

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Joseph's Community Nursing Unit
Centre ID:	OSV-0000542
Centre address:	Patrick Street, Trim, Meath.
Telephone number:	046 943 1229
Email address:	francesg.flynn@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Frances Flynn
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	50
Number of vacancies on the date of inspection:	0

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
05 January 2015 09:30	05 January 2015 18:30
06 January 2015 10:00	06 January 2015 17:30

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

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

Summary of findings from this inspection

This was the eleventh inspection of the centre by the Authority and was completed in response to an application by the provider to renew registration. The inspector reviewed all outcomes in addition to progress with completion of the action plan from the last inspection of the centre in March 2014 to assess compliance with the legislation and standards. The inspector found that not all actions plans were satisfactory completed and are restated in the action plan at the end of this report. The provider commenced an extensive building refurbishment project on the centre premises in 2013 which was in progress on the days of inspection and on completion will result in upgrading of all resident areas. The final phases of the project is scheduled to commence in the third quarter of 2015, to include a purpose built

extension to the existing Butterstream dementia specific unit. It is envisaged that residents in the existing Butterstream dementia specific unit will be re-accommodated in the new extension on its satisfactory completion.

During the inspection the inspector met with residents, relatives and staff members. Residents were complimentary about the service they received and the staff team who cared for them. The inspector reviewed thirteen pre-inspection questionnaires, four from residents and nine from relatives. Overall feedback was positive with regard to the various aspects of the service surveyed with the exception of one condition of personal clothing and difficulty posed to independent mobility by a ramped corridor from Lower Camillus to the rest of the centre, which was communicated to the provider and person in charge.

Areas of the premises did not meet their stated purpose and while the Authority acknowledge a refurbishment project is in progress to address the major non-compliances found, this project is in progress on this inspection. Review is required of a ramped area of corridor that provides residents' only route of access from Lower Camillus to the rest of the centre to ensure residents' independence is not compromised.

Findings referenced in the following outcomes were in moderate non-compliance with the legislation, details of findings are referenced in the body and action plan of this report and included;

- Outcome 2 Governance and Management
- Outcome 6 Documentation to be kept in the Centre
- Outcome 7 Safeguarding and Safety
- Outcome 8 Health and Safety and Risk Management
- Outcome 9 Medication Management
- Outcome 10 Notification of incidents
- Outcome 11 Health and Social Care Needs
- Outcome 13 Complaints
- Outcome 16 Residents' Rights, Dignity and Consultation
- Outcome 18 Staffing

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

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

Findings:

There was a written statement of purpose and function which consisted of a statement of the aims, objectives and ethos of the centre, detailed the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations. A copy of the statement of purpose and function was forwarded to the Authority as required and made available to the inspector on the days of inspection.

A copy of the statement of purpose was forwarded to the Authority. It was last updated on the 24 November 2014. The provider was aware of the need to keep the document under no less often annual review. The statement of purpose provides a clear and accurate reflection of the facilities and services provided and implemented in practice in the centre.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

There was a clearly defined management structure in place that identified the lines of accountability and authority in addition to evidence that the provider worked with the person in charge on a consistent and supportive basis in the governance and management of the centre. The provider nominee for the service is Frances Flynn. She attends the centre on most days and on days when not in the centre obtains an update on the service by telephone from the person in charge. The inspector observed that meetings were held at each staff level and review of the minutes confirmed that these forums functioned to support inter-team communication, address areas requiring review at local and regional management level and to ensure staff were kept informed to comprehensively meet the needs of residents as described in the centre's statement of purpose document.

Daily meetings were chaired by the person in charge with heads of department which included planning and review of any issues and events that occurred over the previous 24hrs. A monthly meeting was scheduled and minuted between the provider and person in charge and risk management in the centre was a standing agenda item for same. There was also evidence that the person in charge and provider attended and represented matters involving the centre at various regional forums. The provider and person in charge availed of the services of regional specialist departments, for example risk management and fire safety services to support them in meeting service requirements.

The inspector found that there was a quality monitoring process implemented in the centre with systems in place to ensure that the service provided was safe and appropriate to meet resident needs. An auditing schedule for the various aspects of the service was established to ensure the quality and safety of care and the quality of residents' lives in the centre were monitored. However, monitoring activity undertaken required some improvement to ensure that recurring areas of deficit were consistently and satisfactorily addressed. For example, the inspector found evidence of recurring areas of variance in monthly audits of care plans. These findings did not ensure that improvements in some aspects of the service were sustained and weakened the overall effectiveness of the monitoring process. The inspector found that some audits did not have action plans developed or timescales for completion of remedial actions specified. It was therefore not clear if all actions required were satisfactorily completed.

Judgment:

Non Compliant - Moderate

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.

<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The inspector viewed a sample of current resident contracts. All contracts of care reviewed were signed and dated. The inspector observed that some residents signed their own contract of care. The fee charged and services provided were stated as required. The centre did not charge residents for participation in social activities.</p> <p>There was a residents' guide available which was recently reviewed by the service. This document was reviewed by the inspector and found to contain information as required by the legislation. The document advised residents of charges for additional services available to them such as hairdressing costs.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 04: Suitable Person in Charge</i> <i>The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.</i></p>
<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: The person in charge of the centre is Patricia Greville. She is a registered nurse with An Bord Altranais agus Cnáimhseachais na hÉireann and has experience in caring for older people as required by the Legislation. The person in charge works full-time in the centre. She demonstrated that she kept her skills up to date since commencing in her role as person in charge in April 2014. Prior to taking up the role of person in charge, Patricia Greville worked on a day to day basis as the on-site manager of the centre within an organisational management structure where the person in charge had dual site responsibility. She has completed a postgraduate course in professional management of aggression and violence and a master's degree in ageing health and the environment. The person in charge has completed required mandatory training courses in addition to courses and study days to support her professional development. She is an accredited trainer for management of challenging behaviour and also supports staff</p>

training with providing training for staff in professional management of aggression and violence (PMAV).

The person in charge demonstrated that she was engaged in the governance, operational management and administration of the centre on a consistent basis. She was knowledgeable about individual resident's needs and their individual choices. Residents knew the person in charge and the inspector observed residents consulting with her in relation to their care.

During this inspection the person in charge demonstrated that she was aware of the Regulations, the Authority's Standards and her responsibilities as person in charge of the centre. She is supported in her role by a team of clinical nurse managers, nursing staff, care assistants, catering, administrative and ancillary staff. The person in charge facilitated the inspection; information was easy to retrieve and was managed with appropriate attention to ensure security of residents' personal information.

Judgment:

Compliant

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Written operational policies as required by Schedule 5 of the Regulations were not adequate to inform practice in protection of vulnerable residents and PRN (as required) psychotropic medication.

The directory of residents was reviewed and found to contain all required information.

Records of psychotropic restraint use were not adequately recorded as required by Schedule 3 Paragraph 4 (g).

Staff employment files contained all required information.

The hours of duty worked by staff and their surname was not recorded on the duty

roster as required by Schedule 4, Paragraph 8 of the regulations.

A record was not maintained of all expressions of dissatisfaction as required by Schedule 4 Paragraph 6.

Judgment:

Non Compliant - Moderate

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider and person in charge were aware of their responsibility to notify the Chief Inspector of the absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence. The person in charge had not been absent from the centre for more than 28 days to date.

The deputy person in charge is a senior nurse appointed as a clinical nurse manager in the centre and is identified as a person participating in management in the Statement of Purpose for the centre.

Judgment:

Compliant

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

Theme:

Safe care and support

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

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

Findings:

The inspector found that there were satisfactory arrangements in place to safeguard residents on this inspection. Arrangements were put in place following findings requiring immediate action during the last inspection of the centre in March 2014 in relation to protection of vulnerable adults. A CCTV viewing unit located in a staff office enabled staff to monitor and control access to the centre. A member of staff worked from a location inside the front door to the centre and monitored access. The front doors were secured. A visitors record book was in operation which one resident commented positively on in a pre-inspection questionnaire forwarded to the Authority.

The inspector was provided with a copy of a staff training record which confirmed that all staff had completed training in elder abuse prevention, recognition and management. All staff files reviewed on the days of inspection had evidence of completed appropriate vetting procedures. Staff spoken with were knowledgeable with regard to their role and responsibilities in protecting residents and reporting any suspicions or disclosures made to them. A policy document was available to inform staff on responding to suspicion, allegation or evidence of abuse or neglect. However, this document did not advise on procedures to take in the event of an allegation against a senior member of staff. Advice was also not adequate to inform the immediate care of residents and access to advocacy services if required. Advocacy services were available to residents in the centre. A whistle blower policy was also available to support staff with disclosure if necessary. This finding is also discussed in outcome 2.

Residents confirmed to the inspector in conversations that they felt safe in their day to day life in the centre and relatives spoken with spoke positively about how staff cared for the residents.. Residents said they 'were treated with respect' 'staff were kind and went out of their way to assist' them. The inspector observed staff - resident interactions on the days of inspection and found that while all staff interactions were satisfactory. Call bells were observed to be answered promptly by staff.

There was evidence that any incidents of staff interactions with residents of a less than adequate standard were fully investigated and residents were adequately protected. There was no disclosures of abuse under investigation on the days of inspection.

Resident finances were reviewed as part of this registration renewal inspection process. Each resident has a named account with the main account titled ' Patient Property Account'. On review of the procedure, the inspector found that all procedures involving residents' finances were transparent and residents were able to access their money when they wished. Supporting policy and procedural documentation to inform management of residents' finances was reviewed during inspection to ensure that all aspects of this arrangement was supported and informed by a comprehensive policy. Residents had access to a lockable facility in their bedroom.

A policy document was in place to inform management of behaviour that challenges exhibited by residents and promotion of a positive approach to managing same whilst supporting the resident concerned dated March 2014. The person in charge informed the inspector that some of the residents currently residing in the centre exhibited behaviour that challenged. Staff had attended training in managing challenging

behaviour and was facilitated by the person in charge who was an accredited trainer.

There were a number of residents who exhibited episodes of behaviour that challenged residing in the Butterstream dementia specific unit and also in Camillus unit. Residents had personalised documentation that identified triggers to their adverse behaviours and established interventions that de-escalated these behaviours. However, this process was not comprehensive in that it did not adequately inform practice especially where PRN (as required) psychotropic medication was available as a de-escalation intervention. A policy document was in place to inform psychotropic medication administration but did not inform PRN (as required) use. This finding is discussed in outcome 2. Use of chemical restraint in the form of PRN psychotropic medication administration was not administered within a documented escalation protocol and therefore discretionary. While each episode of PRN psychotropic administration was reviewed, the evidence found supported that psychotropic medication administration and the subsequent review process did not ensure positive outcomes for residents in management of their challenging behaviour. In addition this finding did not support evidence that chemical restraint was informed by evidence based best practice in restraint management. For example, the inspector observed evidence of use of PRN chemical restraint commenced three months prior to this inspection being used with increasing frequency for one resident in the absence of evidence of increasing severity of challenging behaviours. This was not identified through the PRN psychotropic review process. A significant number of staff had attended training in prevention and management of aggression and violence (PMAV). This finding is discussed further in outcome 11.

Judgment:

Non Compliant - Moderate

***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):

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

Findings:

Areas of Major risk to residents which were identified by the Authority on the last inspection of the centre on 26 March 2014 included;

1. Uncontrolled public access to vulnerable residents
2. Unrestricted access to a building site by means of an open door within close proximity of vulnerable residents.

In response to immediate action required by the Authority to address these risks found, the provider implemented actions in each case to satisfactory mitigate these risks. These areas of risk were satisfactorily addressed on this registration renewal inspection.

On this inspection, the inspector found that there were systems in place to identify and manage risk to ensure the safety and welfare of residents, visitors and staff. Findings supported that improvements made in risk management following the last inspection in March 2014 which were generally sustained. The inspector found that there was a robust system in place to control access to the centre. A record of visitors' was maintained. This finding is discussed further in outcome 8. There was an area of the centre under refurbishment. This area was secure and advisory signage was displayed advising of non-permitted access by unauthorised persons and precautions to be taken by authorised persons on accessing the site.

There was a safety statement available for the centre that was found to adequately inform risk management in the centre. This document was reviewed annually as required.

The inspector found that there was a risk management policy in place as required by the legislation. The risk management policy documentation included sub-policies to advise staff on management of assault and violence, self-harm, and managing behaviour that challenged as required by the legislation. The policy advising on protection of vulnerable adults was missing some detail and is discussed in Outcome 7 of this report.

Hazards/risks were appropriately and assessed with measures to control/mitigate risks to the health and safety of residents stated and implemented. There were no unassessed risks identified on this inspection.

The inspector reviewed the record of resident accidents and incidents in the centre. This record was found to be adequately maintained and was comprehensive. There was evidence of investigation and proactive management of serious accidents to residents and adverse incidents. However, there was evidence that learning from review and implementation of remedial actions to address adverse incidents involving residents was inconsistent. For example, there was evidence of a further medication error since the last inspection in March 2014.

Safety audits of the centre were completed each month, findings were presented and discussed at monthly management team meetings, where risk and safety were standing agenda items. The inspector found when a risk was identified, it was addressed appropriately. However, there was evidence of recurrence of some areas of deficit as evidenced in safety audits that placed residents at potential risk of negative outcomes. This finding is discussed in outcome 2.

Infection prevention and control policies and procedures including infection outbreak management were in place to advise staff. Hand-wash sinks and hand hygiene dispensers were located throughout the centre. Procedures as advised were in place to manage communicable infection. Resident equipment was observed to be clean. However, a moderate layer of dust was found on top of a resident's wardrobe on the day of inspection. Infection prevention and control procedures were regularly audited and this deficit was identified in audits and while addressed, improvement was not sustained. Water temperature control, treatment and outlet flushing was carried out in line with an advisory policy to prevent legionella contamination.

Fire safety procedures were in place and found to be satisfactory on this inspection. Means of escape were routinely checked, clear and unobstructed. Residents had evacuation risk assessments completed including reference to the equipment and

numbers of staff required for their safe evacuation if necessary. The staff training records confirmed that all staff attended fire training as required. A simulated night-time evacuation drill that reflected actual night-time staffing resources to ensure residents could be safely evacuated given resident dependencies, layout of the centre premises and numbers of staff available.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

There was an up to date medication management policy in place to guide and inform practice. Nursing staff were knowledgeable about medication administration and prescribing procedures. However, there was no protocol in place to guide and inform administration of PRN (as required) psychotropic medication which was used for one resident on the days of inspection.

The inspector attended a medication round and observed practice which was in line with professional standards. Nursing staff completed on-line medication management practice updates. The staff nurse completing administration of residents' medications wore a red apron to alert others that medication administration was in progress and interruption should be avoided.

Procedures were in place for management of adverse medication incidents involving residents. There was evidence of two medication errors recorded for 2014. While remedial actions were taken by management in response to these incidents, there was a lack of satisfactory evidence to support adequate review was completed to ensure actions taken to address areas of inadequate practice were effective. Staff who were involved in inadequate practices resulting in medication error undertook a reflective practice exercise and completed refresher on-line training as part of the action taken in response to same. However, this process required improvement to include comprehensive assessment of staff competency to ensure staff are knowledgeable and appropriately skilled in all aspects of medication management.

Storage of residents' medication in a number of locked trolleys was linked to the system of nurse allocation in place where each nurse had responsibility for managing the care of a number of residents including administering their medications. Each trolley had a hand

hygiene dispenser fitted on it to facilitate close and ready access for use. The inspector observed that monthly medication audits identified recurring deficits in medication prescribing best practice. Some discontinued medications were not signed by a GP as required on this inspection.

Medication management was supported by a pharmacist who provided advice, guidance and education on evidence based medication management procedures to staff. However, the pharmacist was not facilitated to complete their professional obligations in terms of auditing and availability to residents. There was also no evidence to support residents were satisfied with the pharmaceutical service as there was no choice of this service available to them.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

A record of all incidents that occurred in the centre was maintained and was easily accessible. All notifications were forwarded to the Authority as required by the legislation with the exception of resident restraint which did not include notification of chemical restraints used. The inspector observed reference to the requirement to send notification in policy documents such as the falls management and protection policies.

Any serious incidents where residents sustained an injury were the subject of comprehensive investigation to identify areas for improvement and learning to prevent recurrence.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

On the days of this inspection there were fifty residents living in the centre, two of whom resided on a dementia respite basis. Thirty four residents had maximum dependency needs, eight had high dependency needs and eight had medium dependency needs.

The inspector reviewed a sample of resident assessments and care plans. Inspection findings supported that residents had assessments of need completed which informed interventions to meet their assessed care needs. Residents' dependency levels and mental well-being were assessed prior to admission and every three months following admission to the centre or more frequently following an event of illness, incident or accident. Daily progress notes reviewed were found to be generally informative and were adequately linked to residents' care plans. Monthly care plan audits were completed that identified deficits which were addressed. However, as discussed in outcome 2, there was evidence of repeated deficits in some areas which requires review to ensure remedial actions taken reflected sustained improvement and evidence of learning.

Residents' care needs were assessed on a three monthly basis, there was a record made of changes to interventions as appropriate. Assessment of need and care plan development was done with residents on admission to the centre, however evidence of involvement of residents or their relatives as appropriate, in care plan reviews was inconsistent.

Residents had adequate access to GP and allied health professional services as evidenced in the sample of care plans and documentation reviewed on the days of inspections. An on-site medical officer provided general practitioner (GP) care to residents with the support of the doctor on call services out of hours. While residents had access to psychiatry of older age services, this service was not represented at case conference meetings for residents with mental health problems especially residents exhibiting behaviour that challenged of increasing frequency or severity with requirements for chemical restraint.

There was evidence that instructions/recommendations were documented as appropriate, following review by allied health professionals and that these were implemented and adequately monitored.

The inspector found that occupational therapy service referral and consultation was provided. Residents with mobility needs were supported to mobilise with the assistance of various items of equipment. Two residents were observed to use motorised chairs. Assessment and support of mobility was of particular significance for residents residing

on Lower Camillus unit to ensure their independence was promoted to freely access all other parts of the centre including the front door of the centre. Lower Camillus unit is located on a lower floor level than the rest of the centre and access is by means of a ramped corridor only which residents reported as having a negative impact on their independence to access all areas of the centre at will.

Residents in the dementia specific area known as Butterstream each had a primary diagnosis of Alzheimers disease or dementia. Two residents were admitted on a respite basis. This area has controlled and monitored access and egress arrangements in place to protect residents living there. Residents in Camillus areas have a mixture of age related medical conditions and cognitive impairment. Camillus is arranged in two distinct areas known as Camillus Upper and Camillus Lower due to closure of a part of the building for refurbishment which inspectors were told was at an advanced stage and its location currently splits the Camillus area.

The inspector found that most practices were reflective of evidence based contemporary nursing practice. However, there was evidence of seudocrema use as a protective skin preparation for pressure area care. In addition administration of psychotropic medications did not reflect best practice restraint use for management of behaviours that challenge. This finding is also discussed in outcome 8 of this report.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

The centre comprises of two resident areas, Camillus and Butterstream. The provider commenced an extensive building refurbishment project on the centre premises in 2013 which was in progress on the days of inspection and on completion will result in upgrading of all resident areas. The final phases of the project is scheduled to commence in the third quarter of 2015, to include a purpose built extension to the existing Butterstream dementia specific unit. It is envisaged that residents in the existing Butterstream dementia specific unit will be re-accommodated in the new extension on

its satisfactory completion.

The inspector found completed refurbishment in the Lower Camillus area meets the requirements of the Legislation and Standards. 30 residents were accommodated in single and twin bedrooms with en-suite shower, toilet and hand basin facilities in each. There were some designated single bedrooms changed to facilitate two residents while refurbishment work was taking place however, the inspector found that this accommodation arrangement did not ensure their privacy and dignity needs were met as one resident had to pass through another resident's private space especially when curtains were closed to access toilet and shower facilities and to exit the bedroom. The provider advised the Authority this was a temporary arrangement with the consent of residents while the current phase of refurbishment was in progress. This finding is also discussed in outcome 16. The living space in this area consisted of a variety of communal sitting areas which included two main communal sitting rooms, one of which has double exit doors into an internal garden. Among the communal sitting areas, residents could access areas where they could meet their visitors in private or relax quietly and enjoy personal interests which was promoted by the décor and colour schemes in these rooms. A dining area with a low counter around a kitchenette was available and accessible to residents if they wished. Large fireplaces are central features in residents' sitting accommodation with occasional tables and decorative lamps throughout. Residents were complimentary of the area and told inspectors that living in the newly decorated and purpose-built unit had a positive impact on their lives in the centre. Many residents expressed their satisfaction with their bedroom and en-suite accommodation. The area also provided a hairdressing salon cleaners room, sluice, storage, clinical area and staff office accommodation. Assistive handrails were fitted in circulating areas and in en-suites. Ceiling hoist equipment was fitted in all bedroom accommodation.

The current phase of refurbishment involves most of the Upper Camillus area, which was securely sealed off on the days of inspection to prevent access by unauthorised persons. Eight residents resided in the unaffected portion of Upper Camillus area to be re-accommodated in the currently closed area of the unit on completion of refurbishment there. This temporary accommodation provided adequate space to meet the needs of residents. However, it was not suitable for long-term use in that it did not provide adequate communal accommodation as residents did not have access to sitting-room facilities outside their bedrooms without leaving the unit. A small dining room was provided in the area as the main dining room was a significant journey from the area and for many residents was too far to travel independently. The non-compliances with the legislation and standards in this area was acknowledged by the provider with re-accommodation of these residents planned for the area currently undergoing refurbishment, which the inspector was advised was at an advanced stage.

Butterstream area is a dementia specific facility providing accommodation for 10 long-term residents and 2 residents on a respite basis. While the inspector acknowledges that work has taken place to improve this facility and make this area suitable to meet the needs of residents living there, this requires improvement and the planned new purpose built extension will enhance the quality of life and independence of residents in line with the standards and legislation. The current facility did not provide residents with independent access to the secure garden area in line with evidence based dementia care

principles and residents were accommodated in multioccupany bedrooms which did not promote their privacy and dignity needs. An external enclosed garden space upgraded since the last inspection in March 2014 was available to the side of the unit. This area was landscaped and had pieces of traditional equipment and various points of interest to prompt residents' reminiscence and communication. However, the access door to this garden was secured and as such did not provide residents without mobility needs independent access at will. A second external narrow enclosed external area was located along the length of Butterstream area with ramped access from each of the bedrooms located to the back of the unit. While this area was cleared of vegetation since the last inspection in March 2014, it was deemed not suitable or safe for resident access and was therefore closed off to prevent unauthorised access.

There was a quiet room decorated in a 'parlour' theme seperate from the main communal accommodation in Butterstream dementia unit, where residents could rest. A small room was also available off the main communal sitting room for residents' use. A kitchenette, dining room and sitting room was accessible to residents and together with the corridor these areas formed their internal circulating area.

Part of the internal garden was available to residents in Upper and Lower Camillus areas and it was envisaged that this entire space would become available on completion of the current phase of the refurbishment project.

A regional maintenance team provided support with ensuring the centre fabric and fittings were maintained to a satisfactory standard and in working order. All resident equipment was serviced/repaired as required as confirmed by maintenance records. However, a comprehensive scheduled maintenance programme was not in place which resulted in some areas of routine maintenance and upkeep being done in response to findings on audits. For example, grass cutting.

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a complaints procedure in place in the centre. The complaints policy was recently reviewed. Patricia Greville is the complaints officer for the centre and responsible for reviewing and investigating complaints. An independent appeal process

was in place.

The inspector reviewed the centre's complaints log and observed that there were no complaints referenced for 2014. However, there was evidence of some dissatisfaction in documentation reviewed on the days of inspection in relation to personal clothing that was not ironed. Some residents expressed difficulties with accessing areas outside Camillus area due to the incline on the ramped corridor. Difficulty with accessing the ramp was also expressed in a pre-inspection questionnaire returned to the Authority.

However the majority of residents and their relatives expressed their satisfaction with the service. Residents spoken with in relation to their satisfaction with the complaints process confirmed that they knew who to make a complaint to and felt they would be listened to.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

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

Findings:

The process used to obtain residents' end of life wishes was the subject of an action plan from the last inspection of the centre in March 2014. The inspector found evidence to support findings that this action was satisfactorily completed. The Inspector reviewed the policy available to inform staff on procedures for managing end of life care for residents and found it to be centre specific and informative.

A room was refurbished to a good standard for families of residents who were in receipt of end of life care, with overnight accommodation and refreshment facilities. There were no residents in receipt of end of life care on the days of inspection.

Residents' end of life wishes/preferences were documented in the sample of resident documentation reviewed by inspectors.

Palliative services attended the centre on referral and provided support to residents and staff with symptom management. The centre has a large church and the inspector was advised that many residents chose to remain in the centre and used this facility for their end of life religious services. An annual service of remembrance was held to remember deceased residents.

The clergy from various faiths were available and attended residents in the centre regularly and as requested.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

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

Findings:

There was satisfactory evidence that residents were provided with adequate fluid and dietary intake to meet their needs on the days of inspection. The food was prepared in a main kitchen and transferred to the dining rooms in Bain Marie units.

Meals were served in four dining room locations located in Lower Camillus, Upper Camillus, Butterstream and in a central dining room outside of these resident areas. The dining room outside these resident areas provided residents with a choice of dining venue. The inspector found that each resident's individual nutritional and dietary needs were met and that they were offered a nutritious and varied diet that provided them with choice of a hot dish at each mealtime. The inspector observed residents at mealtime and found that those that required assistance received same in a dignified and discrete way by one of three members of staff who were assigned to ensure residents were appropriately assisted if necessary. Many residents used mealtimes as a social occasion and chatted with others at the table. The menu was clearly displayed. Residents spoken with told the inspectors that they enjoyed the food provided in the centre. Staff training was in place to inform staff on use of the nutrition assessment tool in assessing and monitoring procedures, food fortification and fluid thickening procedures used. Each table in the dining room had a mixing receptacle for accurate thickening of fluids procedures.

Residents had access to fresh water in their bedrooms and communal areas. Staff were observed to engage in monitoring and encouraging residents to take fluids and fluid balance charts observed were completed and totalled. Residents' weights were monitored and those identified as being at risk of unintentional weight loss had evidence of monitoring and review by dietetic services. The inspector met with the chef on the days of inspection. The chef was aware of and demonstrated how he accommodated residents with specific nutritional support needs, support plans and preferences. He had details of the recommendations made by speech and language and dietetic therapy

services. Care plans were in place to inform care of residents with nutrition and hydration needs which were satisfactorily linked to monitoring and treatment plans and were evaluated in daily progress notes.

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:

A policy was available to advise staff on protecting and promoting residents' privacy and dignity which was implemented in practice.

The inspector viewed 'key to me' style folders located in residents' accommodation in Butterstream dementia unit that were developed to record key information about each individual's life prior to admission with photographic and pictorial reminders of persons/interests that are/were important in defining the individual's personality, achievements, relationships and interests. Reminiscence albums were also available to meet the needs of residents in this area. Prompts and cues were displayed to orientate residents to their environment. Many bedrooms were personalised with residents' ornaments, bedspreads and photographs. Residents in Butterstream dementia unit had pieces of their own furniture from home including chairs and in some cases their beds in their bedrooms in the centre to promote feelings of familiarity and homeliness.

A residents' meeting forum was convened on a regular basis and was minuted. This forum was chaired by a volunteer. While the person in charge was given feedback from residents' meetings, they were not provided with a copy of the minutes and there was no clear arrangements in place for sharing the minutes of the meetings with residents who did not attend same. In addition residents and relatives were encouraged to feedback on their experiences of the service verbally or in writing using the 'Your Service Your Say' feedback boxes which were located at a number of points throughout the centre. Residents spoken with confirmed that they were treated with respect and dignity by staff and that staff were attentive to meeting their needs and queries in a patient and kind way. Their feedback to the inspector supported confidence in staff whom they said valued and cared about them. The inspector observed that interactions between staff

and residents were responsive, friendly and positive on the days of inspection

Visitors were welcomed to the centre and there was a number of areas where residents could meet their visitors in private. Residents' personal care was carried out in private with screen curtains and doors closed on each occasion. Cubicle toilets were refurbished since the last inspection in March 2014 which improved resident privacy in Butterstream area.

While the inspectors found that residents were encouraged and facilitated to make choices about their care and lifestyle in the centre, the ramped corridor negatively impacted on some residents' independence with accessing areas outside Lower Camillus area including the church and front door of the centre. This finding requires review to ensure residents can freely access all areas of the centre if they wish. One resident was in the process of being facilitated to go home overnight. The provider, person in charge and staff were actively involved in assisting this resident to realise this goal.

A refurbishment of residents' accommodation project was under way with one area completed and re-accommodated by residents and another area nearing completion. Residents were involved in the building refurbishment project and were invited to provide feedback on the draft refurbishment plans to ensure their participation and satisfaction with the layout of the area in which they would be living. Copies of the building plans were displayed to enable residents to inform themselves of the changes taking place in their home. In addition there was evidence that residents were afforded choice regarding the colour schemes in their bedrooms.

There were some designated single bedrooms changed to facilitate two residents while refurbishment work was taking place however, the inspector found that this accommodation arrangement did not ensure their privacy and dignity needs were met as one resident had to pass through another residents' private space especially when curtains were closed to access toilet and shower facilities and to exit the bedroom. The inspector also found that there was inadequate space for residents with assistive equipment to pass along the bottom of one bed to access the other bed-space. The provider advised the Authority this was a temporary arrangement with the consent of residents while the current phase of refurbishment was in progress. This finding is also discussed in outcome 12.

Residents socialisation needs were generally met and organised by an activity co-ordinator. Activities for residents on Butterstream dementia unit included sensory based therapies, reminiscence and doll therapy among others on a one to one basis or in small group arrangements. Family involvement in the lives of residents in this area was held in high regard, encouraged and facilitated by staff. A programme of activities was provided for residents in Camillus consisting of a variety of communal and one to one pursuits to meet the varied interests and capabilities of residents. The inspector observed that residents had their activity needs assessed and had care plans in place. However, evaluation was not consistently maintained to record each residents participation and whether activities participated in resulted in positive outcomes for them.

Judgment:

Non Compliant - Moderate

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

Theme:

Person-centred care and support

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

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

Findings:

Residents were facilitated to retain control over their personal possessions and clothing. Wardrobe and storage space in the newly refurbished Lower Camillus area provided residents with good space for storing their personal belongings, clothing and possessions.

Wardrobe were small and had limited space for hanging clothes in Upper Camillus area. Residents were provided with additional drawer unit storage space where required in response to inadequate wardrobe space identified in an action plan from the last inspection in March 2014.

There was a policy to inform management of residents' personal property and possessions which was up to date. A record of each resident's property was completed and up to date in their care plan documentation. The centre has a laundry on-site. The laundry was viewed by the inspector and there was adequate segregation facilities for clean and used linen. The inspector found that the staff member with responsibility for laundry services was knowledgeable regarding laundry and infection prevention and control procedures. Ironing facilities were not robust and there was evidence of dissatisfaction regarding a failure to adequately iron a resident's personal clothing. Linen collection skips were available that appropriately segregated used linen in line with the national policy. The inspector observed that clothing worn by residents on the days of inspection was clean and in satisfactory condition. Personal clothing belonging to residents was neatly stored in a sample of wardrobes viewed. Items of residents clothing viewed by the inspector had the residents identification on them.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best

recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

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

Findings:

The inspector found that staffing levels and skill mix required review to ensure the needs of residents in all areas of the centre were met. The inspector found evidence to support the requirement of a staffing review in the following areas

- resident falls
- staffing arrangements at night on Butterstream and Upper Camillus areas

The inspector examined copies of a 'Review of Incidents and Accidents' during 2014 for the centre, completed by the person in charge. This documentation referenced that 81% of incidents in Butterstream dementia unit and 66% of slips/trips and fall in Camillus area occurred between 08:00 and 20:30hrs. While these incidents were analysed and trended with an extensive list of interventions implemented to reduce the frequency and severity of incidents, a review of staffing levels and skill mix was not listed among these interventions.

Staffing levels during the night in Butterstream dementia unit consisted of one staff nurse and one carer. A staff nurse worked alone on Upper Camillus There was an arrangement where a staff nurse worked alone from 20:45 to 07:45hrs on the eight bedded Upper Camillus unit. There was an arrangement in place where the nurse in Upper Camillus would provide on-site support to the nurse in Butterstream dementia unit in the event of a urgent requirement for increased staff. However this arrangement was not reviewed to ensure that residents residing in Upper Camillus had adequate supervision should this occur.

The inspector reviewed a copy of the staff roster for the centre and found that not all persons working in the centre was recorded. This finding is discussed further in outcome 5 of this report. A modified primary nursing organisation of care methodology was used where each staff nurse was assigned primary and associate responsibility for a group of residents. Associate responsibility was assumed when the designated primary nurse was off duty. This ensured continuity of care and enabled each resident to have a named nurse caring for them. This arrangement was used for the allocation of carers into designated teams to meet the needs of residents as primary carers for a group of residents and associate carers for others. There was adequate arrangements in place to replace unplanned staff leave. A care staff member assisted between the two areas.

Staff were responsive to residents needs and their approach was patient and gentle with them throughout both days of inspection. Many staff spent time talking to residents and

concerns or queries were addressed appropriately. Staff knew residents well and were familiar with their likes and dislikes which they make efforts to accommodate.

The inspector reviewed staff training records which were comprehensive and easily accessible. They evidenced that staff were facilitated to attend a wide variety of professional development education and training to inform their practice. Staff spoken with were confident and knowledgeable regarding their work and competency assessments were done to ensure training needs were met. However staff competency assessment was not part of the remedial process in response following adverse practice incidents in medication administration procedures. A clinical nurse management structure was in place in each clinical area to supervise the standard of care delivery and resident satisfaction.

Training records confirmed that staff mandatory training requirements were completed for 2014.

The staff duty roster did not record the times each member of staff worked in the centre in 24hr format. The surnames of some staff were not entered on the duty roster. This finding is discussed in outcome 5

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St Joseph's Community Nursing Unit
Centre ID:	OSV-0000542
Date of inspection:	05/01/2015
Date of response:	19/06/2015

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The monitoring system in place did not ensure areas of deficit were addressed to ensure improvements were sustained and recurrence was mitigated. Some audits did not have action plans developed or timescales for completion of remedial actions specified. It was therefore not clear if all actions required were satisfactorily completed.

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

Action Required:

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

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

The Registered Provider acknowledges the findings. The audit tool for medication management & care-plan audits have been reviewed and revised to include timeframe and completion date. These are now in circulation with time frames and completion dates to ensure that actions required have been completed and that nothing is outstanding.

The monthly safety walkabout is now completed by the PIC and the Administrator in the centre and action plan is drawn up and discussed with all members of the maintenance, care, household, catering and admin team members. This document is kept live and is signed off when the necessary actions have been completed. When the monthly safety walkabout is conducted on a monthly basis the actions are reviewed to ensure actions have been completed to a high and acceptable standard.

This ensures the service provided is safe, and actions are effectively monitored in a timely manner.

Proposed Timescale: Revised Audits have been completed in April 2015. Safety walkabout is completed monthly and ongoing on a monthly basis.

Proposed Timescale: 30/04/2015

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:

Written operational policies as required by Schedule 5 of the Regulations were not adequate to inform practice in protection of vulnerable residents and PRN (as required) psychotropic medication.

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:

The Registered Provider acknowledges the findings. The Registered Provider has put in place the HSE's Policy on the Use of Physical Restraints in Designated Residential Care Units for Older People in the Schedule 5 Policies. A local policy is in the process of being devised for the Unit.

St Joseph's CNU Policy for the Management of Psychotropic Drug Use has been reviewed following the inspection. The Protocol for the Administration of Psychotropic Medication has also been reviewed to ensure that all other diversional and de-escalation

therapies have been trialled prior to administration of a PRN Medication, thus ensuring that PRN Psychotropic medication is administered as a last resort and kept under review.

All Residents who were prescribed PRN Psychotropic medications have all been reviewed, and are reviewed regularly by the Pharmacist and the Residents General Practitioner.

Local Policy will be forwarded when completed – 30th June 2015
PRN Psychotropic medication Protocol will be forwarded when completed- 30th. June 2015.

Proposed Timescale: 30/06/2015

Theme:

Governance, Leadership and Management

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

Records of psychotropic restraint use were not adequately recorded as required by Schedule 3 Paragraph 4 (g).

A record was not maintained of all expressions of dissatisfaction as required by Schedule 4 Paragraph 6.

The hours of duty worked by staff and their surname was not recorded on the duty roster as required by Schedule 4, Paragraph 8 of the regulations.

Action Required:

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

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

The Registered Provider acknowledges the findings.

The PIC will report to HIQA on a quarterly basis on the number of Residents prescribed PRN Psychotropic Medications and keep under review, as required by Schedule 3 Paragraph 4 (g).

Issues and Complaints logs have been discussed with all Managers and Staff and the PIC has discussed at the Management Team and Monthly Staff Team Meetings, the importance of recording all expressions of dissatisfaction as required by Schedule 4 of the Health Act. These Issues and Complaints logs will be discussed at the morning meeting with the PIC and at the monthly Management Team Meetings to ensure issues are addressed.

The off-duties have been reviewed by the PIC and amended. The newly revised off-

duty is now in circulation where the staff members name is written in full and also their hours of work as per Schedule 4.

Proposed Timescale: 31/05/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Adequate protocols were not in place to inform appropriate use of PRN psychotropic medications that ensured restrictive procedures were avoided where possible. In addition use of chemical restraint was not reviewed from a multidisciplinary focus.

Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

The PIC has reviewed the Protocol for the Administration of Psychotropic Medications on a PRN Basis and amended same to ensure that staff are aware that their use is as a last resort and that all other de-escalation and diversional therapies have been trialled.

Refresher training has commenced for 2015 for all care staff in the Management of Aggression & Violence which focuses on the use of diversional therapies as a means of de-escalation. Staff are educated on the importance and necessity of ensuring that all of these therapies are trialled prior to restrictive holding techniques of PMAV, and prior to the administration of PRN Psychotropic medication.

The PIC as the PMAV Instructor & Adviser has completed a PMAV Intervention Information & Guideline Document, which is discussed at the training and is also located in each Residents plan of Care in order to ensure staff are aware that the use of PMAV restrictive holds is only as a Last Resort, when all other diversional and de-escalation techniques have been tried.

Residents regular and PRN medications are reviewed on a four monthly basis by Primary Nurse, In-house Pharmacist and General Practitioner. All Residents with behavioural issues who require Psychotropic PRN medications has the support of the Psychiatry of Older People and Clinical Nurse Specialists who visit the centre as required.

Proposed Timescale: 31/05/2015

Theme:

Safe care and support

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

Restraint use was not in line with the National restraint guidelines.

Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

The Registered Provider acknowledges the findings. The HSE Policy on the Use of Physical Restraint in Designated Residential Care Units for Older People (Dec 2011) is now in place in the Schedule 5 Policies for Staffs information and guidance.

The Registered Provider will ensure that a Local Policy on the use of Restrictive Procedures is to be developed to include, Chemical, and Physical Restraint and is in line with the HSE's Policy on the Use of Physical Restraint in Designated Residential Care Units for Older People (Dec 2011) and also the HIQA (2013) Guidance for Designated Centres on Restrictive Procedures. This policy will be available and accessible for all staff in the Policy Folder on the Unit and will also be discussed at PMAV training and at staff team meetings and Management Team meetings.

Proposed Timescale: 30/06/2015

Theme:

Safe care and support

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

Ensure the policy document adequately informs management of all aspects of protection of vulnerable residents.

Action Required:

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

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

The Registered Provider acknowledges the findings. The Registered Provider will ensure that the policy document on the management of Elder Abuse will incorporate all aspects of the Protection of Vulnerable Residents from Elder Abuse and will incorporate the HSE Trust In Care Policy.

The PIC and the Administrator complete monthly safety walks and an action plan is drawn up and discussed with members of the team at monthly team meetings and management team meetings.

The Clinical Supervisors conduct a daily safety walk of their own unit each morning

ensuring that there are no risks to the Residents.

The Clinical Supervisors, Administrator and PIC discuss any issues identified at their morning meeting. It is discussed and actions taken to ensure protection of our vulnerable elderly population.

There is a Safety Rep In-house who conducts bi-monthly evacuations with staff and also involving residents if they wish. This now included assimilated night time evacuation. This ensures Residents can be safely evacuated taking into account their dependencies, the layout of the premises and the number of staff available.

Proposed Timescale: 30/06/2015

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:

Findings of recurring deficits in practice did not ensure that learning from adverse incidents involving residents was assured as part of the risk management process.

Action Required:

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

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

The Registered Provider acknowledges the findings and has ensured that the risk management policy includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

The analysis tool monitoring incidences and accidents within the centre has been reviewed to incorporate a Checklist of possible Contributory Factors. This will identify if additional risk assessments and actions are required in order to mitigate re-occurrences and/or reduce the risks of adverse or negative outcomes for the Residents.

Proposed Timescale: 31/05/2015

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:

The pharmacist was not facilitated to meet obligations as specified by the

Pharmaceutical society of Ireland.

Action Required:

Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

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

The Person In Charge acknowledges the findings. The PIC has reviewed the admission data documentation and amended to include and offer the Resident the opportunity to choose a Pharmacist outside of the facility. The Resident also has the choice of GP outside of the centre if they so wish.

The Pharmacist is involved and carries out the four monthly medication reviews together with the General Practitioner and a member of the Nursing Staff. The Resident is kept informed of any changes made to their medications. The PIC has given the Pharmacist the Audit document for St. Josephs CNU, in order for him to conduct an audit while reviewing the medications on a four monthly basis. The Pharmacist will return the completed Audit to the PIC in order to ensure actions are completed by Staff members involved.

Proposed Timescale: 31/05/2015

Theme:

Safe care and support

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

Staff competency in administration of medications required comprehensive review to ensure medications were administered to residents as prescribed at all times.

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:

The Person In Charge acknowledges the findings. The PIC will ensure that the Clinical Nurse Managers or their Deputy will make sure that all discontinued medications are signed off accordingly by the General Practitioner.

Nursing Staff will be required to complete the HSE On-line E-learning Medication Management education on an annual basis and will be assessed on their competency by the Clinical Supervisors following completion of this education and production of the certificate to the PIC. There is a Clinical Supervisor on duty each day that ensures that medications are administered as per policy.

The PIC has reviewed the Audit Tool on Medication Management 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.

Proposed Timescale: 31/05/2015

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

Quarterly notification requirements did not include use of chemical restraints as found on inspection.

Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

The PIC now includes on the quarterly reports to the Health Information & Quality Authority the number of Residents in receipt of PRN Psychotropic Medications and also Residents who have challenging behaviour and require the use of restrictive holds as taught to staff at the PMAV training. All Residents will be identified in the quarterly returns by their Unique Identifier Numbers.

Proposed Timescale: 31/05/2015

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:

Evidence of involvement of residents or their relatives as appropriate, in care plan reviews was inconsistent.

Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

The PIC has reviewed the documentation and a separate document will be formulated to accompany the Residents Care Plan where the Resident and/or the Residents Next of Kin can sign to ensure that they have been involvement in the drawing-up, and reviewing of the Residents Care Plan on a four monthly basis or before as required by the changing needs of the Resident.

Proposed Timescale: 31/05/2015**Theme:**

Effective care and support

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

Ensure residents experiencing difficulty with accessing the centre due to the ramped corridor have their needs assessed and met to promote their independence.

Action Required:

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

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

The Registered Provider acknowledges the findings. The main Dining Room on Upper Camillus has been decommissioned as a dining area.

As an interim measure, all Residents dine in the lifestyle kitchen and dining area on Lower Camillus thus preventing the Resident from having to travel up the ramp to Upper Camillus. An observation of the dining experience has been conducted following this interim measure to ensure that Residents could sit comfortably at the dining table whether in specialised seating or otherwise.

Phase 4 of the refurbishment works due to be completed in late July 2015, will have an additional lifestyle kitchen and dining area which will then accommodate the Residents living in that area and thus the dining area in Lower Camillus will have less residents ensuring that all Residents can sit comfortably at the dining table whether in an assistive chair or otherwise to eat their meals. This will also ensure that Residents and staff can move around the dining area with ease and safety.

All daily activities are being delivered in the living areas on Lower Camillus and in the area on Upper Camillus where the 8 Residents are remaining until completion of Phase 4. This is ensuring that Residents are not at risk of social isolation as a result of the ramped area.

A number of Residents have been assessed and supplied motorised wheelchairs in order to promote independence within their home.

HSE Estates have explored alternatives for the ramped area; however this is structural and cannot be changed even with the current refurbishment works taking place. On

completion of Phase 4 of the refurbishment works, Residents will then be able to freely access the church and front entrance via this corridor independently without asking staff to help them up the ramped area. This will ensure that there are no limitations on Residents movement throughout the centre, unless in the Dementia Unit.

Future development projects within St. Josephs will not include any ramped areas being included.

All staff have moving & handling training on an annual basis

Residents have all been assessed and supplied with suitable seating which have wheels and therefore can be transported throughout the Centre.

Proposed Timescale: 30/04/2015

Theme:

Effective care and support

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

There was evidence of seudocrema use as a protective skin preparation for pressure area care. In addition administration of psychotropic medications did not reflect best practice restraint use for management of behaviours that challenge or professional nursing practice.

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:

The Registered Provider acknowledges the findings. The PIC has informed the Pharmacist that the use of seudocrema is discontinued in the Centre and therefore will no longer be ordered. Clinical Supervisors have discussed with the care teams that the use of seudocrema has ceased as a protective skin preparation for pressure ulcer care in accordance with St Joseph's Wound Care Policy.

All residents who were prescribed Psychotropic Medications have been reviewed.

Proposed Timescale: 31/05/2015

Theme:

Effective care and support

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

While residents had access to psychiatry of older age services, this service was not represented at case conference meetings for residents with mental health problems especially residents exhibiting behaviour that challenged of increasing frequency or severity with requirements for chemical restraint

Action Required:

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

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

The Person In Charge acknowledges the findings. The Department Psychiatry of Older People and Clinical Nurse Specialist are involved with Residents as required. The PIC discussed with the Department of Psychiatry their attendance in future Residents Case Conferences within the Centre, especially for those who require PRN Psychotropic Medications. It may not be always possible to find a suitable time to arrange the case conferences, however, it has been arranged that when Psychiatry for Older People and the Clinical Nurse Specialist visit the Unit to assess a Resident that the Nurse in Charge and the Manager on Duty have the case conference then, with the Resident if appropriate and /or their NOK if available at the time. Following this, the Resident and or their Next of Kin can be informed of the meeting and any changes or recommendations made to the Residents plan of care.

Proposed Timescale: 31/05/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Not all parts of the centre premises are appropriate to the number and needs of the residents in accordance with the statement of purpose prepared under Regulation 3, including meeting the privacy and dignity needs of residents, dementia care best practice facilities and access for residents on Lower Camillus to other parts of the centre.

Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

The Registered Provider acknowledges the findings. Phase 4 of the refurbishment works at St. Josephs is scheduled for completion in July of 2015, when all residents will all have their own single en-suite bedroom. As an interim measure, temporary curtains have been fitted in the shared bedrooms in order to provide Residents with privacy and

dignity. On completion of Phase 4, all of the residents will have their own single en-suite room and there will be no shared accommodation on Camillus Unit.

Phase 4 of the refurbishment works due to be completed in late July 2015, will also have an additional lifestyle kitchen and dining area which will then accommodate the Residents living in that area and thus the dining area in Lower Camillus will have less residents ensuring that all Residents can sit comfortably at the dining table whether in an assistive chair or otherwise to eat their meals. This will also ensure that Residents and staff can move around the dining area with ease and safety.

HSE Estates have explored alternatives for the ramped area; however this is structural and cannot be changed even with the current refurbishment works taking place. On completion of Phase 4 of the refurbishment works, Residents will then be able to freely access the church and front entrance via this corridor independently without asking staff to help them up the ramped area. This will ensure that there are no limitations on Residents movement throughout the centre, unless in the Dementia Unit.

Butterstream Dementia Specific Unit is scheduled to commence in Nov/Dec 2015 with a new build planned, which will provide single en-suite bedrooms for all of the Residents. These new bedrooms will ensure that the privacy and dignity of all Residents is maintained. In the interim, Residents share bedroom accommodation, which are large rooms with curtains provided between each bed providing privacy and dignity to the Residents. All of the Residents in the Dementia Unit mobilise to the bathrooms independently, and to the shower facilities, thus providing them with privacy with these personal activities of daily living.

This new planned facility will have access from the corridors into a secure garden in line with evidence based dementia care principles, allowing Residents to move freely throughout the Dementia specific unit safely. The new garden planned for the unit will be purpose built in line with best practice and will be safe for the Residents. In the interim, the Residents have access to the existing garden area with assistance of staff.

The area identified in this report which had been cleared of vegetation will be where the new facility will be built.

Proposed Timescale: Refurbishment works for Phase 4 scheduled for completion in July 2015. Future visioning works to include New Building for Dementia Specific Use to commence in 2015 and continue into 2016.

Proposed Timescale: 31/07/2015

Theme:
Effective care and support

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

Not all parts of the premises conformed to the matters set out in Schedule 6, having regard to the needs of the some residents.

Action Required:

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

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

The Registered Provider acknowledges the findings. HSE Estates has explored this ramped area within the facility which structurally cannot be changed. However, on completion of the refurbishment works of Phase 4, access to our church at St Joseph's and Upper Camillus will be accessible from the other corridor without Residents having to use this ramped area.

Residents with poor mobility are assisted by staff to attend religious ceremonies in the Church in St. Josephs. Motorised wheelchairs have been purchased and supplied to Residents who have been assessed for their suitability. All Specialised chairs have wheels attached in order for ease of movement. Staff has annual moving & handling training. All activities take place in the living areas throughout the Centre, thus ensuring that the needs of the Residents are met and they are not socially isolated as a result of the ramped area.

Proposed Timescale: 31/07/2015

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:

Not all verbal expressions of dissatisfaction were recorded in the complaints record.

Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

The Registered Provider acknowledges the findings. Issues and Complaints logs have been discussed with all Managers and Staff and the PIC has discussed at the Management Team and Monthly Staff Team Meetings the importance of recording all expressions of dissatisfaction as required by Schedule 4 of the Health Act. These Issues and Complaints logs will be discussed at the morning meeting with the PIC and

at monthly Management Team Meetings to ensure issues are addressed.

The laundry had been equipped with a new iron and ironing board and the Laundry person is providing an ironing service for the Residents in St. Josephs

Proposed Timescale: 30/04/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Multi-occupancy accommodation did not ensure the privacy and dignity needs of residents were met.

Designated single bedrooms changed to facilitate twin accommodation did not ensure the needs of residents residing there were met.

Action Required:

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

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

The Registered Provider acknowledges the findings. Completion of Phase 4 is scheduled for July 2015 and this will provide each Resident on Camillus with their own individual single en-suite bedroom which will ensure the privacy and dignity of the Residents are met.

In the interim, screening is provided in double occupancy bedrooms and the use of an ensuite is available in the rooms for personal care. All staff are aware to ensure the privacy and dignity of each Resident is met in the delivery of personal care.

On completion of Phase 4 of the building works, no Resident on Camillus will be sharing a bedroom, each will have their own single en-suite bedroom.

A new build is planned as a part of the refurbishment works for Butterstream Dementia Specific Facility which will also provide all Residents with their own single en-suite bedroom thus ensuring their privacy and dignity is maintained and respected.

In the interim, Residents share bedroom accommodation, which are large rooms with curtains provided between each bed providing privacy and dignity to the Residents. All of the Residents in the Dementia Unit mobilise to the bathrooms independently, and to the shower facilities, thus providing them with privacy with these personal activities of daily living.

Proposed Timescale: Refurbishment works for Phase 4 scheduled for completion in July 2015. Future visioning works to include New Building for Dementia Specific Use to

commence in late 2015 and continue into 2016.

Proposed Timescale:

Theme:

Person-centred care and support

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

Residents could not exercise choice to independently access the enclosed garden in Butterstream dementia area..

Some residents could not access the church or front door of the centre due to the incline on a ramped corridor.

Action Required:

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

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

The Registered Provider acknowledges the findings. The Refurbishment works planned for Butterstream Dementia Specific Unit will include an enclosed, secure garden area with access doors located along the corridor which will allow all Residents to roam freely and independently throughout the Dementia specific unit safely. The new garden planned for the unit will be purpose built in line with best practice and will be safe for the Residents. In the interim, the Residents have access to the existing garden area with assistance of staff.

The area identified in this report which had been cleared of vegetation will be where the new facility will be built.

HSE Estates has explored this ramped area within the facility which structurally cannot be changed. However, on completion of the refurbishment works of Phase 4, access to our church at St Joseph's and Upper Camillus will be accessible to Residents via the other end of the corridor without using this ramped area. For the interim period, all Residents are assisted to attend the Church and front door when they wish to.

Some Residents have been provided with motorised wheelchairs following thorough assessment by our Occupational Therapist.

All Residents with specialised seating have wheels fitted which are an aid to moving Residents around the Centre.

All staff have mandatory Moving & Handling training delivered in St Josephs on an annual basis.

Proposed Timescale: Refurbishment works for Phase 4 scheduled for completion in July 2015. Future visioning works to include New Building for Dementia Specific Use to commence in late 2015 and continue into 2016.

Proposed Timescale:

Theme:

Person-centred care and support

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

Evaluation was not consistently maintained to record each residents participation in activities and whether activities participated in resulted in positive outcomes for them.

Action Required:

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

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

The Registered Provider acknowledges the findings. A Residents Satisfaction Survey will be developed concentrating solely on the activities provided within the Centre and this will identify if Residents are satisfied with the level and variance of activities provided, and if the activities provided meet the interests and capabilities of the Residents. An action plan and review of Activities will be conducted on collection and analysing of the data obtained from this audit. It is proposed that this audit will take place twice yearly and the results will be analysed and concluded by an independent body, Maureen Finlay (SAGE) who has an office within the Centre.

The daily flow sheet will be reviewed and revised in order for the Residents participation in all activities to be recorded and completed on a daily basis.

Proposed Timescale: First survey to be circulated by 31st May 2015 and second survey to be circulated in the last quarter of 2015.

Daily flow sheet will be reviewed and revised and placed into circulation by 31st May 2015.

Proposed Timescale: 31/05/2015

Theme:

Person-centred care and support

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

The person in charge was not provided with a copy of the minutes of residents' meeting forums and there was no clear arrangements in place for sharing the minutes of these meetings with residents who did not attend same

Action Required:

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

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

The Registered Provider acknowledges the findings. The PIC is now in receipt of the minutes of the Residents Committee Meetings and all Families and/or their Next of Kin are sent a copy of the minutes also.

The Residents Committee is moving towards a Residents Monthly Forum Meeting from May 2015 at a time that is suitable for the Residents. This will be facilitated by an independent body, Maureen Finlay (SAGE) and will be attended by the PIC. The minutes of these meetings will be circulated to residents and/or their Next of Kin.

Proposed Timescale: 30/04/2015

Outcome 17: Residents' clothing and personal property and possessions**Theme:**

Person-centred care and support

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

Ironing procedures for residents' personal laundry was not robust.

Action Required:

Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.

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

The Person In Charge acknowledges the findings. A new ironing board and iron has been purchased for the laundry and the laundry staff member is now ironing all items identified as requiring ironing and returned to the resident.

Proposed Timescale: 30/04/2015

Outcome 18: Suitable Staffing**Theme:**

Workforce

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

Staffing levels and skill mix required review to ensure the needs of residents were met with regard to resident accident and incidents and arrangements in place for staff support on night duty in Butterstream and Upper Camillus area.

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:

The Registered Provider acknowledges the findings. Following inspection a full review of rostered staffing levels and skill mix took place for the duration of the current refurbishment programme which is due for completion in July 2015. The staffing complement for Upper Camillus and Butterstream which consists of 22 Residents is 1 staff member to 7.3 Residents. Should assistance be required on Upper Camillus, staff on night duty carry personal alarms, Mobile phones and a call bell system is in place which links into Butterstream and Lower Camillus who can come to assist. On completion of phase 4, this interim measure will cease.

Proposed Timescale: 30/04/2015

Theme:

Workforce

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

Competency assessments were not routinely done for all staff and in response to adverse medication incidents.

Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

Following an adverse medication incident, a process is in place where the staff member is met with and is required to complete a reflective practice in order to mitigate against reoccurrence. From this inspection, supervision and support is provided by the Clinical Supervisor and the staff member's competency is reassessed thereafter. The HSE Disciplinary Procedure is maybe evoked if there is evidence of poor practice.

Nursing Staff will be required to complete the HSE On-line E-learning Medication Management education on an annual basis and will be assessed on their competency by the Clinical Supervisors following completion of this education and production of the certificate to the PIC.

Proposed Timescale: 31/05/2015

