

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Carlow District Hospital
<b>Centre ID:</b>	OSV-0000553
<b>Centre address:</b>	Athy Road, Carlow.
<b>Telephone number:</b>	059 913 6458 - 087 947 5854
<b>Email address:</b>	patricia.mcevoy@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Patricia McEvoy
<b>Lead inspector:</b>	Ide Cronin
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	10
<b>Number of vacancies on the date of inspection:</b>	8

## 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 decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
23 June 2016 09:00	23 June 2016 17:00
24 June 2016 08:15	24 June 2016 14:00

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

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

**Summary of findings from this inspection**

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority (HIQA) to register the designated centre. The inspector followed up on actions from the previous inspection, observed practices and reviewed documentation such as care plans, medical records, accident logs and policies and procedures.

The inspector met with the person in charge, provider nominee, assistant directors of nursing, clinical nurse manager and staff members. A number of questionnaires from residents and relatives were received and the inspector spoke to residents and a relative during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. The inspector found that overall residents' health care needs were well supported with good access allied health professionals.

It was found that progress was made by the provider in implementing the required improvements identified by the follow up inspection of November 2014. However, acceleration was required to progress the refurbishment of the centre's premises in order to meet the required standards. HIQA acknowledge that progress has been made in relation to the on going project of renovation works to upgrade the four designated general palliative care beds in the centre. These works are due to commence early in August 2016.

Improvements were also required in relation to care assessment and planning, medication management, staffing with particular emphasis on utilisation and deployment of resources to ensure effective consistent care for residents. Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed 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.

The provider has planned to close the centre from mid August 2016, in order to carry out significant refurbishment works. In light of this development it was decided to defer the registration decision until the refurbishment works are completed and the identified moderate non compliances are addressed.

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:**

The inspector was satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided. The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider.

**Judgment:**

Compliant

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

The clinical management structure was adequately resourced. However, as identified on the previous inspection it was not defined in terms of roles, responsibility and clear lines

of authority and accountability. There was an actual and planned duty roster in operation. However, the inspector found that it did not demonstrate an understanding of the levels of need within the service taking into account the client profile which should inform the planning and allocation of resources. The inspector observed that there was a clinical management presence only three days per week in the centre. The inspector found deficits on this inspection in aspects of clinical care and some practices were not in line with best practice and the provision of a sound contemporary evidence base to care.

As on the previous inspection the person in charge has remit for another centre governed under the umbrella of the Health Service executive (HSE). She is on site in this centre twice per week and always available by phone. There are two assistant directors of nursing (ADON). One of the ADON's has responsibility for this centre and would attend handover each morning as there is currently no senior nurse manager in the centre. The person in charge told the inspector this post has been filled but this staff member has not commenced the post yet. As identified on the previous inspection the inspector outlined that a clearly defined management structure was required to be implemented particularly in relation to clinical management structure. This would ensure effective use of resources which would provide a sustainable and improved service which would achieve better outcomes for residents.

The inspector viewed some audits completed by staff and management. Data was being collected on a number of indicators such as medication management, accidents and incidents, hygiene and care planning. The audits highlighted a number of issues and action plans were identified. However, the inspector did not see that there was an established system in place to elicit, use and disseminate feedback which would promote learning as there were ongoing non compliances in relation to areas around medication management and care planning. Further practice development and change management is required to ensure staff are providing care in accordance with contemporary evidenced-based practice.

There was an annual review of the quality and safety of care completed by the provider nominee and person in charge. The inspector observed that it was available on the notice board for residents, relatives and staff. Satisfaction surveys had been completed in January 2016 which included information in relation to hygiene in the centre, information, courtesy and assistance and overall satisfaction with the service. The inspector saw the results which were positive towards the staff and the service.

**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

<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p> <p><b>Findings:</b> A Residents' Guide was available which included a summary of the services and facilities provided, terms and conditions relating to residence, the procedure in relation to complaints and the arrangements for visits. There was also a centre-specific policy on the provision of information to residents. There was an information display area with relevant brochures to provide age appropriate information to residents in relation to protection, finances and bereavements support.</p> <p>The inspector also reviewed a sample of residents' contracts of care and noted that contracts were signed and dated by the resident or their representative. The contract set out the services to be provided. However it did not include the fee for the provision of care and services. Details of any additional services that may incur an additional charge were included. However, there were inconsistencies in relation to additional charges. The contract outlined that hairdressing was included in the fee and the nurse manger told the inspector that residents paid separately for this.</p>
<p><b>Judgment:</b> Non Compliant - Moderate</p>

<p><b><i>Outcome 04: Suitable Person in Charge</i></b> <b><i>The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.</i></b></p>
<p><b>Theme:</b> Governance, Leadership and Management</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The person in charge is the director of nursing who is also the person in charge for the Sacred Heart Hospital which is on the same campus. She took on the role of the person in charge for the Carlow District Hospital in addition to her substantive role in the Sacred Heart in August 2013. She is an experienced nurse and manager and is actively involved in the organisation and management of the service.</p> <p>In addition to significant experience in the care of older persons and management of a designated centre the person in charge had continued her professional development and undertaken post graduate training in nursing practice development and quality and safety in health care. She had a good reporting mechanism in place to ensure that she is aware and kept up to date in relation to the changing needs of the residents. Staff and</p>

residents identified the person in charge as the one with the overall authority and responsibility for the service.

The person in charge demonstrated good clinical knowledge and understanding of her legal responsibilities under the Regulations and Standards. The person in charge told the inspector her current division of time between both sites to ensure adequate supervision and management across both sites and was seen by the inspector to be knowledgeable around the services, residents and their needs.

**Judgment:**  
Compliant

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

**Theme:**  
Governance, Leadership and Management

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

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

**Findings:**

The inspector reviewed a range of documents, including residents' care records, staff records, the directory of residents, insurance certificate, medical and nursing records, duty rotas and training records. The inspector found that overall records were maintained in a manner so as to ensure completeness and accuracy. The directory of residents was in accordance with Regulation.

Some improvements were required in Schedule 2 records – the documents to be held in respect of staff employed, were available but in the sample of files examined the information was difficult to find and needed reorganisation to ensure ease of retrieval of the required information. In a sample of four files reviewed by the inspector there was no photographic identification available as required by the Regulations.

The inspector reviewed a sample of the Schedule 5 policies and found that they were comprehensive and provided guidance to staff. However, the inspector found that some policies did not reflect practices within the centre such as medication management and end of life care. These are outlined under Outcome 7 and 14.

The inspector viewed the insurance policy and saw that the centre was adequately

insured against accidents or injury to residents, staff and visitors.
<b>Judgment:</b> Substantially Compliant

<b><i>Outcome 06: Absence of the Person in charge</i></b> <b><i>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.</i></b>
<b>Theme:</b> Governance, Leadership and Management
<b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.
<b>Findings:</b> The provider was aware of the obligation to inform the Chief Inspector if there is any proposed absence.  As discussed in Outcome 4 the person in charge has responsibility for two centres. The assistant directors of nursing deputised in the absence of the person in charge for both centres. The inspector spoke with both assistant directors of nursing during inspection and found that they were knowledgeable regarding their legal responsibilities including requirements in relation to the submission of notifications to the Chief Inspector.
<b>Judgment:</b> Compliant

<b><i>Outcome 07: Safeguarding and Safety</i></b> <b><i>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.</i></b>
<b>Theme:</b> Safe care and support
<b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.
<b>Findings:</b> Measures to protect residents being harmed or suffering abuse were in place. A centre specific policy was in place for the prevention, detection and response to abuse. This

had been updated since the last inspection and incorporated the Health Service Executive (HSE) policy on Safeguarding Vulnerable Persons at Risk of Abuse 2014.

Staff had received training in adult protection to safeguard residents so as to protect them from harm and abuse. Staff knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including how incidents were to be reported. There were no active incidents, allegations, or suspicions of abuse under investigation. Residents spoken with stated that they felt safe in the centre. There was a visitors log in place.

The financial controls in place to ensure the safeguarding of residents' finances were discussed with the clinical nurse manager. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. Residents' finances were managed in line with the HSE, private property accounts procedures and subject to internal audit.

The centre had adapted the national policy on a restraint free environment to ensure residents were prevented from potential harm. Before implementing a restraint measure, an assessment was completed to determine the suitability of the restraint for the specific resident. There were five residents using bedrails at the time of inspection. There were no other physical restraint measures in use.

There was a policy on the management of behaviour that is challenging. Staff spoken with were familiar with resident's behaviours and could describe particular interventions well to the inspector for individual residents. Some staff had received training in management of behaviours that challenge and dementia care to ensure they have up to date knowledge and skills to respond appropriately.

**Judgment:**  
Compliant

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**  
Safe care and support

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

**Findings:**  
The provider had put systems in place to promote and protect the safety of residents, staff and visitors to the centre. There was an up-to-date health and safety statement dated May 2016. Staff had received training in health and safety. A recent health and safety inspection had taken place by the Health and Safety Authority (HSA). There was a

risk management policy and a risk register in place. However, it did not meet the requirements of legislation as it did not have the measures in place to control the following specified risks:

- accidental injury to residents, visitors or staff
- self harm

There was a comprehensive emergency plan formulated in relation to fire, all emergency situations and where residents could be relocated to in the event of being unable to return to the centre. Clinical risk assessments are undertaken, including falls risk assessment, assessments for dependency, continence, moving and handling.

Fire safety procedures were satisfactory with the fire alarm and emergency lighting serviced quarterly and other equipment serviced annually as required. The evacuation procedure was displayed at strategic points throughout the centre and staff were able to explain evacuation and emergency response should a fire occur. The inspector saw that staff had up to date fire training. However, the inspector saw that fire drills were not completed, including a drill simulated with the least amount of staff that would be available to ensure safe evacuation at all times.

There were systems in place to ensure good infection control management. There were hand sanitising solutions and hand gels available throughout the centre. These were noted to be used frequently by staff as they moved from area to area and from one activity to another. Hand washing and hand drying facilities were located in all toilet areas. There were good supplies of personal protective equipment available.

The training records showed that staff had up-to-date training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents needs. Each resident's moving and handling needs were identified and available to staff. Falls risk assessments and dependency levels were completed on admission.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. The assistant director of nursing told the inspector that the national incident management system was in the process of being rolled out. Currently the assistant director of nursing audits the accidents and incidents on a quarterly basis.

Measures had been put in place to facilitate the mobility of residents and to prevent accidents. These included the provision of handrails in circulation areas, grab-rails in assisted toilets and safe flooring in toilets and bathrooms. The centre had wide corridor enabling easy access for residents in wheelchairs and those people using walking frames or other mobility appliances. The centre had well-maintained enclosed gardens to the rear of the centre with seating for residents and visitors use.

**Judgment:**  
Non Compliant - Moderate

***Outcome 09: Medication Management***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration. Medications were stored in the drugs trolleys, which were secured when not in use. Medication was also stored in a locked cabinet. There was a fridge available for items requiring cool storage and the temperature was checked on a daily basis.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident. The prescription sheets reviewed were legible and distinguished between PRN (as needed), regular and short term medication. The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medicines were being stored safely and securely in the clinic room which was secured. Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses. However, the inspector observed that the controlled drugs were not checked at the changeover of shifts which would be in compliance with professional guidelines and legislative requirements. This was rectified by the second day of inspection.

There was a pharmacist available who provided support on medication management for nursing staff in the centre and nursing staff said that the pharmacist was always available by phone if required. The service provided training to staff on medication management. The inspector saw that a recent training day had taken place for all staff within the campus in medication management. None of the staff from this centre had attended this training. The inspector recommends that all staff attend refresher training on medication management to ensure that staff maintain and improve their competence in accordance with relevant professional requirements and the needs of the service.

The inspector observed that robust procedures were not in place to ensure effective and efficient stock control. Staff with whom the inspector spoke with stated that there were no agreed maximum or minimum stock levels to ensure that adequate stock is maintained that is not excessive and that only medicines required by residents were held in stock.

**Judgment:**  
Substantially Compliant

**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. Quarterly notifications had been submitted to the Authority as required and within the appropriate timeframe.

**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):**  
No actions were required from the previous inspection.

**Findings:**  
Medical care is provided by two medical officers who are contracted to provide a service for 15 hours per week. They visit each day to assess all newly-admitted residents and review other residents as requested by nursing staff. Records confirmed that residents were reviewed regularly by a GP which included regular medication reviews. Out-of-hours medical cover is provided by an on call doctor service.

The inspector reviewed a sample of the resident's care plans in detail and certain aspects within other plans of care to include the files of residents with nutritional issues, end of life care, and residents at high risk of falls. Overall, the inspector found that care plans for residents required review to ensure they are more person centred. The

inspector observed that the plans were not specific enough to guide staff and manage the needs identified as the individual needs were not linked to the plan of care.

Care plans for residents with dementia or cognitive impairment required review also, to ensure they are more person centred. In some instances the inspector found that while the degree of confusion was outlined for example "short term memory loss" there was no information that indicated how this impacted on daily life. Information such as who the resident still recognised or what activities could still be undertaken which would guide staff practice was not evident.

Residents had assessments of daily living and other assessments completed on admission which included; dependency level, moving and handling, falls risk, pressure sore risk assessment, nutrition, and mental test score examination. However, these also required further development to reflect their social needs and to ensure person centred care was delivered.

A narrative record was recorded for residents each day, and while this gave an overall clinical picture of the resident but did not convey the full range of care provided on a daily basis such as the social and psychological support provided to ensure residents well-being.

Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector. There was evidence of good communication with relatives when they visited and via the phone. The inspector found from talking with the staff and residents that residents' overall health care needs were met. Staff could describe changes to the identified needs of residents and delivery of care. The interventions described by the staff reflected the needs of the residents even though not always documented in the care plans.

There was no evidence of resident/ relative involvement in their care planning as identified on the previous inspection.

**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:**

Carlow District Hospital is a single-storey building which also provides facilities for Caredoc, a physiotherapy department and a number of out-patient clinics. The front door leads into a large entrance hall. Adjacent to the entrance hall are a room with a toilet and wash-hand basin for visitors, a large meeting/training room and a small office. Residential accommodation is provided in four single rooms and six four-bedded rooms, each of which has en suite facilities with wash-hand basin, toilet and shower. There is also a room with an assisted shower, toilet and wash-hand basin and another room with a toilet and wash-hand basin.

There is a nurses' station at the centre of the premises with an adjoining pharmacy room. There are offices for the person in charge, the CNM and the administrator. Staff facilities comprise a tea room, a changing room with individual lockers for staff and two toilets with wash-hand basins. There is a treatment room, kitchen, sluice room, linen room, a small room with a public telephone, and a number of storage rooms.

There is an enclosed garden with seating, which residents can access from a number of rooms in the centre of the building. CCTV cameras are used to monitor the entrance to and exterior of the building. Ample car parking facilities are available in the immediate vicinity of the building.

Carlow District Hospital was observed to be bright and clean. The majority of residents were accommodated in multi occupancy rooms which impinged on privacy and dignity. These rooms were generally not personalised. In many cases, lockers and wardrobes were quite small and did not accommodate sufficient clothing to allow residents to exercise choice. There was lockable storage for residents.

There was adequate communal space as there was now a day room and dining room in operation since the previous inspection. However, the inspector noted that there were a number of areas around the centre where there was paint coming off the walls. The sluice room contained appropriate equipment and facilities. There was sufficient assistive equipment in place and adequate storage for this. Cleaning schedules were observed on the back of toilet doors were seen to be signed and dated.

There were a sufficient number of bathrooms, shower rooms and toilets. There was appropriate assistive equipment available such as profiling beds, hoists, pressure relieving mattresses, a chair scales, wheelchairs and walking frames. There was ample storage space for special equipment which was in good condition and service records were available

The person in charge showed the inspector and outlined the plans to convert and upgrade part of the existing centre into a designated palliative care facility. Funding has been made available for that through various sources. These works are to commence early in August 2016.

**Judgment:**

Non Compliant - Moderate

***Outcome 13: Complaints procedures***

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The HSE policy and procedure for comments, compliments and complaints – “Your Service Your Say” was in operation. Leaflets outlining the policy and procedures and giving advice on how to make a complaint were available in a stand in the reception area. The person in charge is identified as the complaints officer for the service.

Staff interviewed conveyed an understanding of the process involved in receiving and handling a complaint. The inspector viewed a comprehensive complaints log and saw that complaints, investigations, actions taken and outcomes were documented in accordance with best practice and that feedback is given to the complainant.

**Judgment:**

Compliant

***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):**

No actions were required from the previous inspection.

**Findings:**

There was an end-of-life policy in place. End of life care formed an integral part of the care service provided at the centre. However, the inspector observed that the end of life policy did not reflect practices within the centre. The policy outlined that end of life care symbols were in use. The nurse manager told the inspector that they were not in use. The nurse manager also told the inspector that following a death debriefing within the staff team did not occur.

The policy of the centre is all residents are for resuscitation unless documented

otherwise. Records reviewed evidenced good input by the homecare team to monitor and ensure appropriate comfort measures. Medication was regularly reviewed and closely monitored to ensure optimum therapeutic values.

Staff spoken with had a good understanding of general end of life care. Staff had completed training in this area and had undertaken courses titled 'What Matters to Me'. One staff nurse was undertaking a post graduate course in palliative care. Individual religious and cultural practices were facilitated. Family and friends were facilitated to be with the resident when they were at end of life stage as observed by the inspector.

There was no evidence that the end of life needs and wishes of residents were discussed with them and/or their next of kin as appropriate and documented in a care plan. The care plans reviewed by the inspector did not address the resident's physical, emotional, social and spiritual needs. They did not reflect each resident's wishes and preferred pathway as part of their end of life care. There were inconsistencies in relation to the resident involvement in the decision making process relating to end of life care.

There was a policy on consent however the inspector was unclear of the process used to obtain a valid consent in accordance with legislation and current best practice guidelines. There was no evidence available in relation to consent being obtained from residents in relation to resuscitation orders. A do not resuscitate (DNR) status was written in a file viewed by the inspector. This had not been reviewed to assess the on going clinical validity of the judgement. There was no evidence of the residents' wishes or choices relating to treatment and care being discussed and documented and as far as possible implemented in order to maximise the principle of autonomy.

**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):**

No actions were required from the previous inspection.

**Findings:**

Meals were cooked in the Sacred Heart Hospital and transported over in a heated trolley. The inspector reviewed the menu and discussed options available to residents. There were nutritious snack options available between meals to ensure sufficient or optimum calorific intake particularly those for those on fortified diets.

A trolley served residents mid morning and afternoon offering a choice of tea/coffee and biscuits. The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in the kitchen and available to catering and care staff. The catering staff member who spoke with the inspector could describe the different textures and the residents who had specific requirements.

There was a good menu cycle. Menus were available to residents on the dining tables. The catering staff told the inspector that they advised the kitchen of the residents' requirements in advance. The dietary needs of residents were conveyed by nursing staff to the kitchen staff. The inspector saw specialist diets and residents likes and dislikes documented on a board in the kitchen.

Some residents required assistance and the inspector observed that this assistance was provided in an appropriate manner. The inspector observed that residents had access to drinking water at all times. Jugs of drinking water and glasses were present by the bedsides of residents.

There was prompt access to the GP and allied health professionals for residents who were identified as being at risk of poor nutrition. There was on going monitoring of residents nutrition and skin integrity. Nutritional screening was carried out using an evidence-based screening tool on admission.

**Judgment:**  
Compliant

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

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

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

**Findings:**  
There is currently is no residents' committee but residents are encouraged to express their preferences and needs. There was evidence of a good communication culture amongst residents, their families and the staff team. Residents were dressed well and according to their individual choice. The inspector observed staff interacting with residents in a courteous manner.

Staff told the inspector that they could follow their religious beliefs and said that they could attend mass or have priests or ministers visit them in the centre. However, mass was only held in the centre on an annual basis. There was mass available locally. Staff told the inspector that they would not routinely take residents to mass locally. Residents were facilitated to exercise their political rights and could vote in local, European and national elections.

A national newspaper was made available to residents each day and local weekly newspapers were also provided. Residents had access to televisions and radios but unfortunately as rooms were shared there was not choice on which programme you watched. On the days of inspection one resident asked if she could change rooms as she was unable to watch the programme that she wished. Some of the residents had their own mobile phones and a public telephone was also available.

Since the previous inspection 0.8 whole time equivalent (WTE) post has been allocated to activities to coordinate an activities programme. On the day of inspection there was a poetry session in place. The inspector observed the residents spent periods of the day with no social stimulation provided for them apart from reading or watching the television. The inspector also found that there was little evidence of sufficient activity-focused care to enhance interaction and communication for residents with cognitive impairment.

**Judgment:**  
Non Compliant - Moderate

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

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

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

**Findings:**  
There was evidence that residents had space for their belongings, including secure lockable storage. Relatives take home the personal laundry of residents and in the event of an emergency, there are domestic type facilities available in the centre.

Inspectors viewed a number of residents' bedrooms. The majority of the residents share multi-bedded rooms and these rooms were not personalised. The inspector acknowledges that the majority of residents are short stay residents and go home. Property lists were completed on admission as observed by the inspector.

**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):**

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

**Findings:**

The inspector reviewed the actual and planned staff roster and the staff numbers on the day correlated with the roster. The inspector reviewed staffing levels and discussed the staff allocation with the clinical nurse manager and the staff team. They described how they allocated workloads and determined staffing requirements. The inspector was satisfied that the day and night staff allocation was appropriate to meet the needs of residents.

However, as outlined under Outcome 2 the deployment of rostered hours required review. The inspector found that the current system of rostering did not facilitate the levels of need within the service taking into account the client profile which should inform the planning and allocation of resources. The inspector observed that there was a clinical management presence only three days per week in the centre.

Training records available conveyed that staff had access to on going education and a range of training was provided. The inspector found that in addition to mandatory training required by the Regulations staff had attended training on caring for residents with dementia, health and safety, infection control and end of life care. A daily communication system was established to ensure timely exchange of information between shifts which included updates on the residents' condition. The inspector saw that staff had available to them copies of the Regulations and the Standards had been made available to them. The inspector viewed minutes of staff meetings and minutes of meetings between management and staff in the centre.

Evidence of professional registration for nurses was available and current. Residents were observed to have good relationships with staff and were comfortable and relaxed when staff approached them. The inspector observed that call-bells were answered in a timely way, staff were available to assist residents and there was appropriate supervision in the dining room and sitting room throughout the inspection days.

There was a national HSE policy for the recruitment, selection and Garda Síochána vetting of staff. As outlined and action under Outcome 5 in a sample of four files reviewed by the inspector there was no photographic identification available as required by the Regulations.

However, there was no evidence of each individual staff member's performance formally appraised at least on an annual basis. There were no volunteers working in the service at the time of inspection.

**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:***

Ide Cronin  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Carlow District Hospital
<b>Centre ID:</b>	OSV-0000553
<b>Date of inspection:</b>	23/06/2016
<b>Date of response:</b>	14/07/2016

### Requirements

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

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

### Outcome 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

The inspector observed that there was a clinical management presence only three days per week in the centre. The inspector found deficits on this inspection in aspects of clinical care and some practices were not in line with best practice and the provision of a sound contemporary evidence base to care.

#### **1. Action Required:**

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

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

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

The clinical management structure will be augmented by the appointment of CNM2 5/7 to take up the post in July 2016.

As previously advised the unit will be closing for renovations on 11 August 2016. During the period of closure rosters will be reviewed and amended in line with service need. This roster review has commenced.

**Proposed Timescale:** 31/01/2017

**Theme:**

Governance, Leadership and Management

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

Ensure that there is a clearly defined management structure implemented particularly in relation to clinical management structure.

**2. Action Required:**

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

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

Appointment of CNM2 July 2016. Following feedback from recent HIQA inspection 6 July 2016 terms of reference have been drawn up in conjunction with staff and their representative groups for the roster review to be undertaken.

The roster will be based on the clinical service need. A local clinical governance team to include nursing staff and visiting staff/ teams will be established to agree and document the specific roles and responsibilities in relation to all services that are provided at the centre. This will be lead out by the ADON in conjunction with the CNM2

**Proposed Timescale:** 28/02/2017

**Outcome 03: Information for residents**

**Theme:**

Governance, Leadership and Management

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

The contract did not include the fee for the provision of care and services.

**3. Action Required:**

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

Following inspection the contract of Care has been amended to include the fee's and the provision of services has been reviewed and amended where the inconsistencies were identified

**Proposed Timescale:** 14/07/2016

**Theme:**

Governance, Leadership and Management

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

There were inconsistencies in relation to additional charges. The contract outlined that hairdressing was included in the fee and the nurse manger told the inspector that residents paid separately for this.

**4. Action Required:**

Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

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

Following inspection the contract of Care has been amended to include the fee's and the provision of services has been reviewed and amended where the inconsistencies were identified

**Proposed Timescale:** 14/07/2016

**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 inspector found that some policies did not reflect practices within the centre such as medication management and end of life care.

**5. 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:**  
Medication management practice resolved immediately as per policy 23 June 2016.

**Proposed Timescale:** 14/07/2016

**Theme:**  
Governance, Leadership and Management

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

In a sample of four staff files reviewed by the inspector there was no photographic identification available as required by the Regulations.

**6. 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:**

Up until February 2016 personal files were held offsite within the previous governance arrangements. A full review of the personal files will be undertaken and documentary evidence that was absent will be addressed.

**Proposed Timescale:** 31/12/2016

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

**Theme:**  
Safe care and support

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

The risk management policy did not meet the requirements of legislation as it did not have the measures in place to control the specific risks associated with accidental injury to residents, visitors or staff.

**7. Action Required:**

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Risk assessments are completed when identified as per policy.

**Proposed Timescale:** 25/06/2016

**Theme:**

Safe care and support

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

The risk management policy did not meet the requirements of legislation as it did not have the measures in place to control the following specified risk:

- self harm

**8. Action Required:**

Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

Self Harm Policy in place – All risk assessments will be completed as risk identified. This specific risk not relevant at present.

**Proposed Timescale:** 25/06/2016

**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:**

Robust procedures were not in place to ensure effective and efficient stock control. There were no agreed maximum or minimum stock levels to ensure that adequate stock is maintained that is not excessive and that only medicines required by residents were held in stock.

**9. Action Required:**

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

Pharmacist contacted. All stocked reviewed and process in place for effective and efficient stock control.

Process commenced 7 July 2016.

**Proposed Timescale: 20/07/2016**

**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:**

There was no documentary evidence that residents or their representative were involved in the development and review of their care plan.

**10. Action Required:**

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

CNM 11 has introduced a care plan for short stay 04 July 16 feedback from staff requested.

Training provided for CNM 1 - 29 June 2016. Staff training on care plans arranged for staff - 19 July 2016.

**Proposed Timescale: 31/01/2017**

**Theme:**

Effective care and support

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

Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.

**11. Action Required:**

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

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

Training for staff on assessment – 19 July 2016. Part of review and documentation audit.

**Proposed Timescale: 31/01/2017**

**Theme:**

Effective care and support

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

Residents capacity was not assessed or reviewed prior to their involvement in decisions regarding consent to level of care interventions at end of life stage.

**12. 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:**

This is incorporated as part of the introduction of a new care planning system in relation to resident's capacity and decision making.

**Proposed Timescale:** 31/01/2017

**Theme:**

Effective care and support

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

There was no evidence of any formal reviews in relation to care planning taking place for residents who resided longer than the average length of stay in the centre.

**13. 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:**

Admission and discharge policy is clearly communicated to referrers the expectation is that as the Carlow District Hospital would not have residents for more than 30 days. However in exceptional circumstances when it is beyond our control a formal monthly review will take place in respect to the individual.

**Proposed Timescale:** 31/01/2017

**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 majority of residents were accommodated in multi occupancy rooms which impinged on privacy and dignity. These rooms were generally not personalised. In many cases, lockers and wardrobes were quite small and did not accommodate sufficient clothing to allow residents to exercise choice. There were a number of areas around the centre where there was paint coming off the walls.

**14. 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:**

Plan for temporary closure which will address the above matters. Confirmed date for this – 11 August 2016 plan to reopen January 2017 proposed timeframe five months.

**Proposed Timescale:** 31/01/2017

**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:**

The care plans reviewed by the inspector did not address the resident's physical, emotional, social and spiritual needs. They did not reflect each resident's wishes and preferred pathway as part of their end of life care. There were inconsistencies in relation to the resident involvement in the decision making process relating to end of life care.

**15. 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:**

Decision making Training/End of Life – 29 June 2017 and end of life care plan introduced as per policy – 24 June 2016.

**Proposed Timescale:** 31/01/2017

**Theme:**

Person-centred care and support

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

A do not resuscitate (DNR) status was written in a file viewed by the inspector. There

was no evidence of the residents' wishes or choices relating to treatment and care being discussed and documented and as far as possible implemented in order to maximise the principle of autonomy.

**16. 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 plan introduced 24/06/16 which incorporates resident's wishes or choices relating to treatment.

**Proposed Timescale:** 24/06/2016

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

**Theme:**

Person-centred care and support

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

The inspector observed the residents spent periods of the day with no social stimulation provided for them apart from reading or watching the television. The inspector also found that there was little evidence of sufficient activity-focused care to enhance interaction and communication for residents with cognitive impairment.

**17. Action Required:**

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

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

In relation to the introduction of care planning, focus that activities are not just provided by staff assigned to activities. All staff have a responsibility in relation to social needs. CNM 11 reviewing allocation of staff to include aspects of social care.

**Proposed Timescale:** 31/01/2017

**Theme:**

Person-centred care and support

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

There is currently is no residents' committee in operation.

**18. Action Required:**

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted

about and participates in the organisation of the designated centre concerned.

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

When a residents' forum meeting takes place in a centre on the same campus, representation of the current residents will be asked to attend.

**Proposed Timescale:** 31/01/2017

**Theme:**

Person-centred care and support

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

Mass was held in the centre on an annual basis and staff told the inspector that they would not routinely take residents to mass locally.

**19. 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:**

Residents are given the choice of being offered Mass on Wednesdays and Sundays on the campus.

**Proposed Timescale:** 14/07/2016

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

The deployment of rostered hours including the skill mix required review. The inspector found that the current system of rostering did not facilitate the levels of need within the service taking into account the client profile which should inform the planning and allocation of resources.

**20. Action Required:**

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

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

Following feedback from recent HIQA inspection on 6 July 2016. Terms of reference have been drawn up in conjunction with staff and their representative groups for the roster review to be undertaken. The roster will be based on the clinical service need

with the appropriate skill mix.

**Proposed Timescale: 28/02/2017**

**Theme:**  
Workforce

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

There was no evidence of each individual staff member's performance formally appraised at least on an annual basis.

**21. Action Required:**

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

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

Performance review to be introduced and commenced 06 July 2016.

**Proposed Timescale: 31/01/2017**