

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Carthage's House Limited
Centre ID:	OSV-0000687
Centre address:	Lismore, Waterford.
Telephone number:	058 54309
Email address:	stcarthageshouse@gmail.com
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St. Carthage's House Limited
Provider Nominee:	Mary Fenton Morrissey
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	35
Number of vacancies on the date of inspection:	16

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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
24 May 2017 07:30	24 May 2017 17:00
25 May 2017 07:30	25 May 2017 15:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially 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	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This unannounced inspection took place over two days, the purpose of which was to monitor on going compliance with the regulations. The inspection also followed up on the actions that resulted following the centre's previous inspection in December 2016. However, only 10 of the 19 action plans issued on the last inspection had been completed. In addition, eight of the 16 actions from this inspection were as a result of continuing non compliances with the regulations.

The centre was not sufficiently resourced to ensure the effective delivery of care in accordance with the statement of purpose. There was evidence that the arrangements for the position of the person in charge were not adequately resourced for her to effectively discharge her role or function. This significant failing was evident on this inspection and the previous inspection in December 2016. The inspector met the provider representative and spoke to five members of the governing board. The inspector informed the provider representative and board members that the issue of continued inadequate resources for the person in charge

to fulfil their role and function under regulation was a serious failing. The inspector put them on notice that this continued failing required urgent attention and reflected negatively on their fitness as provider of the centre. The provider representative and board members stated that inadequate resources was the reason why some action plans developed to achieve compliance had not progressed or completed to date. In addition, the provider representative and board members stated that the failings in relation to the premises which included inadequate laundry/sluice/cleaners room had also not been addressed again due to lack of funding. However, these non-compliances had been previously identified during inspections as far back as 2015. The provider representative and the board of management were again requested to ensure that they addressed these areas of non-compliance particularly in relation to ensuring adequate resources were made available to support the person in charge.

The centre was set up by local people to provide support with activities of daily living to residents with a low to moderate dependency. It is owned and managed by a voluntary organisation with charitable status through a voluntary board of directors. Twenty-four hour nursing care is not provided in the centre. The centre was purpose built and opened in its current location in 1994. Residents are charged a weekly fee, an annual grant is allocated to the centre via statutory funding and additional funds were raised through on-going local fundraising. Residents and staff who spoke with the inspector confirmed that the centre was adequately heated, reasonably maintained and residents were provided with adequate food and drink to meet their needs.

The care provided to residents was adequate with an emphasis on providing a relaxed, homely and supportive environment. There was a respectful, supportive and positive atmosphere in the centre and residents had choices for example about getting up times, what to get involved in and where to have their meals. The inspector noted that residents engaged in activities within the centre such as prayer services, art and crafts and pongo and some also continued their attendance at other day services. A number of residents had their own motor cars and continued to access local services and social connections within their communities. Residents to whom the inspector spoke commented on the kindness and attentiveness of staff, the social interactions and the good quality of food provided. Residents described the centre as "home from home" and stated that they felt safe in the centre.

There were 10 outcomes reviewed as part of this inspection, two of the 10 outcomes were compliant and two outcomes deemed substantially compliant with the regulations. However, the following five outcomes were deemed to be moderately non-compliant; health and safety and risk management, medication management, health and social care needs, suitable premises and residents' rights, dignity and consultation. In addition, one outcome was deemed as major non-compliant: governance and management. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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

Since the last inspection the statement of purpose and function had been reviewed to ensure that it accurately reflected the service and facilities provided in the centre. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose included the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007. There was evidence that the statement of purpose was kept under review and readily available for residents and staff to read. The statement of purpose was found to meet the requirements of legislation

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 centre was owned and managed by a voluntary organisation through a voluntary board of directors. It was set up by local people to provide support with activities of daily living to residents with a low to moderate dependency. The centre was purpose built and opened in its current location in 1994. Residents were charged a weekly fee, an annual grant was allocated to the centre via statutory funding and additional funds were raised through on going local fundraising. Residents and staff who spoke with the inspector confirmed that the centre was adequately heated, maintained and residents were provided with adequate food and drink to meet their needs.

However, as identified on the last inspection in December 2016 the centre was not sufficiently resourced to ensure the effective delivery of care in accordance with the statement of purpose. The person in charge stated that she was not sufficiently resourced to effectively discharge her role or function. There was evidence on this inspection and the last inspection to support this contention. For example, the identified failings in relation to inadequate health and social care audits or reviews. Inadequate risk management, medication management and care planning details of which are detailed in the respective outcomes of this report.

The inspector met the provider representative and spoke to five members of the governing board including the chairperson. The inspector informed the provider representative and board members that the issue of continued inadequate resources for the person in charge to fulfil their role and function under regulation was a serious failing. The inspector put provider representative and board members on notice that this continued failing required urgent attention and reflected on their fitness as provider of the centre.

The provider representative and board members clearly identified inadequate resources as the reason why some action plans had not progressed or completed to date. As identified on the previous inspection, there were insufficient resources available to ensure that the centre was adequately managed. This was evidenced by the continued non-compliances identified throughout the course of the inspection which identified that the person in charge was inadequately resourced to fully discharge the function of her role. For example, the person in charge continued to also work as a the nurse from 1pm until 5pm for four days and from 9.00am to 5pm for the remaining day each week. This arrangement significantly reduced the person in charges' time to attend to specific areas under her regulatory remit. There was evidence from this and previous inspections as far back as 2015 to support this finding particularly in the context of the size, design and layout of this 51 bedded residential centre. In addition, the provider representative and board members stated that the failings in relation the premises including the inadequate laundry/sluice/cleaners room had not been addressed due to lack of funding. The provider representative and board of management clearly stated that they wished to resolve these on going non compliances and had been actively engaged with the funding agency in relation to these matters. At the feedback meeting at the end of the inspection, the inspector requested provider representative and board of management

to review the supports available to the person in charge in order that she could fully discharge her regulatory responsibilities and the effective governance and management of the centre.

There was a clearly defined management structure. Staff and residents were able to identify who was in charge and what the lines of accountability were. On the first day of inspection, the person in charge, the provider representative and four members of the board of management made themselves available to the inspector. On the second day of the inspection, the provider representative, and three members of the board of management including the chairperson, attended the feedback meeting at the end of the inspection.

The person in charge stated that she had daily informal meetings with the provider, these meetings did not have a set agenda and minutes were not maintained. Since the last inspection the person in charge had attended a board of management meeting. The inspector was provided with copies of the minutes of the most recent meetings of the board dated 27 April 2017 and 16 May 2017. On the agenda were matters such as sourcing additional funding, finance, health and safety issues, and building maintenance.

There was evidence of some improvements since the last inspection. For example, the provider representative identified that a number of additional health care staff and nurses had been recruited since the last inspection. She also confirmed that all staff including those recently recruited had the required vetting disclosure as required under the 2013 Regulations and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016. This was discussed further and under outcome seven of this report.

On the last inspection there was an issue in relation to fire safety and the installation of automatic fire door releases. On this inspection, the inspector noted automatic fire door releases had been installed on all residents' bedroom doors. However, there were a number of other doors that had yet to have automatic fire door releases installed. The provider representative stated that these works had yet to be completed due to lack of adequate funding and would be completed as soon as such funding was made available.

There was an audit schedule in place that included medication audits, a kitchen safety audit and a health and safety audit. However, they were not adequately contemporaneous to inform practice as the most recent audits were recorded as being completed in 2015. This issue was further discussed and actioned under outcome 8 of this report.

The centre's 2016 annual review was available for inspection. However, it was not adequate as it was a one page document that set out the improvements that were to take place and listed plans for 2017. The review did not record how the quality and safety of care was delivered to residents in the centre to ensure that such care was in accordance with relevant standards. In addition, this review had not been prepared in consultation with residents and their families and had not been made available to residents and or their representatives, if appropriate.

Judgment:
Non Compliant - Major

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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 displayed an adequate knowledge of the standards and regulatory requirements and was found to be committed to providing quality person-centred care to the residents.

Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service and said she was approachable. It was clear that she always made herself available to them whenever they needed to discuss anything with her.

The inspector interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. The inspector was satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. However, she was also the nurse responsible to provide the clinical and nursing care for 24 hours of the 40 she was rostered to work. The person in charge stated that this rostering arrangement had impacted on her ability to fulfil her role as required under regulation. This matter was discussed under outcome 2 of this inspection report.

Judgment:
Compliant

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

Theme:
Safe care and support

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

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

Findings:

The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated a good understanding of safeguarding and elder abuse prevention. They were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. Safeguarding training was provided on an on-going basis in-house. However, from a review of the staff training records most but not all staff had received up-to-date training in a programme specific to protection of older persons and one staff had yet to receive elder abuse training. 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.

The centre maintained expenses records in relation to a small number of residents and the inspector saw evidence that adequate financial records were maintained. There was no restraint in use in the centre. There were no residents who required support for responsive behaviour.

As already discussed in outcome 2, 'governance and management', the person in charge confirmed that since the last inspection all staff members did have the required Garda vetting disclosure.

Judgment:

Substantially 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:

On the last inspection improvements were required in health, safety and risk management. The timeframe given to HIQA by the provider representative for completion of undertakings in response to the previous action plan in December 2016, had not passed. Some proactive measures had been taken by the provider representative. For example the board had commissioned a review by a fire safety expert to ensure fire issues were identified. This fire safety consultant report was presented to the governing board on the 26 May for consideration. The provider

representative was requested to provide HIQA with a copy of the action plan developed to address any residual fire safety issues.

There were fire policies and procedures that were centre-specific. The fire safety plan was viewed by the inspector and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The inspector saw that fire training was provided to staff on dates in 2017. Staff had up to date fire training as required by legislation. Completed logs were maintained on weekly checks of fire equipment, doors, exit routes and emergency lighting. All fire exits were noted to be free of any obstructions. The person in charge told the inspector and records confirmed that fire drills were undertaken at regular intervals. The fire alarm and the emergency lights were last serviced in March 2017. Since the last inspection all residents' bedroom doors had been fitted with automatic door closures. The provider representative confirmed that the remaining doors would also be fitted with automatic door closures by July 2017. However on the first morning of the inspection a number of doors were wedged open by door wedges or by the placement of furniture. These doors included the doors into the dining room (which was adjacent to the kitchen) and sitting room. This issue was immediately addressed by the person in charge. There was one resident who smoked tobacco in the centre and there was a smoking area provided for residents' who smoked tobacco. There were adequate arrangements in place including records of a risk assessment completed for this resident. This also referenced their capacity to smoke safely including any monitoring/observations requirements.

There were some measures in place to prevent accidents including grab-rails in toilets and handrails on corridors and safe walkways were seen in the outdoor areas. Some clinical risk assessments were undertaken, including assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. Accidents and incidents were recorded on incident forms and were submitted to the person in charge. There was evidence of action in response to individual incidents. However, there continued to be inadequate arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents. For example, from the 11 recorded falls from January to May 2017 there were gaps in the recorded documentation in relation to the treatment, management and follow up actions. A number of accident/incident reports had not been comprehensively completed. For example some of the accident records did not record if the General Practitioner (GP) had been contacted, some records did not record residents' observations or some did not record if the residents' next of kin had been notified. In addition, there were no recorded follow up actions, learning or audits evident from available records. There were no adequate falls risk assessment's or falls care plans available to assist in guiding practice and prevent any reoccurrences. These issues had been identified on the last inspection and the provider representative had given July 2017 for completion of this action.

The health and safety statement seen by the inspector was centre-specific and the health and safety policy was recorded as being most recently reviewed in 2016. There was a risk management policy as set out in schedule 5 of the regulations and included the requirements of regulation 26(1). The policy did cover, the identification and

assessment of risks and the precautions in place to control the risks identified. There was an emergency plan also dated July 2016. however, there continued to be inadequate hazard identification and assessment of risks throughout the designated centre. There was a list of some identified hazards in the centre. Risk assessments were done in the format of audit that listed the control measures in place. However, the level of risk had not been assessed to determine its likelihood and severity. This issue had been identified on the last inspection and the provider representative had given July 2017 for completion of this action. However, the inspector found the following potential hazards that had not been risk assessed:

- there was unsecured access to the staff changing room which contained a number of staff personal items including a number of unsecured personal bags
- there was unsecured access to the laundry/slucice/cleaning room

Hand-washing facilities had liquid soap and paper towels available. The internal circulation areas, toilets and bathrooms were adequately equipped with handrails and grab-rails. Staff confirmed that personal protective equipment such as latex gloves and plastic aprons were available. Overall the centre including the communal areas and bedrooms were generally found to be clean. There was an adequate standard of general hygiene at the centre. However, there were a number of infection control issues including:

- cleaning practices as described by some staff were not in keeping with the centres' cleaning policy or with best practice
- the training matrix indicated that most but not all staff had completed training in hand hygiene and infection prevention and control and this issue was actioned under outcome 18 of this report.
- the floor covering in some areas required repair/replacement for example the linoleum floor covering was cracked on the corridor and could not be appropriately cleaned
- there was evidence of rust like material located on the pipes in some toilets
- there were ingrained stains on the floors of some of the toilets

In addition, the laundry room/area continued to be unsuitable in the design, size and layout; as it did not provided inadequate space for the separation of clean and dirty laundry. The water taps in the sluice type sink were unsuitable in design (domestic type) and there was no wash hand sink available for staff use. The provider representative acknowledged that the laundry room continued to be unsuitable. The laundry room was also used as the cleaners room and sluice room which potentially increased the risk of cross contamination and hospital acquired infections. Sections of plaster on the walls of the laundry room were in need of repair. Other parts the laundry wall had rough plaster finish therefore preventing adequate cleaning. This issue was actioned under outcome 12 of this report. The provider representative stated that there were plans in place to address the laundry room issues however, the provider representative also stated that this was contingent upon adequate funding being provided. This issue had been identified on the last inspection and the provider representative had given December 2017 for completion of this action.

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):

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

Findings:

The centre had operational policies relating to the ordering, prescribing, storage and administration of medicines. Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system. The person in charge had audited medication management practices most recently recorded in August 2016. The centre implemented measures to monitor the safety of medication at each stage of the medication management cycle. Residents were facilitated to have their medicines dispensed by their pharmacist of choice. All medicines were stored securely within the centre and a fridge was available for all medicines or prescribed nutritional supplements that required refrigeration. The temperature of this fridge was monitored and a written record was available. Nursing staff with whom the inspector met outlined adequate procedures for the ordering and receipt of medicines in a timely fashion. The medication trolley was secured and the medication keys were held by the staff nurse on duty. The inspector reviewed a number of medication prescription charts which included the resident's photograph, date of birth, GP and details of any allergy. Medication administration sheets identified the medicines on the prescription sheet and allowed space to record comments on withholding or refusing medications.

There was a system in place for reviewing medications on a three monthly basis by the GP and pharmacist and this was documented in residents' notes.

Controlled drugs were stored in accordance to best practice guidelines and nursing staff were checking the quantity of medications at the start and end of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

The option for residents to self-medicate was in place and this was supported by a centre specific policy. There was adequate and secure storage provided for the residents' medicinal products and access was limited to the resident. However, the practice described to the inspector by staff was not in keeping with the centres' policy or the guidance issued by An Bord Altranais agus Cnáimhseachais. For example there was unsuitable supervision or recording provided to facilitate the resident with self-administration. There was inadequate evaluation (including on-going evaluation) of the residents' ability to self-administer as appropriate. The practice of self-administration of medications was not adequately evaluated and audited. In addition, the residents care plans did not contain adequate details to provide safe, person centred and consistent practice. This issue was actioned under outcome 11 of this report.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

On the previous inspection improvements were required in relation to care plans for residents whose needs were outside the centre's scope of care as per their statement of purpose. This issue was not evident on this inspection. On the last inspection, further improvements were required in relation to residents' care plans. Improvements were required regarding residents' health and social assessments to ensure that all residents' needs were formally identified in a timely manner. Care plans were inadequate to address specific residents' identified needs including, wound care, discharge from the centre or symptom management. The provider had committed a proposed timescale of 1 May 2017 for completion of these actions however, these issues had not been addressed.

The centre provided care primarily for residents with long-term nursing care needs. The statement of purpose stated that "the centre provided supportive care for those who have been assessed as low to medium dependency and not requiring full time nursing care". On the days of inspection there were 35 residents in the centre, with one additional resident in hospital. The majority (32) of the residents were assessed as having low dependency needs and the remaining three residents were assessed as having moderate health and social care needs.

It was evident from speaking with staff that they knew the needs and life history of the residents in detail. On observation of care interventions, staff were seen to anticipate residents' needs in a timely and sensitive manner. Residents were at ease with staff who were assisting them. Residents told the inspector that the staff looked after them very well. Residents were complementary about the care and support provided by staff. Residents confirmed that they felt that the staff informed them of their health care needs and any changes in their conditions. Residents had access to GP services and out-of-hours medical cover was provided. Psychiatry of later life services were available including on going visits by the community psychiatric nurse that was provided to

residents upon referral. There was evidence of residents obtaining a full range of other services on a referral basis. Including speech and language therapy (SALT) and occupational therapy (OT), dietician, chiropody, dental and optical services. The inspector reviewed residents' records and found that some residents had been referred to these services and results of appointments were recorded in the residents' notes.

There was evidence that residents' health and social care needs were met. Residents were provided with the opportunity to retain their own GP if they wished and the person in charge informed the inspector that there were seven GP's currently attending the centre. All residents had a care plan in place and there had been some improvements in the care planning since the last inspection. For example, there was evidence of some improved assessments for example wound care plans and care plan reviews had been provided for all residents. However, as identified on the last inspection, improvements were required in care plan documentation. From a sample of care plans reviewed, care plans were not adequate for the following reasons:

- not all care plans provided adequate guidance/details to support person centred care provision
- not all care plans reflected the individual needs of the residents. For example one resident who was awaiting transfer to another facility did not have any reference to this impending transfer in their care plan. There was no record of any discussion, planning or agreement with the resident regarding this imminent and important move
- there had been 11 recorded falls in the centre since January 2017. However, there were inadequate falls care plans with no assessments, or review completed after each fall or preventative measures detailed in the care plans reviewed
- there was no assessment or plan to guide/inform the provision of meaningful activities for residents
- for residents that self medicated there was no suitable assessment or plans to guide safe medication practice. This issue was actioned under outcome 9 of this report
- for a resident with a identified swallowing difficulty there was no adequate plan to guide practice in relation to providing suitable support with eating and drinking
- residents weights and vital signs were regularly recorded. However, such observations were not recorded on suitable observation charts therefore they were difficult to retrieve, review or audit
- there was a tick box record that indicated each resident received care on a daily basis. However, it was not a nursing record of the person's health and condition and treatment given, in accordance with any relevant professional guidelines as required by regulation.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

The centre comprised of a single storey building that had been purpose built and opened in 1994. It comprised of a main building with 31 single rooms and two doubles. A further eight en-suite residential units were conjoined by a glass corridor at the rear of the building. The centre had capacity for 51 residents with a total of 35 in residence. At the time of inspection all accommodation at the centre was single occupancy. There was a large communal sitting room in the main building along with a dining room and a small oratory.

Overall the design and layout of the centre fitted with the aims and objectives of the statement of purpose and the centre's resident profile. It promoted residents' independence and wellbeing. Storage facilities for equipment was adequate and there was suitable storage for residents' belongings. There was a functioning call bell system in place however, there was no call bell facility available in any of the three sitting rooms.

The centre maintained a safe environment for residents' mobility with hand-rails in circulation areas and corridors kept clean and tidy. There was appropriate lighting and colour schemes. The centre was generally adequately maintained however, there were areas that required attention due to wear and tear including sections of the linum flooring, some toilet floors, tiles and repainting on some of the walls and doors.

Heating and ventilation was suitable. Water was at a suitable temperature. Pipe work and radiators were safe to touch. The main sitting room was bright and had adequate space and there was a separate dining room adjacent to the kitchen. There was a small, quiet sitting room which was suitable for private meetings. Staff toilets, changing and storage space was adequate and well maintained. The outside areas were not overly interesting but adequate with safe paths and some seating. The interior of the centre was decorated in a tasteful manner. The reception area, dining room, sitting room, other communal areas and bedrooms were generally homely. A variety of comfortable seating was provided in the day rooms and in the entrance area.

Overall the centre met most of the requirements of the National Quality Standards for residential Care Settings for Older People in Ireland. However, as identified on previous inspections, the laundry facilities referenced in outcome 2 were not fit for purpose. The laundry room/area continued to be unsuitable in the design, size and layout; as it did not provided inadequate space for the separation of clean and dirty laundry. The water taps in the sluice type sink were unsuitable in design (domestic type) and there was no wash hand sink available for staff use. The provider representative acknowledged that the laundry room continued to be unsuitable. The laundry room was also used as the cleaners room and sluice room which potentially increased the risk of cross

contamination and hospital acquired infections. The plaster in sections of the laundry room wall was in need of repair and other sections of the wall had rough plaster finish therefore prevent adequate cleaning. This issue was actioned under outcome 12 of this report. The provider representative stated that there were plans in place to address the laundry room issues however, that this was contingent upon adequate funding being provided. This failing in relation to the laundry room had been identified on the last inspection and the provider representative had given December 2017 for completion of this action.

Judgment:

Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

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

Findings:

On the previous inspection it was not evident that all residents had the opportunity to raise concerns or put forward suggestions about the running of the centre. Residents' meetings had been held in the centre in previous years however, these had not been conducted since 2015. On this inspection there had been some improvement with evidence that residents had been consulted in relation to their care planning. The provider representative outlined how members of the Board had consulted residents in relation to establishing an on going consultation process. The provider representative described plans to implement a residents forum meeting with an identified/agreed chairperson who was a resident. However, there were no records of this consultation available for review by the inspector. In addition, this chairperson had unexpectedly become unavailable and had yet to be replaced. Therefore, it was not evident that all residents had the opportunity to raise concerns or put forward suggestions about the running of the centre. This continued non compliance was again discussed with the provider representative and members of the Board at the close of the inspection.

The vast majority of residents living in the centre were able to clearly articulate the wishes and preferences. The person in charge and the provider representative outlined how they spoke to all residents nearly on a daily basis. Residents confirmed that they had easy access to both the person in charge and the provider representative and were

seen interacting with both on each day of inspection. However, there continued to be little evidence of on going consultation. The person in charge had issued ten residents' surveys at the end of 2015 and all ten were completed. However, this was the last such survey available. There was inadequate auditing as outlined and actioned under outcome 8 of this report. There was an inadequate annual review for 2016 in which residents had not been consulted as required by regulation.

The inspector observed that residents had the opportunity to exercise personal autonomy and choice, be it what hour they chose to get up or dine at or whether or not they partook in activities. Residents were facilitated to exercise their civil, political and religious rights. There was no restriction on visit times. Residents were able to access radio, television or newspapers. Staff were observed delivering care in a dignified way that respected privacy, for example, by knocking on the resident's bedroom door and awaiting permission before entering. There were some activities provided by mainly volunteers and also by individual staff. Religious preferences were catered for with Mass celebrated by the local priest each Tuesday. Any other religious practices from other religions were also catered for including the local Church of Ireland clergyman who also visited the centre. There was a chapel available in the centre that was well maintained. Outside of religious ceremonies, the chapel was available as a quiet space for residents to pray and reflect. A number of residents had their own motor cars and continued to access local services and maintain social connections with their communities. There were activities such as pongo, arts & crafts, and cards were on offer in the centre. Two residents who played musical instruments also played each Wednesday morning for residents and another musician also attended the centre. During this inspection, residents were seen to partake in a music session in which these residents played musical instruments whilst other residents sang along. However, each resident was not provided with adequate opportunities to participate in activities that were meaningful and purposeful to him or her, and which suited his or her needs, interests and capacities. This finding was evidenced due to the lack of any structured consultation system or process. There were no assessment of residents in relation to occupation and recreation, and opportunities to participate in activities in accordance with their interests and capacities. In addition, there were no care plans that would inform/guide staff in how to support and assist residents in pursuing occupation and recreation, and opportunities to participate in activities in accordance with their interests and capacities. Activities therefore were dictated by the routine and resources of the centre and not by the wishes of residents or their suitability. The failing in care planning was already actioned under outcome 11 of this report.

Judgment:

Non Compliant - Moderate

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:

On the last inspection improvements were required in relation to insufficient staffing and lack of written agreements for volunteers however, both these issues had been adequately progressed by the provider. For example, since the last inspection a number of additional health care staff and nurses had been recruited. The provider representative confirmed that all staff including those recently recruited, had the required vetting disclosure as required under the 2013 Regulations and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016. This was discussed further and under outcome seven of this report.

The person in charge informed the inspector that copies of the regulations and HIQA standards had been made available to all staff. From a review of minutes of staff meetings the inspector noted that a number of issues such as care standards, HIQA inspections and notifications were discussed with staff. The staff rota was checked and found to be maintained with all staff that worked in the centre identified. Systems were in place to provide relief cover for planned and unplanned leave. There were actual and planned rosters were in place. The provider representative, the person in charge and staff confirmed that they were also available for staff to contact outside of hours, if required. There was nurse cover in the centre from 8am until 5pm and from 8pm until 10pm each day. There was a staff nurse or the person in charge on call to staff in the centre at all other times. The person in charge continued to work as a the nurse on duty from 1pm until 5pm for four days and from 9.00am to 5pm for the remaining day each week. Care staff including night staff spoken to gave examples of when this nurse/management supportive arrangement had worked well. For example when a resident had sustained a fall or if care staff had any concerns. However, as already outlined in outcome 2 of this report, the person in charge stated that this staffing arrangement had impacted on her ability the ability to discharge the administration function of her role. There was evidence from this and previous inspections to support this failing, particularly in the context of the size and design of this 51 bedded residential care facility. The provider representative and the board of management were again requested to review this arrangement and make appropriate resources available to support the person in charge. This issue was actioned and detailed under outcome 2 of this report.

The inspector spoke with day and night duty staff who confirmed that staff were rotated between day and night duty to ensure adequate supervision for all staff. Staff confirmed that they had been facilitated in accessing continuing professional education by the provider representative. Records reviewed showed that staff had been provided with opportunities to receive updated training in a number of areas including: safeguarding,

moving and handling, fire safety. However, as outlined under outcome 8 the training matrix indicated that most but not all staff had completed training in hand hygiene and infection prevention and control.

Adequate recruitment processes were in place including a Garda vetting process and the provider representative confirmed that all staff had been Garda vetted. The inspector spoke to recently recruited staff and noted that all care staff received an induction. This included working supernumerary and shadowing another staff member to ensure that the new member of staff was able to become familiar with residents, their needs, the policies and procedures and acquire suitable mandatory training such as fire safety and manual handling training.

There was a system for annual staff appraisal's which the provider representative stated was being reviewed. The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. All nursing staff were on the live register with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland and many of the support staff had completed the Further Education and Training Awards Council (FETAC) level five qualifications.

The person in charge confirmed that any volunteers attending the centre had been suitably supported and monitored, including ensuring that volunteers were clear in relation to their roles and responsibilities while in the centre. Appropriate and respectful interactions were observed throughout both days between residents and staff.

Judgment:

Substantially Compliant

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:

Vincent Kearns
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 Carthage's House Limited
Centre ID:	OSV-0000687
Date of inspection:	24 May 2017
Date of response:	29 June 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:

To prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

1. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

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

This action is already included under "2 Action Required" above.

Proposed Timescale: 29/09/2017

Theme:

Governance, Leadership and Management

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

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.

2. Action Required:

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:

The person in charge and 3 Board Members will carry out a review of the quality and safety of care delivered to the residents within the next 3 months in consultation with the residents and their families. This will be carried out on an annual basis in future.

Proposed Timescale: 29/09/2017

Theme:

Governance, Leadership and Management

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

To ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

3. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

The Board are well aware of the lack of resources and applied to the HSE for an increased allocation last January. A meeting of the Board with the HSE about this occurred on June 6th 2017 and the Board are awaiting a decision from the HSE. We hope that this will be forthcoming before the end of September.

Proposed Timescale: 29/09/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

To ensure all staff are suitably trained in the detection and prevention of and responses to abuse.

4. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Only a few new staff remain to be trained and this will be completed by the start of August 2017.

Proposed Timescale: 04/08/2017

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:

To ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

5. Action Required:

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

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

This action will be completed by September 29th.

Proposed Timescale: 29/09/2017

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre including risk accessing the following:

- there was unsecured access to the staff changing room which contained a number of staff personal items including a number of unsecured personal bags
- there was unsecured access to the laundry/slucice/cleaning room

6. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

Key pads will be placed on the doors to the changing room and laundry.

Proposed Timescale: 15/07/2017

Theme:

Safe care and support

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

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 including the following identified issues:

- cleaning practices as described by some staff to the inspector was not in keeping with the centres' cleaning policy or in keeping with best practice
- the training matrix indicated that most but not all staff had completed training in hand hygiene and infection prevention and control and this issue was actioned under outcome 18 of this report.
- the floor covering in some areas required repair/replacement for example the linum floor covering was cracked on the corridor prevent suitable cleaning
- there was evidence of rust like material located on some of the pipes in some toilets
- there were ingrained stains on the floors of some of the toilets

7. 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:

Point 1. The cleaning practices have been revised and each toilet is now cleaned with a disposable cloth.

Point 2. All staff will be trained in hand hygiene by the 07/07/2017.

Point 3. Replacment of floor coverings requires funding and will be carried out as soon as the extra funds are made available by the HSE.

Point 4.The rust issue will receive attention by the 21/07/2017.

Point 5.New tiles will be placed in the relevant toilets as soon as funds are made available from the HSE.

Point 6. The publications of HIQA relevant to the control of infections are available to all staff for reading and implementation.

Proposed Timescale: 29/09/2017

Theme:

Safe care and support

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

To provide adequate means of escape, including emergency lighting and ensure that no designated fire safety doors are unsuitably wedged open.

8. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

New locks have been ordered and will be put on the doors to the dining room and day room as soon as they are received.

The emergency lighting is checked and documented on a monthly basis.

Proposed Timescale: 30/06/2017

Theme:

Safe care and support

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

To make adequate arrangements for detecting, containing and extinguishing fires including the implementation of all requirements in relation to recommendations from the fire safety report.

9. Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

All staff are trained and updated every 6 months on how to contain and extinguish fires.

Smoke alarms are found in every bedroom and the batteries are checked every 3 months.

Proposed Timescale: 29/09/2017

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:

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 including self-administration of medications.

10. 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:

All residents medications are administered in accordance with the directions of the prescriber of each resident.

Residents self medication records will be updated monthly.

Proposed Timescale: 30/06/2017

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:

To prepare a suitable 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.

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:

This is being done for all residents on admission.

Proposed Timescale: 30/06/2017

Theme:

Effective care and support

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

To arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2) including the following:

- not all care plans reflected the individual needs of the residents for example one resident who was awaiting transfer to another facility did not have any reference to this impending transfer in their care plan. There was no record of any discussion, planning or agreement with the resident regarding this imminent move
 - there had been 11 recorded falls in the centre since January 2017 however, there were inadequate falls care plans with no assessments, or review completed after each fall or preventative measures detailed in the care plans reviewed
 - there was no assessment or plan to guide/inform the provision of meaningful activities
 - for residents that self medicated there was no suitable assessment or plan to guide safe medication practice this issue was actioned under outcome 9 of this report
 - for a resident with a identified swallowing difficulty was no adequate plan to guide practice in relation to providing suitable support with eating and drinking
- residents weights and vital signs were recorded however, such observations were difficult to retrieve, review or audit as such records were not comprehensively recorded

12. Action Required:

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

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

Point 1. Where a resident requires transition to a nursing home, information on nursing homes will be given to him/her and discussed with the resident's family and the outcome will be recorded on the relevant care plan.

Point 2. Where a resident falls, his/her care plan will re-evaluated and the outcome recorded.

Point 3. All residents have access to TV, radio, music, books etc. Each resident will be asked individually about other hobbies they might have. These will then be evaluated and the appropriate action taken.

Point 4. A daily assessment of the self-medicating resident will be maintained.

Point 5. Daily flow sheets will be adapted where necessary.

Point 6. In future, all weights, blood pressures etc will be tabulated in each residents' care plan.

Proposed Timescale: 21/07/2017

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:

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 including

- providing emergency call facilities accessible from each resident's bed and in every room used by residents
- appropriate sluicing facilities
- clean and suitably decorated
- adequate laundry facilities including a wash hand basin in each laundry room.

13. 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:

Point 1. Call bells will be put into all rooms by 01/09/2017.

Point 2. Improvement in sluicing facilities are dependent on the availability of extra funding from the HSE.

Point 3. Cleanliness and decoration and decoration are also dependent on the availability of extra funding.

Point 4. The Board are currently investigating out-sourcing the laundry and tenders are being sought. This should be completed by 22/07/2017.

Proposed Timescale: 01/09/2017

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:

To provide opportunities for residents to participate in activities in accordance with their interests and capacities.

14. 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:

TV, radio, books are available 24/7 and live music is available twice weekly. We will also consult each resident about any other hobbies that they might have. These will be evaluated and the appropriate action taken.

Proposed Timescale: 21/07/2017

Theme:

Person-centred care and support

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

To ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

15. Action Required:

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

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

The Chairman and some members of the Board have consulted the residents on whether a formal consultative system should be put in place. The overwhelming response was that the present system, where any problems are brought to the attention of the PiC, was quite adequate. The Board respects the wishes of the residents in this regard. An annual meeting of the residents and the board will be held and the findings will be documented.

Proposed Timescale: 01/09/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

To ensure that staff have access to appropriate training including training in hand

hygiene and infection prevention and control.

16. Action Required:

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

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

All staff will be trained in hand hygiene and infection control by the 07/07/2017.

Proposed Timescale: 07/07/2017