

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Columban's Retirement Home
Centre ID:	OSV-0000166
Centre address:	Dalغان Park, Navan, Meath.
Telephone number:	046 909 8232
Email address:	praleighssc@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Maynooth Mission to China (Incorporated)
Provider Nominee:	Patrick Raleigh
Lead inspector:	Una Fitzgerald
Support inspector(s):	
Type of inspection	Announced
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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 announced and took place over 2 days.

The inspection took place over the following dates and times

From:	To:
12 September 2017 09:30	12 September 2017 19:00
13 September 2017 07:30	13 September 2017 16:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an inspection carried out to monitor ongoing regulatory compliance.

During the course of the inspection, the inspector met with residents and staff, the provider nominee, person in charge and the management team. The views of residents and staff were listened to, practices were observed and documentation was reviewed. Surveys completed by residents were also reviewed.

The inspector found that care was delivered to a high standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The management team had proactively engaged with all stakeholders to ensure that the culture within the centre was open and transparent. The management team responsible for the governance, operational management and administration of services and resources demonstrated good knowledge and an ability to meet regulatory requirements.

The management and staff were striving to continuously improve outcomes for

residents. There is a newly appointed person in charge since the last inspection and the centre had undergone significant change initiatives that were having a positive impact. A person-centered approach to care was observed. Residents appeared well cared for and expressed satisfaction with the care they received. There was good evidence that independence was promoted and residents have autonomy and freedom of choice. Residents spoke positively about the staff who cared for them.

There was a total of 20 action plans required from the last inspection. Findings from this inspection highlight that significant progress had been made in addressing the non-compliances identified. There are no action plans carried over from the last inspection. Overall, good compliance with the regulations was found during this inspection. The findings are discussed in the body of the report and improvements are outlined in the Action Plan at the end for response.

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 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):

No actions were required from the previous inspection.

Findings:

There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. The management team has undergone significant change since the last inspection. Multiple change initiatives have been commenced and improvements and progress in all areas of care services was evident. For example, policies and procedures that were identified during the last inspection that required review had all been updated. Management and staff had good knowledge of residents and their care needs.

There was a written statement of purpose that described the service and facilities that are provided in the centre. The statement of purpose consists of a statement of the aims, objectives and ethos of the designate centre. The management have kept the statement of purpose under review and revised the content at intervals of not less than one year.

As per the regulations, the statement of purpose had detailed the organizational structure of the designated centre. However, some minor changes to clarify reporting and line management responsibility to reflect current reporting structure was required. This was amended during the inspection and a copy of the new statement of purpose was submitted to HIQA. The clinical management team were working in partnership to achieve better outcomes for residents. Staff spoken with were familiar with their line management and reporting structures.

Management had suitable governance systems and arrangements in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. Audits of resident outcomes that captured statistical information was compiled and reviewed by management on a regular basis. For example, audits were carried out and analysed in relation to falls prevention, wound and pain management, incident review and analyses.

However, a report detailing or demonstrating an annual review of the quality and safety of care delivered to residents had not been completed as required. The person in charge informed the inspector that the data and information required for the annual review for 2017 is currently being developed. This report will set the priorities for 2018.

The inspector reviewed staff files and found that all the documentation required under Schedule 2 of the regulations was not available. Volunteers did not have garda vetting disclosures in place and their roles and responsibilities were not defined in writing. This is discussed in more detail in Outcome 18 Suitable Staffing.

There was evidence of consultation with residents in a range of areas, for example, when care plans were developed and reviewed, participation in the residents' forum, and in the organisation of social and recreational activities or events. Residents were familiar with management arrangements. Discussions with residents during the inspection and satisfaction surveys from resident and relatives were overwhelmingly positive. Residents who met the inspector were very positive about the facilities and provision of services.

Judgment:

Non Compliant - Moderate

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The centre was managed by a suitably qualified and experienced nurse. The person in charge took up the position since the last registration inspection in the centre and held authority, accountability and responsibility for the provision of the service. The person in charge had followed up on the action plan from the last inspection and there was clear evidence of the positive impact this was having on the centre. For example, the appointment of the new activities staff member and the regular outings enjoyed by residents.

The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions and was focused on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents.

Judgment:

Compliant

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

Theme:

Safe care and support

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

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

Findings:

The inspector followed up on the findings from the previous inspection and was satisfied that all appropriate steps had been taken by the management team. The inspector observed a culture of promoting a restraint free environment. The restraint policy was last updated in November 2016. Alternative measures such as low-low beds were available. The inspector reviewed the restraint register and there was no incidents of chemical restraint reported. At the time of inspection only one resident had bedrails in place. The inspector reviewed the care plan and documentation. There was clear evidence that the bedrail was in use at the residents own request and that this was discussed and reviewed at regular intervals. A written consent form signed by the resident was also seen.

The inspector saw positive and respectful interactions between staff and residents and that residents were comfortable in asserting themselves and bringing any issues of concern to staff. Residents spoken to articulated clearly that they had confidence in the staff and expressed their satisfaction in the care being provided. Inspectors reviewed the system in place to manage residents' money and found that overall reasonable measures were in place and implemented to ensure the management of resident's finances were fully safeguarded. Each resident had a lockable cupboard in their bedroom. Management of personal monies had been recently discussed at a resident meeting and records showed that all residents were given the choice to have a safe placed in their bedroom. Records indicated that 14 residents had chosen to avail of this option.

The inspector was satisfied that there were policies and procedures in place for the protection of residents from abuse. The policy on Safeguarding and Safety had last been reviewed in September 2016 to reflect best practice guidelines. The person in charge and the registered provider were actively engaged in the operation of the centre. All staff had received training on the prevention of elder abuse and staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse. In conversations with residents, the inspector was informed by all

residents spoken too that they felt safe and secure in the centre.

The centre has a policy dated September 2016 on procedures in place to support staff with working with residents who have responsive behaviours (how people with dementia and other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The person in charge informed the inspector that among the current residents only one resident currently had an active behaviour monitoring log in place. The inspector reviewed the care plan in place. Staff were familiar with the de-escalation techniques best adopted to manage any potential incidents. A referral to an appropriate specialist clinical team had been made.

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):

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

Findings:

The centre had policies and procedures relating to health and safety within the centre. The centre has a risk management policy last reviewed in September 2016 that includes items set out in Regulation 26(1). The centre had a current risk registrar that is kept under constant review by the PIC and was last reviewed 10/09/2017. The register identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents.

Arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to personal protective equipment such as aprons and gloves, hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers. Household staff spoken to were knowledgeable on the system in place to ensure that the cleaning regime minimises the risk of cross infection. The cleaning schedule included the routine daily chores but also contained detail of a deep cleaning schedule. However, the documentation reviewed by the inspector did not support the practices in place. This was discussed with the management team during the inspection and the supervisor agreed that further review of the detail of the records was required. The standard of cleanliness throughout the building was of a good standard. Residents spoken too confirmed that their rooms were cleaned on a daily basis.

Suitable arrangements were in place in relation to promoting fire safety. Fire safety and response equipment was provided. The fire safety equipment was serviced on an annual basis. However, the fire alarm system was not serviced on a quarterly basis. The PIC had signed a service level agreement with an external provider to ensure that the system is serviced every quarter in the future. The inspector was shown a copy of the signed agreement. Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Fire evacuation procedures were prominently displayed throughout the building. All staff had received annual fire training. In addition staff spoken to were knowledgeable about fire safety and evacuation procedures. A fire drill was carried out on 5th September 2017. The documentation highlighted areas of improvement and the inspector was satisfied that the PIC was actively working on closing out on all actions required.

Judgment:

Substantially Compliant

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):

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

Findings:

There were written operational policies dated December 2016 relating to the ordering, prescribing, storing and administration of medicines to residents. Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the delivery and collection by the pharmacy, and checking, storage, return and disposal of medicines by nurses. The processes in place for the handling and checking of medicines received including controlled drugs were examined. Practices found and procedures described were in accordance with current professional guidelines and legislation.

Audits of medication charts was carried out monthly by the clinical nurse manager. An external provider also carries out 3 monthly audits and the records were available for the inspector to review. The inspector reviewed the documentation on reported incidents. There was clear evidence that all incidents were reviewed and learning from incidents and reported errors informed improvements to protect residents. A system was in place for a regular prescription review by the resident's general practitioner (GP) and pharmacist every three months

Resident self-administration is encouraged and supported by the clinical team. The inspector reviewed a sample of resident files. There was clear evidence that all residents have appropriate assessment carried out and continued monitoring occurs to minimise

any risk of medication errors.

Nursing staff were observed as they administered medications. Residents were unhurried and reminded of the purpose of the medicines administered. Prescription and administration records were maintained in accordance with the centre's policy and professional standards.

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):

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

Findings:

Residents' health and care needs were met through timely access to medical treatment. Residents had good access to a general practitioner and allied healthcare professionals. The inspector focused and tracked the journey prior to and from admission of a number of resident files. The review looked at specific aspects of care such as, wound care, mobility, access to health care and supports. The inspector followed up on the action plan from the last inspection and was satisfied that the actions had been implemented.

On admission all residents had a comprehensive nursing assessment. The inspector observed that initial care plans were written within the 48 hour timeframe as per the regulations. The assessment process involved the use of validated tools to assess each resident's dependency level, level of mobility; falls risk assessment and skin integrity. Assessment outcomes were linked to care plans that were seen to be reviewed by the clinical team at intervals of three months and more frequently when clinically indicated. However, the records did not evidence consent and consultation every four months with the resident as required by the regulations.

Clinical observations such as blood pressure, pulse and weight were assessed on admission, and monthly or as required thereafter. Care was seen to be delivered to each resident in accordance with their identified needs. Residents spoken too were familiar with their care plan.

Staff provided end of life care to residents with the support of their general practitioner and have access to specialist community palliative care services if required. Each file reviewed had end of life care documentation in place as was required from the last inspection. The inspector reviewed the documentation and noted that resident refusal to discuss end of life care wishes was clearly respected and documented. The end of life planning is kept under regular review. There was no resident receiving end of life care on the day of inspection. Religious and cultural practices were facilitated by the Columban community.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked. There was a system in place to ensure that special dietary requirements are communicated between the clinical team and kitchen staff.

Residents were assessed to identify their risk of developing pressure related skin injuries. Residents at risk had specific equipment in place to mitigate level of risk, such as repositioning regimes and pressure relieving mattresses and cushions. There was one resident with a wound dressing care plan in place on the day of inspection. The inspector reviewed the file. A detailed care plan was available. The inspector reviewed the wound management procedures in place. Tissue viability specialist services were available to support staff with management of any residents' wounds that were deteriorating or slow to heal.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

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

Findings:

The inspector found that the centre promoted residents' capacity to exercise personal freedom and choice, and maximised their independence. A person-centred approach was evident, with several examples of residents being supported by staff to pursue their individual interests. Staff were seen to be kind and friendly towards all residents and respectful towards their privacy and dignity, for example, knocking on residents'

bedroom doors and waiting for permission to enter, introducing themselves and explaining procedures in advance.

Work was ongoing since the last inspection to ensure that residents had opportunities to participate in meaningful activities in line with their interests and capabilities. An activity co-ordinator had been appointed. This role had brought about significant improvements that impacted positively for residents. Practice development in relation to activity provision was being facilitated, and this was being used to enhance the quality of the activity programme. For example, the documentation to record activity participation had been reviewed by the activity coordinator.

There was evidence of consultation with resident's in a range of areas on a daily basis and a formal resident meeting held monthly. The inspector reviewed the minutes of the last meeting and there was clear evidence that the wishes of the residents are listened to and followed up on.

Resident's have access to independence advocacy services. The centre is part of the local community and residents have access to radio, television, newspapers, information and frequent outings to local events. During the days of inspection the inspector observed multiple examples how the routines, practices and facilities maximize residents' independence. The activity programme within the centre offers a wide variety of options for all residents. There was evidence of outings that had been organized and enjoyed by residents. The inspector was also informed of planned trips that are arranged for the coming weeks.

Overall there was clear evidence that residents have the opportunity to participate in activities that are meaningful and purposeful that suits their individual needs and interests.

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:

Staffing levels and skill mix on the day of inspection were sufficient to meet the social and healthcare needs of the residents. The inspector reviewed the actual and planned roster for staff and found that management, nursing, care and support staff during the day were adequate.

Staff confirmed that they had sufficient time to carry out their duties and responsibilities, and the management team explained the systems in place to supervise and appraise staff. Staff were seen to be supportive of residents and responsive to their needs. Requests and residents' alarm bells were promptly responded to by staff during the inspection. Residents chose the time that they wished to get up, eat and seek assistance with personal care and dressing, and this was facilitated by the staff team.

In preparation for the inspection, relatives and some residents had completed questionnaires regarding the centre. In these questionnaires, respondents were complimentary regarding the management and the staff. In discussions with the inspector, residents confirmed that staff were supportive and helpful.

Recruitment procedures were in place, and samples of staff files were reviewed against the requirements of schedule 2 records as per the regulations. All four files had garda vetting disclosures in place. The inspector found gaps with respect to references from most recent employers and unexplained gaps in employment. The inspector also requested to review the files of the volunteers. The management confirmed that volunteers do not have Garda Vetting disclosure and their roles and responsibilities are not clearly defined. This was discussed with the management team and the inspector was reassured that a full review of the files will be carried out as a priority and the action plan response will provide an update on progress. The provider nominee reassured the inspector that no employee or volunteer would have involvement or direct resident contact until Garda vetting is completed and returned. The gaps found in the files of staff under this outcome are actioned under Outcome 2 Governance and Management.

Evidence of professional registration for all registered nurses was available and current.

A mandatory and relevant staff training programme was in place and a record of training for all staff was available. Mandatory training such as moving and handling, fire training and the prevention, detection and management of abuse had been provided and there were no gaps identified. Manual handling practices observed were safe and appropriate, with assistive equipment available for use.

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:

Una Fitzgerald
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 report¹

Centre name:	St Columban's Retirement Home
Centre ID:	OSV-0000166
Date of inspection:	12/09/2017 and 13/09/2017
Date of response:	02/10/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Management had governance systems and arrangements in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. However, a report detailing or demonstrating an annual review of the quality and safety of care delivered to residents had not been completed as required.

1. Action Required:

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

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

1) Annual review of Quality and safety using HIQA template will be completed by 31st Dec 2017 and similarly every year going forward. This will be carried out by the PIC.

Proposed Timescale: 31/12/2017

Theme:

Governance, Leadership and Management

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

The inspector reviewed staff files and found that the documentation required under Schedule 2 of the regulations was not available. This is discussed in more detail in Outcome 18 Suitable Staffing.

2. Action Required:

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

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

- 1) Full review of staff files is in progress by the PIC and the HR manager.
- 2) Centralised system of all staff files in the HR office- will be accessible to the PIC and the HR manager during business hours.
- 3) Identity disparity of a nurse with NMBI pin addressed and the nurse is now registered under her current name.
- 4) Garda vetting-please refer to action plan under outcome 18-suitable staffing.

Proposed Timescale: 30/11/2017

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 documentation reviewed by the inspector did not support the cleaning practices in place. A review of the records was required.

3. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the

standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

- 1) Deep cleaning schedule updated to a new and clearer format and implemented by supervisor on 22/09/17
- 2) All cleaning, laundry and catering staff completed infection control training on 28/09/17.

Proposed Timescale: 02/10/2017

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:

On admission all residents had a comprehensive nursing assessment. Assessment outcomes were linked to care plans that were seen to be reviewed by the clinical team at intervals of three months and more frequently when clinically indicated. However, the records did not evidence consent and consultation every four months with the resident as required by the regulations.

4. Action Required:

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

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

- 1) A Review of all care plans and discussion with residents by the key nurses is in progress-to be completed by 31st Oct 2017
- 2) Staff nurses have been made aware of the regulatory requirement of care planning with the residents at staff meeting on 27th Sept 2017 and minutes have been circulated.
- 3) SI 415 study day planned for Nurses and managers on 31/10/2017

Proposed Timescale: 31st Oct 2017 and on-going every 4 months

Proposed Timescale: 31/10/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The management confirmed that volunteers do not have Garda Vetting disclosure on file.

5. 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:

4)Garda vetting-all new recruits and volunteers will be either Garda vetted by the Missionary society or entered into Joint sharing of vetting agreement. Development of agreement complete on 28.09.17. All contractors and volunteers currently with us are in the process of being retrospectively vetted through the safeguarding officer. This is expected to be completed by 30th November 2017 as per Section 21 of the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016 which allows for retrospective vetting until 31st December 2017 for individuals currently in employment.

Proposed Timescale: 30/11/2017

Theme:

Workforce

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

The inspector requested to review the files of the volunteers. The management confirmed that volunteers do not have their roles and responsibilities defined in writing.

6. 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:

- 1) Service Agreement and role profile including supervisory/reporting relationship and Garda vetting requirements fully developed in consultation with the key stakeholders for current contractors and volunteers and sent out on 29/09/17. Awaiting return of signed copies.
- 2) Template disseminated to HR and management for future volunteers and contractors.

Proposed Timescale: 31/10/2017

