<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Phoenix Park Community Nursing Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000476</td>
</tr>
<tr>
<td>Centre address:</td>
<td>St Mary's Hospital, Phoenix Park, Dublin 20.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 6250300</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:rosemary.reynolds@hse.ie">rosemary.reynolds@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Deirdre Murphy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Nuala Rafferty</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Jim Kee; Shane Walsh; Sheila McKeivett</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>183</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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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**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tr>
<td>10 March 2015 09:30</td>
<td>10 March 2015 20:30</td>
</tr>
<tr>
<td>11 March 2015 08:30</td>
<td>11 March 2015 18:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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

This was an announced inspection and formed part of the assessment of the application for renewal of registration by the provider. The inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents and staff members of the centre were also sought.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider, for the purposes of application to register were found to be satisfactory. The nominated person on behalf of the
provider and both persons in charge demonstrated knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland throughout the inspection process.

The fitness of the nominated person on behalf of the provider and persons in charge was determined by interview during the previous registration inspection process and through ongoing regulatory work such as inspections.

A number of residents’ questionnaires were received by the Authority during the inspection. The opinions expressed through both the questionnaires and conversations with the inspectors on site were broadly satisfactory with services and facilities provided. In particular, residents were very complimentary on the manner in which staff delivered care to them commenting on their good humour and respectful attitude.

Overall, evidence was found that residents’ healthcare needs were met. Residents had access to medical officers and consultant geriatrician services within the centre. Access to allied health professionals such as physiotherapy, speech and language therapists and to community health services were also available.

The inspector found there were aspects of the service that needed improvement such as risk management, care planning governance and premises. One unit within the overall centre was not found to meet the requirements of Regulation 19 or Standard 25 (Physical Environment) of the National Quality Standards for Residential Care Settings for Older People in that the physical design and layout of the premises did not meet the needs of the current resident profile and overall the unit was not accessible, hygienic, spacious or well maintained. The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.
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:
A written statement of purpose that broadly described the service and facilities in the centre was available and contained the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Some revisions were required to ensure completeness of the information in respect of the size and function of communal rooms, criteria for admission and age range of residents to whom accommodation is provided.
The provider forwarded a revised document to the Authority which meets the requirements of Schedule 1.

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):
No actions were required from the previous inspection.
Findings:
There were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose and a clearly defined management structure that identified the lines of authority and accountability. An overarching structure that included a management strategy team and operational community nursing units team for both the community nursing units and other health services such as rehabilitation which co exist on the same campus were in place.

Both persons in charge worked closely with the provider and medical director for rehabilitation services. A Senior Nurse Management system was in place and included a senior nurse manager person's in charge clinical nursing team and clinical nurse specialists. Management meetings were well established and reviewed all aspects of service provision, staffing, health and safety, training, complaints and any other relevant issues some of which were seen to be actioned.

An annual review of safety and quality of care was also in place. However although there was evidence that the systems in place were monitoring many aspects of the service provision, improvements were found to be required. Findings relating to restraint practices, care planning and assessment, premises and risk management which are detailed under the relevant outcomes further in this report did not fully assure the inspection team that the service provided was safe, appropriate to residents’ needs, consistent and effectively monitored.

For example;
- the recommendations of allied health professionals were not included in all nursing care plans to ensure the timely commencement of treatment
- audit processes in place were not effectively monitoring practices and cultures found such as high levels of restraint; personal care privacy and dignity; assessing planning or recording of care.
- medication management practices were not meeting professional standards required by the Nursing and Midwifery Regulatory Board in relation to administration storage or practices in place for monitoring controlled drugs.
- documentation of care provision was not sufficiently accurate or complete to determine the standard of care delivered.
- evaluations of care plans together with nursing progress notes and other supporting documentation to evidence the delivery of a high standard of care were not appropriately linked to give a clear and accurate picture of residents’ overall health management.

Although a quality and safety review system was in place there was no formal audit process by the senior nurse management team to effectively monitor the standard of care delivered to residents. The governance systems in place did not support consistent effective monitoring or transfer of learning to ensure improvements in the quality of care delivered.

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.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a guide to the centre available to all residents. Each resident is provided with a copy of the guide on admission and some units had a copy on display and available to view.

Each resident had an agreed written contract which deals with the resident’s care and welfare. The contract included all details of the services to be provided for that resident and the fees to be charged.

**Judgment:**
Compliant

### Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The centre was managed by two suitably qualified and experienced nurses. Both held authority, accountability and responsibility for the provision of the service within separate units.

They were found to be engaged in the governance, operational management and administration of the centre on a daily basis. During the inspection, knowledge of the Regulations was demonstrated and the inspection process was facilitated by providing documents and having good knowledge of residents’ care and conditions.

**Judgment:**
**Outcome 05: Documentation to be kept at a designated centre**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspectors found that all of the policies and procedures listed in Part 2 and all records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Older Persons) Regulation 2013 were not being maintained in the centre. Inspectors also found deficiencies in the documentation of medication administration, and in relation to medication practice that did not conform with the medication management policies.

It was found that all records listed in Schedule 4 and Schedule 2 of the regulations were being maintained in terms of accuracy and were updated regularly. The inspectors reviewed a sample of staff files and found that they met all of the requirements listed in Schedule 2. However not all information required in Schedule 3 was being maintained. The residents' directory did not contain all information required by the regulations including; the address and telephone number of the general practitioner or the time and cause of death of all residents who had passed away while under the care of the centre.

All of the policies and procedures listed in Schedule 5 were being maintained with the exception of two, although five had not been reviewed within the past three years as required by the regulations.

The following policies were not available in the centre:

- Staff training and development
- Responding to emergencies

The following policies had not been reviewed in the last three years:

- The prevention, detection and response to abuse
- The use of restraint
- The provision of information to residents
- The creation of, access to, retention of and destruction of records
- Temporary absence and discharge of residents

It was also noted that where policies were available, up to date and reviewed, they were not being implemented in a full or consistent manner throughout the centre. Examples included the medication and risk management policies.

Medication records as detailed in Schedule 3 of the regulations were not being consistently maintained, and the policies and procedures relating to medicines required by Schedule 5 were not always appropriately implemented. Inspectors noticed a discrepancy in the balance of one MDA (controlled) drug stored on one of the units, and this was brought to the attention of the Clinical Nurse Manager (CNM) on duty. The documentation regarding the administration of this medicine to a resident had not been properly completed and the resultant balance had not been sufficiently checked by staff before the balance had been signed off. Inspectors observed the administration of medicines to residents and found that some nursing staff were signing the administration record before administering the medicines to the residents, which is not in line with best practice guidelines or the centre’s own policy.

Inspectors reviewed a number of medication prescription and administration sheets and identified a number of issues that did not conform with appropriate medication management practice:
- photographs of the residents were not always present.
- the prescribed frequency of administration was not clearly indicated on the prescription sheet.
- the prescriber had not signed for each individual medicine on the prescription sheet.
- the prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.
- there was no evidence on some prescription sheets to indicate that reviews had been completed at the necessary three monthly intervals.
- not all medicines were prescribed generically
- the maximum daily dosage for PRN (as required) medicines was not always clearly indicated on the prescription sheet.

The documentation of care was not sufficiently accurate or complete to determine that a high standard of evidence based nursing care was being delivered to residents to fully meet their personal care needs. The recording of personal care to residents did not identify the frequency with which residents were offered or refused showers or baths. Inspectors were unable to make informed judgements as to whether residents were being provided with frequent showers or baths. Records available and reviewed indicated that many residents only receive showers once or twice per month. Evidence that all care plans were reviewed on a quarterly basis or as resident’s needs changed and records of residents current overall condition as required by the regulations was not available.

An action in relation to these findings is included under Outcome 11 Healthcare.

Judgment:
### 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:**
To date, notification of a proposed absence of the person in charge has not occurred, however, appropriate arrangements for the management of the designated centre during an absence of the person in charge were in place.

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

**Findings:**
There were measures in place to protect residents being harmed or suffering abuse. Staff spoken to during the inspection were knowledgeable regarding challenging behaviour and appropriate responses to this type of behaviour. Inspectors reviewed the centre's policy on elder abuse, and found that it gave staff appropriate guidance on the prevention, detection and response to abuse. Staff spoken to during the inspection were all aware and knowledgeable of the elder abuse policy and confirmed that they had undergone recent training on this subject. However it was found that not all staff had attended training in safeguarding and prevention of elder abuse, an action in relation to this is included under Outcome 18.
Residents spoken to confirmed that they felt safe in the centre, and relatives that inspectors met also confirmed that they were satisfied that residents were safe within the centre. There were flow charts available in the units explaining elder abuse to staff and residents.

Two of the larger units have porters on duty at the reception desks during the day and a security presence on the units at night time. Although one unit does not have a reception desk the entrance was found to be secured through a key pad system to enable staff entry whilst the door remained locked at all times.

However, Inspectors found that the use of bed rails was widespread throughout the centre, and that appropriate assessments for this type of restraint were not being fully completed. Evidence of a high use of restraint was found although there was no clear rationale for it's use in many cases. This finding replicates similar findings from the last monitoring inspection in May 2013

Inspectors found that there was a risk averse culture of restrictive practice with bed rails in place for the majority of residents on several units.

In conversation with nursing staff, clinical nurse managers and senior managers it was found that the practice of using two upper bed rails was not considered a restrictive practice as these rails were considered to be enablers. However it was found that many residents for whom these rails were in use were unable to re position themselves as they were either completely immobile or did not have sufficient upper body strength to utilise the rails. Although alternative safety measures such as bed alarms, roll out mats and low low beds were in use, they did not replace the use of the two upper 'safety rails' but were used in conjunction with them making these alternative measures redundant.

Risks associated with the use of some bed rails were also identified by inspectors. In one unit, inspectors found a high use of full non integrated bed rails with gaps at the top and bottom of the bed that had not been appropriately risk assessed to ensure the safety of residents. Risks associated with these rails included risk of entrapment of head or limbs with potential for serious injuries.

An action in relation to this finding is included under Outcome 5 of this report.

Efforts to reduce restrictive practices and put in place systems to promote a restraint-free environment were found to be needed. A policy on the use of restraint was in place in the centre, but evidence to show that all considerations were explored and found to be unsuitable before a decision was taken to use a form of physical restraint was not available.

Samples of documentation on the use of and reasons for restraints in place were viewed and discussed with senior nurse managers and nursing tutors during the inspection. However records and practices in place did not accord with national policy as published on the Department of Health website, to show that;
- alternative measures prior to using the restraint had been tried, for how long, how recently or with what results
- risks involved in using the restraint had been considered
- what were the benefits, if any, of using the restraint as opposed to other measures.

Judgment:
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:
Inspectors found that there were policies and procedures in place for risk management, emergency planning and health and safety within the centre. Risk management and health and safety policies and procedures were available and implemented throughout the centre. The health and safety statement was reviewed annually and reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre were found. Arrangements were also in place for investigating and learning from serious incidents/adverse events involving residents, for example a falls risk programme called 'forever autumn' was in place which identified residents who were at risk of falls and put in place appropriate measures to minimise and manage the risks. Inspectors found that this system also promoted residents rights to respect dignity and confidentiality through the use of visible yet discreet symbols.

A risk register was maintained and available which in general covered the identification and management of environmental risks in the centre.

The emergency plan detailing procedures to be followed in the event of fire, gas leak, chemical gas explosions, intruders and flooding and the associated evacuation procedure was clearly visible on all units. There were also separate fire procedures clearly visible on the units. Detailed floor plans were displayed beside these instructions, although all emergency exits were not clearly indicated on these maps.

Inspectors reviewed documentation relating to fire safety including: daily and weekly check lists completed by staff, certificates confirming servicing of fire equipment including fire extinguishers, fire blankets and emergency lighting, and service reports for the fire alarm system. Fire drills within the centre had been commenced in February 2015 and inspectors were shown the planned schedule for fire drills for 2015.

However, at the time of inspection, fire drills had not yet been conducted in all units within the centre. Although, some staff spoken to were on the whole knowledgeable regarding procedures to be followed in the event of fire, and had recent training, overall staff knowledge was inconsistent regarding the procedures to be followed in the event of fire, including the identification of the person on duty who would co-ordinate the evacuation.
Safe systems to ensure residents were protected from risks of burns were not implemented. Inspectors carried out random checks on water and radiator temperatures in some areas and found water temperatures in excess of 60 degrees and radiator temperatures of 46 degrees. This was brought to the attention of the provider nominee prior to the end of inspection who responded promptly to address the risk. Evidence was provided that the risk was mitigated with recordings shown to inspectors that the water temperature was regulated to 43 degrees however ongoing review of the implementation of checks to monitor water and radiator temperatures was found to be required. An action in relation to this finding is included under Outcome 12 Premises

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Medication Management**

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

**Theme:**
Safe care and support

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

**Findings:**
Inspectors found that there were written operational policies in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents. There was a comprehensive system in place for reviewing and monitoring safe medication management practices, including the review of medication errors. However Inspectors observed a number of practices that were not consistent with appropriate medication management practice, including the documentation of administration of medicines to residents, the times of administration, prescribing issues and storage conditions for certain medicines. Some of these findings and actions required are detailed under Outcome 5.

Medicines were supplied by a retail pharmacy business in a monitored dosage system that consisted of individual 'pouches'. All medicines were stored securely within the centre, and fridges were available for all medicines or prescribed nutritional supplements that required refrigeration.

Inspectors found that certain medicines were not being stored appropriately on one of the units, and that opened bottles of medicines and nutritional supplements were not being marked with the date of opening.

Inspectors found two types of medication were stored inappropriately in the window of one of the designated medication storage room and two of the nutritional supplements stored in the fridge had no date of opening recorded on the bottles. Staff were not
consistently indicating the dates on which certain prescribed liquids and nutritional supplements had been opened on other units.

The documentation of administration of medicines to residents was not being completed according to the centre's medication management policies. Inspectors reviewed a number of medication prescription and administration sheets and identified a number of issues that did not conform with appropriate medication management practice. These findings are outlined under Outcome 5.

Inspectors also observed that on one unit the morning round of medicine administration was still not completed at 11.15am, which was outside the acceptable prescribed timeframe for those residents to receive their medicines.

The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland, and inspectors reviewed minutes of multi disciplinary team meetings attended by prescribers, nursing staff and the pharmacist.

Medication audits were conducted in the centre and inspectors reviewed one of the resultant action plans. Medication errors were appropriately recorded and discussed at clinical incident review meetings and also at the drug and therapeutics committee. The quality and safety manager, and the practice development assistant director of nursing follow up on any action plans associated with these medication errors and ensure appropriate feedback to staff, and that any learning needs are identified and implemented.

Judgment:
Non Compliant - Moderate

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**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 occurring in the designated centre was maintained and, where required, notified to the Chief Inspector.

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

Theme:
Effective care and support

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

Findings:
Residents had good access to medical care and consultant geriatrician services. There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services. Access to palliative care specialists, dietician physiotherapy and speech and language were also available.

The arrangements to meet residents’ assessed needs were set out in individual care plans and each resident had some care plans completed, but care plans were not found to be in place for every identified need. Although for the majority of residents, healthcare needs were met, significant areas for improvement continued to be required in the documentation of care given and these findings replicate findings made on previous inspections.

A strong system to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents’ health was not in place. These plans were not being checked regularly to make sure they were detailed enough to maintain or improve a resident’s health. The daily nursing progress notes did not always refer to changes in health care plans or changes to treatments or recommendations made by clinicians to give a clear and accurate picture of residents’ overall health.

Examples include;
- healthcare plans were not in place for residents with active medical issues such as; respiratory tract infections; high blood pressure; epilepsy and depression.
- recommendations by clinicians for changes to treatment regimes were not always included in care plans which were in place and this resulted in delays to commencement of recommended treatments.
- where care plans were in place they did not contain enough detail to ensure they were effectively managing the health problem for example care plans in place to manage pain did not reference the site of the pain; whether the pain was acute or chronic and was not linked to an assessment of the level of intensity/frequency in order to prevent or reduce its recurrence.
- all care plans were not reviewed on a quarterly basis or as needs changed as required by the regulations and in some instances it was noted that care plans had not been
reviewed since May 2014. Where plans were reviewed the review did not include a
determination of effectiveness to ensure improvement in the standard of care being
delivered.

It was also found that most although not all care plans were generic in nature and were
not person centred.

A number of core risk assessment tools to evaluate levels of risk for deterioration were
also completed but comprehensive assessments were not fully completed for every
identified need. These included cognitive impairment assessments; nutritional
assessments and restraint assessments.

Overall it was found that evaluations of care plans together with nursing progress notes
and other supporting documentation to evidence the delivery of a high standard of care
were not appropriately linked to give a clear and accurate picture of residents’ overall
health management.

A requirement to improve clinical governance to ensure resident’s healthcare needs
were appropriately identified, assessed, managed reviewed and implemented is further
referenced under Outcome 2 in 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 designated centre is comprised of the following:

Teach Iosa, which was established in 2007 accommodates 100 male and female
residents in four wards, Oisin and Conall on the ground floor, Ailbhe and Tara on the
first floor (25 male and female residents in each). This unit is built around a court
yard garden and the accommodation in each of the four units is comprised of 17 single, two
twin and one four bedded bedroom, all of which have a small patio area and en suite
shower facilities. Communal space in each unit is different and includes separate
sitting/conservatory areas or combined sitting/dining/recreational rooms. Oisin unit has a family room, quiet prayer room and facilitates the laundry service for Teach Iosa.

Teach Cara has 50 beds in two mixed gender wards Bebhinn (ground floor) and Setanta (first floor) which accommodate 25 male and female residents in each with 17 single, two twin and one four bedded bedrooms. All of which have en suite shower facilities. A laundry facility in teach Cara services 86 residents in Bebhinn, Setanta and Chapelview. Additional facilities located on the site which serve the designated centre include pharmacy, large main kitchen with full catering team, porters, stores/logistics and maintenance buildings, activity centre, chapel of rest and administration buildings.

The inspectors found that Teach Iosa and Teach Cara met most of the residents' needs. The units were clean, clutter free and adequately lit with both natural and artificial light. Each resident was encouraged to personalise their own room if they wished and some residents had brought in their own furniture and replaced the curtains in the room. All single rooms on the top floor had balconies that many residents had decorated with flowers and plants. Efforts to provide a warm domesticated and comfortable living environment was noted in many parts of these units such as art work and pictures, the creation of a 'remembrance corner' using furniture and ornaments donated from families and staff. Both of these units were found to have both communal and private space to allow residents to receive visitors. Residents also had access to enclosed outdoor spaces, such as courtyard rooftop gardens. Shared twin and four bedded rooms were observed to be large with sufficient space for the use of assistive equipment such as hoists and appropriate screening. Sufficient storage was available for personal possessions and shower and toilet facilities were located a short distance across the corridor. A dining table was situated in the centre of the room which was used as an activity space outside of meal times.

Overall for both Teach Iosa and Cara it was found that in general, adequate private and communal space was provided and the design, layout and decor of these units provided a comfortable environment for residents with appropriate furnishings and areas of diversion and interest. Residents' bedrooms were personalised with pictures photographs and home furnishings. Call bells were available in reach of residents, grab rails and safe flooring facilitated safe mobilising and in general the centre was comfortably warm.

However, issues identified on previous inspections in relation to limited dining room space in both units were again found on this visit and other improvements were found to be required and these include;
- limitations to dining room space remain to be addressed. These rooms were small and unable to facilitate more than 10 residents at any one time.
- call bells in day rooms were not always available and where they were provided were not accessible to residents
- residents ensuite bathrooms particularly those on the external perimeters of the units were cold. Inspectors were told that this was a long standing problem with the underfloor heating which staff had raised many times with the maintenance department but as yet has not been resolved. As a result staff often warm the bathrooms using portable heaters before residents can use it.
-although appropriate and sufficient assistive equipment was in place and available for use and most were found to be in good working order, with up to date service records some items of equipment were noted to be in need of repair and servicing such as a shower trolley that it had not been serviced since 2013. The hose for expelling water from the trolley was also visibly broken. Staff confirmed that this trolley was still in use.

The Chapel view building is an old detached building and currently does not meet the requirements of Regulation 19 or Standard 25 (Physical Environment) of the National Quality Standards for Residential Care Settings for Older People in that the physical design and layout of the premises does not meet the needs of the current resident profile and overall the unit was not accessible, hygienic, spacious or well maintained. Internally the building requires significant maintenance and re decoration work to be completed, as there is paint visibly peeling off the walls in numerous areas and tiles that require replacement. The internal corridor was found to be very dark, as were all the four bed wards located on both sides of the unit.

The unit consists of; eight four bed communal bed rooms and four single rooms. It also contains;

Four toilets and two of the following; bathrooms; sluices; linen rooms; nurses offices and one of the following; day/dining room kitchenette; clinical room; staff room; staff shower and toilet

The single rooms did not facilitate resident’s privacy or dignity. These rooms were located between two corridors with doors on both sides and inspectors noted that there was a constant throughput of staff going through these rooms with both doors open at all times. These rooms also required to be reviewed in terms of layout to ensure sufficient space for personal possessions and use of assistive equipment. Currently the design and layout of all communal bedrooms do not meet resident’s needs. Space between beds is very limited with barely sufficient room for staff to stand between beds to provide care, particularly when residents are sitting out in chairs at the side of their beds. Each resident has a small locker and narrow wardrobe for storing their clothing or other personal possessions. Adequate storage space for large items of equipment is not available and most equipment is stored in various areas including bathrooms, toilets single rooms and on the corridors.

Residents did not have access to appropriate and sufficient toilet and shower facilities. A total of four toilets and two assisted bathrooms were available for 36 residents, however, one was out of commission resulting in three toilets for 36 male and female residents. The availability of one toilet and one bathroom to 18 residents is not adequate and is a recurrent issue as a toilet was also out of commission on the last registration inspection and raises concerns that the provider has not seen fit to repair replace or otherwise meet the basic needs of residents or promote their rights to privacy dignity, choice, or well being over the last three years.

Little effort to improve or maintain the fabric of the building was found since the initial registration inspection in 2011. At that time it was noted that full refurbishment of all residents bedrooms furniture and décor; repairs to paintwork, skirting, architrave, doorways, windows and window frames, radiators, flooring and wall tiles or paintwork in all rooms, corridors sluice areas, showers and toilets was required yet no evidence of any improvements were found on this visit.

Some evidence was available that the provider had commenced the process of reviewing and replacing old equipment and a number of new profiling beds were in place. This
review needs to be continued for all equipment including but not limited to; bed tables
lockers wardrobes beds commodes shower chairs and wheelchairs. Improved levels of
lighting throughout but particularly in and on the internal corridor where there is limited
natural light and a limited view to the external environment.

Communal space was very limited with only one large day room used for all activities
including dining for all meals. There was one small room available on both the male and
female side that could be used by residents to receive visitors, watching TV or other
recreational activities but one of these was also used to store supplies and also
contained staff lockers, and both rooms lacked privacy as they were accessible from
both corridors and used as access routes on an ongoing basis.

Inspectors checked the temperature of the hot water in various locations on the unit
and found that the temperature ranged from 58-62 degrees Celsius, posing a risk of
scalding to residents using any of the wash-hand basins or hot water supply in any of
the toilets or bathrooms. The hospital manager immediately contacted the necessary
maintenance personnel to ensure that this problem was rectified as soon as possible.
Externally, improvements were noted to the grounds of the centre with improved
directional signage and lighting, general tidiness and cleanliness, maintenance of
bedding and pavement. Safety aspects in the grounds had also improved with gates in
situ at the main entrances which are closed at night and on site security personnel in
place.
However it was noted that one wall between Teach Iosa and the Chapelview units was
in a poor state of repair and at risk of collapse, this wall was being propped up by bricks
and planks of wood.
This was brought to the attention of the provider who advised inspectors the
management team were trying to resolve this issue but the wall was a protected
structure and this was causing delays in appropriately addressing the repair.

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:**
It was found that the centre had an effective complaints procedure. However this
procedure was not found to be consistently applied throughout the whole centre.
There was an up to date policy on the management of complaints in place in the centre. The inspectors reviewed the complaints logs in both Teach Iosa and Teach Cara. It was found that all complaints had been appropriately responded to, followed up on and investigated where required. Evidence that the complainant had been informed of the outcome of any investigation was also noted. Verbal complaints were being documented and responded to in an appropriate manner. A user friendly complaints procedure was on display in a number of the units, although not on all.

One unit did not have a complaints policy displayed or available for staff or residents and staff informed inspectors that a record of complaints was not in place.

Judgment:
Non Compliant - Moderate

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**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:**
All lines of enquiry were reviewed in full under this outcome on a thematic inspection in June 2014 an overall care practices and outcomes for residents and relatives were to a high standard. However some aspects were found to be in moderate non compliance.

Only those aspects which required to be improved were reviewed again on this inspection.

Findings on this inspection replicated those on the thematic inspection in that arrangements were in place for capturing residents’ end-of-life preferences in relation to issues such as; preferences for place of death or funeral arrangements. Equipment and facilities for both residents and relatives were available to a good standard and religious and spiritual needs were all met.

However improvements to care planning systems including an end of life plan of care to identify, implement and manage all care needs associated with the active dying phase was still not in place for residents who required same.

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

Theme:
Person-centred care and support

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

Findings:
All lines of enquiry were reviewed in full under this outcome on a thematic inspection in June 2014 and overall it was found that residents’ nutritional status were assessed and reviewed as necessary and there was appropriate access to allied health professional and associated services such as dental, dietician, speech and language diagnostic services.

All residents spoken with praised the quality of the food and confirmed that it was appetising and a dietician review of the menu found it was wholesome and nutritious. Service of meals in the dining room, the options available outside of core meal times and the promotion of independence and choice required to be reviewed. On review of a sample of clinical documentation it was noted that there were improvements to care plans risk assessments and monitoring of nutritional intake.

Good practices in relation to; provision and use of assistive equipment; choice and presentation of food; regular snacks offered and availability of accessible water were found again on this occasion and discussions were held to improve hot options available for residents who miss meals during the day and do not return to the centre more than 90 minutes after the main kitchen closes.
A determination on the adequacy of documentation of food intake could not be made as food monitoring was not in place for those residents reviewed by inspectors.

However some aspects were found to be in moderate non compliance on the thematic inspection and were reviewed again on this inspection.
Improvements continue to be required in the following areas;
- the three week rolling menu offered choice to residents on both normal and modified diets only six days of the week-no choice was available on one day each week.
- the provision of assistance in a dignified manner to those residents who required same with their meals was found to be inconsistent.

In some areas staff and volunteers were found to be providing assistance in a respectful unhurried and dignified manner, however in other areas it was noted that some staff stood over residents, did not wait to ensure they had swallowed one portion of food before attempting to give another and were using large table spoons to place large volumes of food in the mouths of people with swallowing difficulties who were assessed as having trouble coping with large volumes of food in their mouth.
An action in relation to this is included under Outcome 16.
Judgment:
Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
A consultation process was found to be in place for residents although it was noted that it was not consistently implemented.
Residents' meetings were held at regular intervals in most units and the minutes of some of these were reviewed by inspectors. The meetings were facilitated by external advocates. Any issues that arose from these meetings were passed on to the relevant person in charge who discussed it with the Clinical Nurse Managers of the relevant unit. Suggestion boxes were also on display on each ward for any resident or family member to provide feedback at any time they wished. Feedback questionnaires were issued to residents yearly and in a sample viewed, all issues that arose were addressed.

Access to internet had been requested by residents a number of times. Documents viewed confirmed that management team had explored all options to try to facilitate internet access however this had proved unsuccessful to date. Although it was noted that management had worked very hard to meet residents requests it had been over two years since the request was made and inspectors were told they had received few updates on progress throughout this period.

The inspectors found that the residents' civil, political and religious rights were met. Residents who choose to vote in local/general elections or in any referendum were facilitated to vote in the main building in St. Mary's Hospital. Catholic mass was held three times a week. Staff also informed the inspectors that a Church of Ireland minister visited the centre every three months, or more regularly if requested by any residents who wished.

Residents were able to receive visitors in private. They all had access to newspapers, television and had access to a portable land line telephone which they could take in private if they wished.
However improvements to residents’ rights and choice in relation to the availability of confidential information was found to be required. Confidential information contained in files were held either at the base of their bed or outside their bedroom door. There was no evidence that all residents had been consulted with to receive their permission to store their personal information in a location that was openly accessible. It was further noted that guidelines relating to aspects of care provided to manage identified needs were displayed above their beds.

**Judgment:**
Substantially Compliant

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**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

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

**Findings:**
With the exception of issues found in the chapel view unit under outcome 12, inspectors found there was adequate storage for residents belongings, and that residents were enabled to maintain control of their own personal belongings in Teach Cara and Iosa.

All residents had their own wardrobe and bedside locker, this included lockable storage. Records of each resident's personal belongings was taken on admission to the centre. This was also updated each six months to ensure personal belongings were safe and secure in the centre. The centre did not hold any personal money for residents.

The inspectors reviewed the laundry facilities in the centre. It was determined that the laundry facilities were adequate to ensure that each resident's clothing and personal belongings was returned to them. Each resident's laundry was placed in individual blue bags that were labelled with their name. Each residents clothing was washed separately and returned to the residents room with a new labelled bag placed on top of the clothing. All clothing was laundered in the centre, whereas linen was sent to an external company.

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

Theme:
Workforce

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

Findings:
It was found that at the time of this inspection, the levels and skill mix of staff were sufficient to meet the needs of residents. The staff rota was checked and found to be maintained with all staff that worked in the centre identified. Inspectors noted there was no reduction in staffing at weekends or on night duty. A bank of relief staff provided cover to units for planned and unplanned leave. Actual and planned rosters were in place in all units.

Although many warm and mutually respectful interactions were found between residents and staff throughout the inspection and in conversations with many residents staff were highly praised for the good humoured manner in which they delivered care, improvements were found to be required such as;
- although work systems in place included supervision of care delivery on a daily basis by nursing staff and clinical nurse managers there was evidence of a culture of institutional practices which did not evidence a good standard of nursing practice. Examples include; lack of evidence of regular showers and hair washing; high use of restrictive practices; inappropriate assistance to residents at mealtimes which did not promote or uphold residents dignity.
- training for all staff in areas of practice which require mandatory training such as fire safety, moving and handling had been delivered but all staff had not attended training in safeguarding and prevention of elder abuse. Also further training was noted to be required in areas of clinical practice such as, restrictive practice assessment and care planning; documentation and recording of care and dementia care.
- appropriate and sufficient supervision and guidance, auditing of care delivery, assessments and implementation of care interventions by the senior management team and clinical nurse managers was not in place to prevent the continuation of institutional practices and raise the standard of nursing practice.

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:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Phoenix Park Community Nursing Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000476</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>10/03/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22/06/2015</td>
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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:
Management systems in place did not ensure that the service provided was safe, appropriate to residents’ needs, consistent and effectively monitored.

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

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:

1. Schedule of Audits – an audit cycle has been developed by senior management to address issues highlighted in report. This audit cycle will include care plans, restraint procedures, medication management, meals and mealtimes, complaints, fire policy and procedures. Action plans will be formulated after each audit by the person(s) carrying out the audits with the CNM. It will then be signed off by the CNM. Findings of Audits and actions plans will be reported back to the Audit Committee (see point 2) for monitoring. This group will in turn report to the Clinical Quality & Safety Committee which meets every two months. See attached copy of audit cycle for further information.

2. One single Audit Governance Committee will be established with provider nominee, Persons in Charge, Quality & Safety Manager, Practice Development, Nurse Tutor and representative HSCP and CNM’s which will focus on these issues. Findings of audits, actions plans, re audits and findings of these will be reviewed by this group and will feed directly into the clinical Quality & Safety committee on campus as standing agenda item. This group will be chaired by the provider nominee.

3. Nursing Metrics will be a standing item on all ward meetings as well as monthly meetings with Senior Nurse Managers. Nurse Managers are now bringing the Nursing Metrics and their action plans to monthly CNM meetings. Nursing metrics will be incorporated into the Audit Governance Committee as described above. The electronic Traffic Light system, with associated percentage, will be beneficial in identifying performance levels at a glance and will aid presentation and feedback to both staff and Senior Nurse Managers and the Governance Group. Action plans will be developed and implemented in order to improve standards of care and thereafter staff will continue to monitor progress in terms of quality improvement in these areas. Each ward will have their own audit folder with copies of all relevant documentation.

4. The new care planning system introduced in late 2014 has been audited since the inspection and recommended changes were brought to the care planning committee on 27/04/2015. These changes include changes to Assessment of Activity of daily Living, Daily care plan sheet, changes made to bed rail assessment tool and the structure was modified (e.g. the amount of weeks on each page was reduced to make it more legible).

5. Nurse Tutor is spending one day per week on the wards to provide support to staff on the ground looking at standards of practice. Feedback on her findings will be reported monthly to Director of Nursing and Persons in Charge at the senior nurse manager meeting.

6. Allied Health Professionals have been communicated to regarding how information needs to be conveyed at ward level to ensure that it is included in care plans.

Proposed Timescale:

1. Schedule of audits has been developed. See attached audit cycle.

2. Single Audit Governance Committee to be established by 31/05/2015 which will be chaired by provider nominee.

3. Audits as outlined on cycle to be completed by 30/08/2015 with follow up actions clearly assigned as described above.

4. New care plans will be put in place on all wards by 30/08/2015

5. Nurse tutor has commenced her work on the floor.

6. Communication to Allied Health Professionals regarding communicating information has been issued.
Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The medication management policies and procedures in the centre were not being fully implemented to ensure safe administration, prescription storage and auditing processes were followed which meets current best practice according to relevant professional guidelines for example;
-the balance of one of the MDA (controlled) drugs was not accurate at the time of inspection.
-all medicines were not being stored appropriately
- all liquid medications such as nutritional supplements were not being marked with the date of opening
Other findings are detailed in the body of this report.

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:
1. The practice of transcribing MDA balances into a separate record book has now ceased. This will reduce the risk of transcribing error.
2. Medications are no longer stored inappropriately. Reminder posters were circulated to all CNM’s for display in treatment rooms
3. Labels are now put on each bottle when opened.
4. All of the above measures to be included in the medication management audit
All actions have been completed.

Proposed Timescale: 22/06/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All polices listed in Schedule 5 had not been reviewed within the past three years.

Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them
Please state the actions you have taken or are planning to take:
- Responding to emergencies policy is currently being drafted. Emergency plan is in place.
- Staff training and development policy is National HSE policy. In place.
- The service uses the National HSE “Safeguarding Vulnerable Persons at Risk of Abuse Policy”.
- Use of restraint is National HSE policy and the policy is due for renewal locally in May 2015. There will be revisions to reflect the use of restrictive procedures included.
- Provision of information to residents policy being reviewed
- Creation of records policy being reviewed
- Temporary absence and discharge of residents being reviewed
All above policies will be reviewed by 31/05/2015

Proposed Timescale: 31/05/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risk management policy was not being fully implemented in respect of the use of restrictive practices.
There was a lack of full and appropriate assessment in relation to the use of non integrated bed rails with gaps at the top and bottom of the bed that had not been appropriately risk assessed to ensure the safety of residents.

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:
1. The Restraint Policy was reviewed in May 2015. Restrictive procedures have been added to the policy. The policy will be signed off by the senior Management Committee and the policy will be circulated to all departments. Compliance with the policy will be monitored through audit. Please refer to the Audit Cycle Schedule attached with this action plan.
2. Information on restrictive Procedures has been added to the Restraint Policy Education Programme which commenced from 25/03/2015. It is mandatory that all staff attend Restraint Training. The managers are responsible to ensure that their staff members are up-to-date with the training.
3. Risk assessments are currently being carried out for all residents with non integrated bed rails
4. Changes in practice at ward level will be supported by the Nurse Tutor

Proposed Timescale: 1. The restraint policy has been reviewed.
2. Restraint Policy Education Programme commenced from 25/03/2015
3. Risk assessments for all residents with non-integrated bed rails will be completed by 08/05/2015

**Proposed Timescale:** 08/05/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The Directory of Residents did not contain all information as listed in Schedule 3.

**Action Required:**
Under Regulation 19(3) you are required to:
Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

**Please state the actions you have taken or are planning to take:**
The service now has one directory which includes all required information about current residents in addition to information regarding deaths for the particular year.

**Proposed Timescale:** 22/06/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records of medication administration were not being maintained in accordance with relevant professional guidelines as required under Schedule 3 (d) (e) of the regulations in that:
- nursing staff were signing the administration record before administering the medicines to the resident
- not all of the prescription and administration sheets indicated that a review of the resident's medication had been completed at the required intervals.

**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:**
1. Direct observation of drug rounds are taking place by practice development department to ensure that signing practices are in line with best practice guidelines. 4 units have been carried out since the inspection took place. Feedback was given immediately as required.
2. Review of photographs on all Kardex to take place with immediate effect. A
3. Communication has been issued to staff to remedy with immediate effect.

4. Drug Kardex has been redesigned to accommodate prescribed frequency & has been ordered with HSE print.

5. Existing medical staff have been communicated to by the medical director stating the requirement to ensure that 3 monthly reviews of prescribed medications are carried out and that the ‘review date and signature’ box on the Kardex is completed to highlight these reviews have taken place.

6. Existing medical staff have been communicated to by the medical director stating generic prescribing is to be encouraged.

7. Existing medical staff have been communicated to by the medical director that they need to indicate which drugs may be crushed.

8. Existing medical staff have been communicated to by the medical director that the maximum daily dosage for PRN medicines must be clearly indicated.

9. All of these directives will be included in the rolling induction programme with each intake of new medical staff.

10. A reminder checklist of these directives will be issued to all medical staff 3 months following each induction session and medical staff will be required to acknowledge in writing that they are adhering to these directives.

11. These directives will be included in medication management audit.

12. Issues of relevance to medical staff arising from these audits and review of the returned checklists will be fed back to the Drugs and Therapeutics committee and any issues arising will be dealt with directly by the medical director.

13. These directives were discussed at Practice Development meeting 24/04/2015 & will be discussed at the next Drugs & Therapeutics Committee on 18/06/2015.

1. Direct observation of drug rounds on each ward in the PPCNU will be carried out by 30/06/2015.

2. Drug Kardex to be reissued by 31/05/2015.

3. Communication was issued to all existing NCHD’s.

4. These points will be included in induction programme from July 2015 for new intake of NCHD’s.

5. A reminder checklist will be issued to all NCHD’s 3 months following each induction session.

4. All the above Points will be discussed at next Drugs & Therapeutics Meeting on 18/06/2015.

**Proposed Timescale:** 31/07/2015
Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence to show that all considerations were explored, in line with national policy as published on the Department of Health website, and found to be unsuitable before a decision was taken to use a form of physical restraint was not available.

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:
1. The bedrail assessment tool has been reviewed and updated to reflect best practice in line with national policy. A commitment to providing a restraint free environment is being promoted.
2. A review of all the residents who have bedrails in use will be conducted with the CNM’s and the Nurse Tutor. The outcome of the systematic review will be that the bedrail usage will decrease and the staff nurses will be able to state the rational for bedrail usage which is evidence–based and compliant with the regulations. It is expected there will be an increase in the nurses knowledge of the regulations and standards in relation to restrictive procedures.
3. An education programme has been developed and will be provided to staff on the use of restrictive procedures. This will focus on alternative measures which can be implemented. This commenced on 25/03/2015
4. A restraint audit will be done within the first week of initiation of the procedure and then quarterly after this by the Nurse Tutor.
5. Ongoing monitoring of usage will be carried out by the Persons in Charge.

Proposed Timescale: 13/05/2015
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:
Some units within the centre had not completed fire drills at the time of inspection. Fire drill were not conducted in all units within the centre and staff knowledge was inconsistent regarding the procedures to be followed in the event of fire, including the identification of the person on duty who would co-ordinate the evacuation.

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

Please state the actions you have taken or are planning to take:
1. A programme for fire drills has been established for each of the units to comply with twice yearly requirements with the support of the HSE fire training safety officer
2. A consistent approach to fire is being adopted across the service. Each day a specific individual is assigned by the CNM for fire safety.
3. An audit of adherence to fire policy and procedures will take place
4. Maps on wards have been updated locally to clearly highlight emergency exits. In addition architect maps will be reconfigured and simplified professionally to address this issue.
Proposed Timescale: 1. All 7 units completed the first of the twice yearly fire drills by 30/04/2015
4. Has been actioned
5. Audit of adherence to fire policy and procedures will be carried out by 31/05/2015.
6. Maps will be completely finished by 31/05/2015

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:
Medicines were being administered to residents at times later than those indicated by the prescriber on the prescription sheet.

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
Please state the actions you have taken or are planning to take:
Length of time carrying out the round will be included in direct observation audit. In addition to direct observation of medication administration rounds all staff will be reminded to wear the red apron during medication administration in an effort to reduce the number of distractions and interruptions during administration which will assist in reducing the administration time. Increased support for Agency nurses will be provided by Clinical Nurse Managers or Senior nurses at medication rounds as required. Where medication rounds are taking longer than one hour the resident’s doctor will be notified and medication prescription times will be amended to accurately facilitate feasible administration times

Proposed Timescale: Direct observation audits on each of the units in the PPCNU will be completed 30/06/2015

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

### Outcome 11: Health and Social Care Needs

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Assessment, care planning and clinical care did not accord with current evidence-based practice. Complete comprehensive nursing assessments were not carried out for each resident.

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

Please state the actions you have taken or are planning to take:
The assessment tool has been reviewed to ensure all areas are assessed on admission. Changes made include adding diagnoses. A care plan will be devised for any ongoing issues which require active intervention. Any current issues will have active care plans. Appropriate referrals to the relevant Health and Social Care Professionals will be made.

Proposed Timescale: 1. The assessment tool has been reviewed by 15/05/2015 and necessary changes made.
2. All new admissions are now using this revised tool.
3. Assessment tool for current admissions will be phased out within 3 months as 3 monthly assessments take place.

**Proposed Timescale:** 15/05/2015
Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence that all care plans were reviewed on a quarterly basis or as residents needs changed and records of residents current overall condition as required by the regulations was not available

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:
1. Care plans will be reviewed on a three monthly basis by the Persons in Charge and nurse tutor.
2. Care plans will be updated as required for each resident
3. Narrative notes will be written to reflect changes in prescribed care.

Proposed Timescale: 1. See attached audit cycle for details of reviews.

Proposed Timescale: 08/05/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documentation of care was not sufficiently accurate or complete to determine that a high standard of evidence based nursing care was being delivered to residents to fully meet their personal and healthcare care needs.

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:
1. Care plans will be reviewed on a three monthly basis. The Persons in charge and Nurse Tutor will conduct quarterly audit to ensure the standards are being met. The Persons in charge will report findings back to the CNM’s and action plans will be developed with the support of the nurse tutor.
2. The nurse tutor following audits of the care planning system will meet with each nurse to discuss their care plan in relation to adequate assessments of the residents needs, providing interventions that are person centred and evidence based.
3. Additional support will be given to the CNM’s by the Nurse Tutor to ensure they can supervise and support the staff with their documentation.

4. All findings and action plans will be reported back to the Audit Governance Committee.

   1. The first of the care plan audits began on 22/04/2015
   2. CNM Care Planning Education will take place in Teach Cara on 11/05/2015

**Proposed Timescale:** 11/05/2015

### 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:**

The design and layout of the centre is not currently suitable for the purpose of achieving the aims and objectives set out in the statement of purpose.

**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:**

1. Senior management met with HSE Estates Department on 24/04/15 to review possible solutions in relation to the dining spaces in both new units. The units were visited by an architect on 28/05/15 who is currently drafting proposals for review. The scope of works, costed plans and a programme of works have not been clarified, but can be provided when available.

2. It had been the intention of the HSE to close the unit in question by June 2015. However, a decision was taken by the HSE at the end of 2014 to keep this unit open. As a result no works took place on the unit in the intervening timeframe as the unit was due to close. However, full refurbishment is planned for the unit. Supporting documentation was forwarded on 08/05/2015, including a refurbishment brief, a project update on Chapelview and a revised programme estimating that the unit will be ready for occupation by November 2017 subject to no delays to planning or approvals process. A progress report at Stage 2A will be forwarded in July which will address all key issues, and will include costings as well as developed sketch plans and confirmation that progress is per as the programme set out. Explicitly costed plans or other documents are not yet available from the design them so cannot at this time be provided. However, a number of meetings were held in June on site between stakeholders and the design team.

Proposed Timescale: 1. Progress on the above will be provided in 6-8 weeks.
2. Refurbishment of unit will be completed by 30/12/2017 subject to no delays in any of the process. Please refer to accompanying attachments previously submitted on 08/05/2015.
Proposed Timescale: 30/12/2017

Theme:
Effective care and support

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

The centre currently does not meet the requirements of Regulation 17 or Standard 25 (Physical Environment) of the National Quality Standards for Residential Care Settings for Older People in that; the physical design and layout of the premises does not meet the full needs of the current resident profile and all aspects of the premises are not accessible, hygienic, spacious or well maintained. The premises do not fully conform with all requirements of schedule 6 of the regulations

Examples include but not limited to;

- evidence that all equipment was annually serviced or maintained in good working order was not available
- the temperature of the hot water supply in one unit was at a temperature that posed a considerable risk of scalding to residents.
- emergency call facilities were not available or accessible in all rooms used by residents
- dining areas were not large enough to meet the needs of all of the residents
- adequate heating was not provided in some en-suites in the designated centre.
- the premises was not kept in a good state of repair internally
- the premises was not suitably decorated, had blistered plaster on walls and paint flaked on handrails, walls and architrave along corridors and in communal rooms in the chapelview unit
- an insufficient number of independent and assistive toilets, baths and showers
- multi occupancy rooms of four, five, six and eight bedded rooms were not suitable for individual and collective needs
- a lack of storage space for personal items and assistive equipment existed
- inappropriate storage of clinical and assistive equipment in sluice rooms, bathrooms, corridors, day rooms and smoke rooms was found in many areas
- a private place to receive visitors in private was not available
- maintenance was not adequate to support the needs of dependent persons, long standing problems with toilets out of order and under floor heating not addressed; corridor lights flickering and one external wall noted to be at risk of collapsing.

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:
1. Equipment mentioned – shower trolley has been serviced
2. Toilet is now in working order
3. Hot water temperature in chapel view has been regulated. A new boiler had been installed in the unit 5 days prior to the inspection. This was the reason for the high
water temperature and has since been resolved. A programme for weekly temperature checks is now in place.

4. Call bells are on order from the company responsible for providing them and should be in place by 30/06/15.

5. 2 ensuites have been done since the inspection. The method used appears to have resolved the problem. HSE Estates are developing a programme to address the remaining "cold " rooms which will involve two rooms being done together. It is estimated that this programme will be completed by 30/10/15.

6. Please refer to information provided in Outcome 12 above and additional documentation provided by HSE Estates addressing this matter forwarded on 08/05/2015. As stated above a progress report can be issued at Stage 2A in July 2015. HSE Estates are also available to meet with HIQA.

7. External Wall - A meeting was held between local HSE management, HSE estates and the Office of Public Works on 08/06/15 to identify a potential solution as this wall is a protected structure. A scope of works and costings for this work are currently being calculated by the OPW with a programme of works not yet clarified.

Proposed Timescale: 1. Call bells will be in situ by 30/06/15
2. Cold rooms will be completed by 30/10/2015
3. Refurbishment of unit will be completed by 30/11/2017 subject to no delays in the process
4. Works on external wall to be completed by 31/12/15

Proposed Timescale: 30/11/2017

### 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:
A record of all complaints made by relatives or their representatives or relatives was not maintained in all units within the designated centre.

**Action Required:**
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
1. A central record of complaints is always maintained by the provider nominee as designated complaints officer. A log of all complaints is being maintained on each unit.
2. Audit of complaints process will be conducted to ensure compliance with policy.

Proposed Timescale: 1. In place
2. Audit will take place by 31/05/2015
### 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:**
A copy of the complaints procedure was not prominently displayed in all units

**Action Required:**
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
The complaints procedure is prominently displayed in all units

### Proposed Timescale: 22/06/2015

**Outcome 14: End of Life Care**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
An end of life plan of care to identify, implement and manage all care needs associated with the active dying phase was still not in place for residents who required same

**Action Required:**
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

**Please state the actions you have taken or are planning to take:**
- End of life care plans are being reviewed and the nurse tutor has been consulted and is offering support to ensure these are person centred, reflecting the residents care needs and preference.
- Proposed Timescale: Has commenced and will be completed by 29/05/2015. There will be ongoing support provided to ensure standards are being met.

**Proposed Timescale: 29/05/2015**
**Outcome 15: Food and Nutrition**

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Ensure choice is available at meal times each day for normal and modified consistency diets.

**Action Required:**
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

**Please state the actions you have taken or are planning to take:**
There is a choice on the menu daily. Menus will be clearly displayed with all available choices on each unit.

**Proposed Timescale:** 22/06/2015

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**Outcome 16: Residents' Rights, Dignity and Consultation**

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents rights to choice and dignity were not upheld in relation to the storage and displaying of confidential information and assistance provided by staff at meal times.

**Action Required:**
Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

**Please state the actions you have taken or are planning to take:**
1. Alternative arrangements will be put in place to ensure swallowing guidelines are no longer on display above the resident's bed.
2. 1 hour training sessions will commence on May 11th facilitated by SLT will focus on safe eating and drinking guidelines, and will also encompass respect and dignity during dining experience.

**Proposed Timescale:**
1. Alternative arrangements will be put in place by 31/05/2015
2. Training sessions will take place once a week for four weeks and will be completed by mid June 2015.

**Proposed Timescale:** 15/06/2015
Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Appropriate and sufficient supervision and guidance, auditing of care delivery, assessments and implementation of care interventions by the senior management team and clinical nurse managers was not in place to prevent the continuation of institutional practices and raise the standard of nursing practice.

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

Please state the actions you have taken or are planning to take:
1. The governance structure has been streamlined. Meeting which were previously held with CNM’s and Practice development will now include the Persons in Charge. These meetings will focus on audit findings, standards and quality matters. It is intended that this integrated approach will raise the standard of nursing practice.
2. Schedule of Audits – an audit cycle has been developed by senior management to address issues highlighted in report. This audit cycle will include care plans, restraint procedures, medication management, meals and mealtimes, complaints, fire policy and procedures. Action plans will be formulated after each audit by the person(s) carrying out the audits with the CNM. It will then be signed off by the CNM. Findings of Audits and actions plans will be reported back to the Audit Committee (see point 2 ) for monitoring. This group will in turn report to the Clinical Quality & Safety Committee which meets every two months. See attached copy of audit cycle for further information.
3. One single Audit Governance Committee chaired by the provider nominee will be established with Persons in Charge, Quality & Safety Manager, Practice Development, Nurse Tutor and CNM’s which will focus on these issues. Findings of audits, actions plans, re audits and findings of these will be reviewed by this group and will feed directly into the clinical Quality & Safety committee on campus as standing agenda item.
4. Nurse Tutor is spending one day per week on the wards to provide support to staff on the ground looking at standards of practice

Proposed Timescale: 1. The nursing meetings described above will take place on the last Friday of every month.
2. Schedule of audits has been developed and is attached
3. Single governance group to be established by 31/05/2015
4. Nurse tutor has commenced her work on the floor.

Proposed Timescale: 31/05/2015

Theme:
Workforce
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff had not attended mandatory training in safeguarding and prevention of elder abuse.
Further training in areas of clinical practice such as, promoting a restraint free environment; assessment and care planning; documentation and recording of care were identified as required.
Additional training to ensure consistency of knowledge in fire safety and fire drills was also identified.

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

Please state the actions you have taken or are planning to take:
1. All of the nursing team members that are of date with mandatory training have been written to and given the next available training date. A copy of the letters has been sent to the CNM’s and a list of names was submitted to the Director of nursing on 23/04/2015. All staff whose training is out of date have been written to with details of next training dates
2. The nurse tutor following audits of the care planning system will meet with each nurse to discuss their care plan in relation to adequate assessments of the residents needs, providing interventions that are person centred and evidence based.
3. The CNM’s will be given education on the care planning system to ensure they can supervise and support the staff with their An education programme has been developed and will be provided to staff on the use of restrictive procedures. This will focus on alternative measures which can be implemented. This commenced on 25/03/2015
4. A programme for fire drills has been established for each of the units to comply with twice yearly requirements. 5 of the 7 units have carried out fire drills to date in 2015 with the support of the HSE fire training safety officer
5. A consistent approach to fire is being adopted across the service. Each day a specific individual is assigned by the CNM for fire safety.
6. An audit of adherence to fire policy and procedures will take place

Proposed Timescale: 1. Letters reminding staff of mandatory training obligations have been issued.
2. Ongoing training and support in relation to care plans has commenced
3. All fire drills will be completed by 30/04/2015
4. Audit of fire policy and procedures and action plans to address same will be completed by 31/05/2015

Proposed Timescale: 31/05/2015