

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St Joseph's Supported Care Home
<b>Centre ID:</b>	OSV-0000555
<b>Centre address:</b>	Kilmoganny, Kilkenny.
<b>Telephone number:</b>	051 648 091
<b>Email address:</b>	sjhome15@gmail.com
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	St. Joseph's Supported Care Home
<b>Provider Nominee:</b>	Nicholas Flavin
<b>Lead inspector:</b>	Sheila Doyle
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	17
<b>Number of vacancies on the date of inspection:</b>	3

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 09 August 2016 09:30 To: 09 August 2016 17:30

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

St Joseph’s Supported Care Home is a 20-bedded centre which provides long-term and respite care for residents who are assessed as having low to medium dependency needs and who require minimal assistance. The person in charge was not available at the time of inspection and the inspector met with the nurse deputising in her place.

The inspector was satisfied that residents received a quality service. There was evidence of a substantial level of compliance, in a range of areas, 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 safety of residents was promoted. A risk management process was in place for all areas of the centre although improvement was required to the risk management policy. Staff had received training and were knowledgeable about the prevention of abuse of vulnerable persons. There was evidence of safe recruitment practices.

The health needs of residents were met to a high standard. Residents had access to general practitioner (GP) services, to a range of other health services and care plans were in place.

The dining experience was pleasant and residents were treated with respect and dignity by staff.

Improvements were required regarding medication management which was also identified as an area for improvement at the previous inspection. The complaints policy and documentation relating to volunteers also required action.

These are discussed further in the body of the report and the actions required are included in the action plan at the end.

**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 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):**

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

**Findings:**

The inspector was satisfied that the quality of care and experience of the residents was monitored and developed on an ongoing basis. Effective management systems and sufficient resources were in place to ensure the delivery of safe, quality care services.

There was a clearly defined management structure that identifies the lines of authority and accountability. This had been identified as an area for improvement at the last inspection. The inspector noted that the statement of purpose had been updated to reflect the organisational structure.

Audits were being completed on several areas such as complaints, incidents, hygiene and medication management. The results of these audits were shared with all staff at team meetings. There was evidence of improvements being identified following these audits and interventions put in place to address them. For example following the infection control audit, additional training was organised for staff.

Data was also collected each week on the number of key quality indicators such as the use of antibiotics and the number of wounds, to monitor trends and identify areas for improvement.

The inspector saw that plans were in place to develop this area further. A Safety and Quality group had been set up to monitor the service and identify areas for improvement.

Regular residents' meetings were carried out on a regular basis. The inspector read the minutes and noted that comments from residents had been taken on board. Resident satisfaction surveys were also completed to measure residents' satisfaction with the service provided. Again there was evidence that residents' comments were taken on

board. The inspector noted that food and the dining experience was rated as being very important to the residents and ongoing development work was taking place in this area.

The annual review of the quality and safety of care was completed and this had been identified as an area for improvement at the last inspection.

**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 person in charge was on annual leave at the time of inspection.

The inspector noted that she held a full-time post and was a registered nurse with experience appropriate to the role. A clear reporting system was in place with the person in charge reporting to both the provider and also a governance board. A senior staff nurse reported to the person in charge and, in the event of the person in charge being absent, deputised in that role. Residents spoken with knew the person in charge by name and said they would discuss with her any issues that arose.

The inspector reviewed the staff file and noted that the person in charge had maintained her continuous professional development and had continued to attend training and seminars relevant to her role.

**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
<p><b>Outstanding requirement(s) from previous inspection(s):</b> Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p><b>Findings:</b> This outcome was not inspected against other than the policy relating to medication management which is discussed under Outcome 9. The action required relating to the medication policy is included under this outcome.</p>
<p><b>Judgment:</b> Non Compliant - Moderate</p>

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

**Theme:**  
Safe care and support

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

**Findings:**  
The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. The inspector saw that elder abuse detection and prevention training was ongoing and training records confirmed staff had received this mandatory training. This was not the case at the previous inspection and action was required. This training was supported by a policy document on elder abuse which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise.

Residents managed their own finances. This had also been identified as an area for improvement at the last inspection and the required action was completed. The inspector saw that residents had their own personal lockable space in their bedroom.

Staff had attended training on the management of behaviours that challenge and there was a policy in place to guide practice. Advice and support was available from the psychiatry of old age services. No resident was exhibiting behaviour that challenged at the time of inspection.

There was a policy on restraint but no resident was using restraint at the time of

inspection.

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

**Findings:**

The inspector was satisfied that the designated centre had sufficient procedures in place to protect the health and safety of residents, visitors and staff. Improvement was required to the risk management policy to ensure it met the requirements of the regulations.

The inspector read the risk assessment policy which was the policy available at the time of inspection. This did not meet the requirements of the regulations. For example it did not detail the measures and actions in place to control risks such as unauthorised absence, assault, accidental injury, aggression, violence and self-harm. Individual policies were in place to outline the procedures to follow but they were not included in the risk assessment policy available.

The inspector saw that fire extinguishers, emergency lighting and a fire detection system were in place and received maintenance at the required intervals. Fire exits were unobstructed and the exit procedures were on display throughout the centre.

Staff training was up-to-date in relation to fire prevention and precaution. The inspector also noted that many residents had also attended this training.

The inspector noted that fire alarm system was in working order and fire exits, which had daily checks, were unobstructed. Fire drills with training were carried out on a regular basis. Residents also took part in the fire drills. A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents outlining their level of mobility and possible assistance required.

Staff spoken with were clear on the procedure they would follow in the event of a fire.

An emergency policy was in place and evacuation plans were on display. Alternative accommodation arrangements were in place in the event of an evacuation of the premises.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

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

**Theme:**

Safe care and support

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

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

**Findings:**

The inspector found that although some improvement had occurred, additional action was required to ensure that each resident was protected by the designated centre's policies and procedures for medication management.

As a voluntary, supported care home with low dependency residents the centre did not have nursing staff on a 24 hour basis and, where residents were not administering their own medication, trained care staff undertook the administration of medication. To support staff in this role a specific dispensing system of pre-packed medications was in use along with a process to reconcile medication. This system was consistent with the profile of residents and supported both choice and independence for residents in relation to the management of their medication.

Actions were required from the previous inspection. At the previous inspection it was identified that the maximum dose that could safely be administered in a 24 hour period of medication to be administered as and when required was not consistently recorded. The inspector noted that this had been addressed.

However one resident required his medication to be crushed. The inspector saw that this was not prescribed as such as required by national guidelines.

It was noted at the previous inspection that improvement was required around the management of unused medication. While some improvement had occurred additional action was required to safeguard staff and residents. The current system is that the medications for return to pharmacy are put into a basket in a locked trolley. However adequate records were not maintained of what was in the basket nor was there a signature from the pharmacist confirming that the medications were returned to pharmacy. As at the last inspection the medication management policy did not include a procedure for the disposal of medication. Action on this finding is recorded against outcome 5 on documentation.

The inspector saw that there was a medication fridge in use. Daily temperature records were maintained. However the inspector noted that the temperatures recorded were

outside the acceptable range on an almost continuous basis since June 2016. No remedial action had been taken to address this.

Also, as at the previous inspection, the centre's medication management policy did not provide adequate direction on the procedure for prescribing, administering and reviewing PRN medication, the appropriate procedures for medications to be crushed nor the procedure to follow if the temperature of the medication fridge was outside of acceptable levels.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Staff maintained a register of MDAs. The inspector checked a sample of balances and found them to be correct. End of shift checks were carried out by two staff.

The inspector noted that the pharmacist was now available to residents for advice and support and this had been identified as an area for improvement at the last inspection.

Some residents in the centre undertook self-medication. Each resident had an assessment carried out to establish their capacity to self-medicate and the level of supervision required. This had also been identified as an area for improvement at the last inspection. Medications were delivered in a monitored dosage system by the pharmacist and these were stored in a locked cupboard in the resident's room.

A medication resource folder was developed and the inspector saw that this contained useful information including details on various medications and common abbreviations in use. Staff had completed medication management training and competency assessments were also completed

**Judgment:**

Non Compliant - Moderate

***Outcome 11: Health and Social Care Needs***

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

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that each resident's wellbeing and welfare was maintained

by a high standard of evidence-based care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs were set out in an individual care plan.

Samples of clinical documentation including nursing and medical records were reviewed which indicated that all recent admissions to the centre were assessed prior to admission. This pre-admission assessment was generally conducted by the person in charge who looked at both the health and social needs of the potential resident.

Comprehensive assessments were carried out and care plans developed in line with residents' changing needs. The assessment process involved the use of validated tools to assess each resident including assessment for the risk of malnutrition, falls and pressure ulcer development. A care plan was developed within 48 hours of admission based on the resident's assessed needs.

There was documented evidence that residents and their families, where appropriate, were involved in the care planning process, including recording end of life wishes and care preferences.

Based on a sample of records viewed by the inspector, residents' health needs were met and they had timely access to GP services including out-of-hours services. There was evidence of referral for assessment to allied health services such as dietetics, speech and language, chiropody and dental. All residents spoken with expressed satisfaction with the service provided.

There was a varied activities programme with arts and crafts, exercises, bingo, quiz sessions and music included. Residents told the inspector how much they enjoyed the activities. Residents said they had never painted before coming in to the centre and showed the inspector their artwork which was on display around the centre. Other residents told the inspector how much they enjoyed the music. The inspector heard residents enjoying a ring throwing competition during the inspection.

**Judgment:**  
Compliant

***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 inspector was satisfied that the complaints of each resident, his/her family, advocate or representative, and visitors were listened to and acted upon and there was an effective appeals procedure. However the policy did not meet the requirements of the regulations.

The inspector reviewed the policy and saw that it detailed the procedure to follow should a complaint be received. However it did not contain details of the person nominated to ensure that all complaints were appropriately responded to and that the required records were maintained.

The inspector also noted that while the policy was in the front hall, the procedure was not on display in a prominent position as required by the regulations.

Otherwise the inspector saw evidence of good management of complaints. A log was maintained and adequate details were recorded. Residents told the inspector who they would talk to if they had a complaint but the number of complaints received was minimal.

**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:**

The inspector was satisfied that residents were provided with food and drink at times and in quantities adequate for their needs. Food was wholesome and nutritious while also properly prepared, stored and cooked.

The inspector visited the kitchen and found that it was clean and organised. The chef on duty discussed the special dietary requirements of individual residents and information on residents' dietary needs and preferences which was documented and records held in the kitchen. One resident currently required their meal in an altered consistency and this was well managed by the kitchen staff.

Weights were recorded on a monthly basis or more frequently if required. Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were repeated if any changes were noted

in residents' weights.

The inspector visited the dining room during lunch and saw that this was a popular social occasion. Tables were nicely laid and meals well presented.

The inspector reviewed the menus and saw that choices were available at each meal. Residents spoken with also expressed satisfaction with the food provided. One resident told the inspector that it was like a hotel while another told the inspector that it was meals and snacks all day and she loved it.

The inspector saw that snacks and drinks were readily available throughout the day. The inspector observed and residents confirmed that the catering staff continued to produce a wide range of home-baking including brown bread which was a firm favourite with the residents.

**Judgment:**  
Compliant

***Outcome 18: Suitable Staffing***

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

**Theme:**  
Workforce

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

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

**Findings:**

The inspector was satisfied that there were appropriate staff numbers and skill mix to meet the assessed needs of residents. All staff were supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. However improvement was required to ensure that the documentation relating to volunteers met the requirements of the regulations.

Several volunteers and outsourced service providers attended the centre and provided very valuable social activities and services which the residents said they thoroughly enjoyed and appreciated. However, with the exception of one volunteer, there was no evidence that they had been vetted appropriate to their role or that their roles and responsibilities were set out in a written agreement as required by the regulations. This had been identified as an area for improvement at the last inspection as well.

A recruitment policy in line with the requirements of the regulations was implemented in practice. The inspector examined a sample of staff files and found that all were complete. The inspector saw that a checklist was in place to ensure that all staff files met the requirements of the regulations.

Up to date registration numbers were in place for nursing staff. An actual and planned roster was maintained in the centre with any changes clearly indicated.

There was a varied programme of training for staff. Records read confirmed all staff had completed mandatory training in areas such as safeguarding and prevention of abuse, moving and handling and fire safety. A training matrix was maintained. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. This included training in medication management.

The inspector saw that other courses were planned including infection control.

**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:***

Sheila Doyle  
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>	St Joseph's Supported Care Home
<b>Centre ID:</b>	OSV-0000555
<b>Date of inspection:</b>	09/08/2016
<b>Date of response:</b>	23/08/2016

#### 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 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 policy did not include a procedure for the disposal of medication and was not sufficient to guide practice in all elements of medication management.

**1. Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement

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

policies and procedures on the matters set out in Schedule 5.

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

The Medication Management Policy will be altered to include a paragraph on the safe disposal of Medication. This will cover medication which for example has inadvertently been dropped on the floor. It will detail what staff should do in this instance thus ensuring Medication is disposed of safely.

**Proposed Timescale:** 22/09/2016

**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 the regulations.

**2. Action Required:**

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

The Risk Management policy will be reviewed to make it more detailed in the management of Risk as outlined in the report.

**Proposed Timescale:** 22/09/2016

**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:**

Improvement was required around the management of unused medication.

**3. 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:**

We have introduced a "Medication returned to Pharmacy Book" This will be housed in the Drug Trolley and will record, 1. Name of resident, 2. Name of medication, 3. No. of Items, 4. Reason for Return, 5. Signature of pharmacist who collects said medication. This has been communicated to all Staff and Pharmacy Personnel.  
Proposed Timescale: Already in place.

**Proposed Timescale:** 23/08/2016

**Theme:**

Safe care and support

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

Medications to be crushed prior to administration were not individually prescribed.

**4. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

The Resident in Question previously had crushed medication reflected on his MARS sheet but this did not get carried forward to the new MAR sheet. Pharmacy now have it printed on his Medication sheet and the GP will sign this instruction each time the new MAR Sheet is generated. Should there be a change in the need for crushed medication, this will be communicated to Pharmacy and removed from the MAR sheet accordingly.  
Proposed Timescale: Already in Place.

**Proposed Timescale:** 23/08/2016

**Theme:**

Safe care and support

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

The temperature within the medication fridge was outside of acceptable limits.

**5. Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

A new thermometer has been ordered for the Medication fridge and all staff have been educated on the importance of not only recording, but interpreting and reporting any issues with the temperature readings.

**Proposed Timescale: 31/08/2016**

**Outcome 13: Complaints procedures**

**Theme:**

Person-centred care and support

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

The complaints procedure was not on display in a prominent position as required by the regulations.

**6. 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 now on display in the front hall beside the complaints policy and complaints box/forms and also on the notice Board in the day room.

Proposed Timescale: Already in place.

**Proposed Timescale: 23/08/2016**

**Theme:**

Person-centred care and support

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

There was no person nominated to ensure that all complaints were appropriately responded to and that the required records were maintained.

**7. Action Required:**

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

The Provider will now review all complaints on a weekly basis at the weekly meetings and ensure that they are satisfactorily concluded. This will further be demonstrated in an update in the Complaints Policy. Our Complaints Form will also be updated to reflect the final conclusion to a complaint.

**Proposed Timescale: 31/08/2016**

## Outcome 18: Suitable Staffing

**Theme:**  
Workforce

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

With the exception of one volunteer, there was no evidence that volunteers had their roles and responsibilities set out in a written agreement as required by the regulations

**8. Action Required:**

Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

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

We will develop new "roles and responsibilities documents" to cover all volunteers.

**Proposed Timescale:** 22/09/2016

**Theme:**  
Workforce

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

With the exception of one volunteer, there was no evidence that volunteers been vetted appropriate to their role as required by the regulations.

**9. Action Required:**

Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

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

A list of available volunteers will compiled going forward and all will be Garda Vetted.  
Proposed Timescale: All paperwork returned and Garda vetting in place by December 2016.

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