cardiac patients
(e) Wound care: an audit on wound care took place on 21st May, 15 and is ongoing on all members of staff. Findings will be discussed when all members have been audited, with a view to increasing knowledge on wound care and to adhere to wound care policies and to ensure staff know how to access information if they feel it necessary. One CNM1 is coming the wound care/tissue viability course in RSCI in September and will act as a source of expertise once qualified, again adding to the body of knowledge in the Centre. The wound care sheets are being examined under the audit process and any gaps identified will be addressed, e.g. size and type of wound will be identified and chart changed to reflect this.

(f) Pressure ulcer training day was carried on the 23rd April, 15th. This should increase staff knowledge on pressure area care

(g) MUST screening is carried out on all patient/residents on admission. They are weighed on admission and before discharge (as short stay) and any referrals sent e.g. to GP or PHN. MUST policy in situ.

Proposed Timescale: 03/06/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A high standard of evidenced based nursing care was not delivered in the areas of falls, wound care and nutrition.

Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
All these areas are screened and assessed by nursing staff using new assessment form and care plans drawn up according to patient need

Proposed Timescale: 03/06/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Medication management required improvement as outlined in outcome 9.

Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident,
including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
See out come 9

Proposed Timescale: completed

**Proposed Timescale:** 03/06/2015

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**Outcome 13: Complaints procedures**

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaint’s policy did not fully meet the requirements of the Regulations. It did not include the complaints officer and the nominated person as per regulation 34.

**Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
The complaints policy has been amended to include the person who is responsible for overseeing that complaints are being managed and responded to.

**Proposed Timescale:** 03/06/2015

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The staffing levels and skill mix did not meet the assessed needs of residents, the complexity of the service and the layout.

**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:**
Please see outcome 2
Proposed Timescale: Recruitment of two RGN's in progress

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**Proposed Timescale:** 15/08/2015  
**Theme:**  
Workforce  

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Staff did not have access to appropriate training including refresher training in order to meet the assessed need of residents.  

**Action Required:**  
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.  

**Please state the actions you have taken or are planning to take:**  
Staff training needs have been added to performance review form and will be assessed according to needs identified.  

Pressure Area/Ulcer Prevention Management study day was provided on the 23rd April 15 for Nursing and Care Staff.

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**Proposed Timescale:** 23/04/2015  
**Theme:**  
Workforce  

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Staff were not aware of the Act and any regulations made under it.  

**Action Required:**  
Under Regulation 16(1)(c) you are required to: Ensure that staff are informed of the Act and any regulations made under it.  

**Please state the actions you have taken or are planning to take:**  
Information sessions planned for week of 15th June for all staff.

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**Proposed Timescale:** 30/06/2015