Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	St Joseph's Hospital
Centre ID:	OSV-0000284
Centre address:	Bon Secours Care Village, Mount Desert, Lee Road, Cork.
Telephone number:	021 454 1566
Email address:	carevillage@bonsecours.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Bon Secours Health System Limited
Provider Nominee:	
Lead inspector:	Aoife Fleming
Support inspector(s):	Maria Scally;Vincent Kearns
Type of inspection	Announced
Number of residents on the date of inspection:	65
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.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following an application to vary registration conditions. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
24 March 2015 08:00	24 March 2015 18:30
30 March 2015 08:30	30 March 2015 09:30

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

Outcome 02: Governance and Management
Outcome 04: Suitable Person in Charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This was the sixth inspection of St Joseph's Hospital by the Health Information and Quality Authority's Regulation Directorate. The purpose of this inspection was to inform an application to vary the registration conditions. As part of the inspection process inspectors met with residents, the person in charge, the clinical nurse managers (CNMs), the hospital accountant/facilities coordinator, staff nurses, care staff, catering staff, household staff, Bon Secours sisters and administration staff. Inspectors observed practices and reviewed documentation such as care plans, medical records, training records, complaints logs. A number of staff files were checked for compliance with regulations and relevant policies were reviewed. The findings of the inspection are set out under 9 outcome statements. These outcomes are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013(as amended); the National Quality Standards for Residential Care Settings for Older People in Ireland.

Most of the actions required from the previous inspection had been addressed and the inspectors viewed a number of improvements. The inspectors found the premises, fittings and equipment were of a high standard overall although some

improvements were required in the area of maintaining a safe environment and preventing risk. There was a good standard of décor throughout and inspectors noticed that residents were using personal items of furniture in their bedrooms which added to the homely atmosphere.

Questionnaires from residents and relatives were viewed by inspectors prior to the monitoring event. The feedback from residents and relatives was one of full satisfaction with the service and the care provided in St Joseph's Hospital. Both relatives and residents praised the staff, the facilities and the care they received in the centre.

The person in charge was involved in the day-to-day running of the centre and was found to be easily accessible to residents, relatives and staff. There was evidence of individual residents' needs being met and improvements made based on their feedback.

Some actions are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

These improvements included: staff training, the identification and management of risk, aspects of infection prevention and control, staff training and the documentation of complaints.

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

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The centre was managed by a full time person in charge who assured inspectors that there were sufficient resources in place to ensure the delivery of safe and quality care to the residents. The person in charge was supported by three experienced clinical nurse managers (CNMs) and there were clear lines of authority and accountability.

An annual review of the quality and safety of care was conducted in the centre by the PIC and actions and improvements were brought about as a result of the learning from this review. The review covered the following areas; falls, medication management, antibiotic prescribing, household/cleaning, health and safety and risk assessment, use of restraint, complaints and catering. The review was developed in consultation with residents as customer satisfaction surveys and the minutes of resident and family meetings were incorporated into the review.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:
A suitable person in charge (PIC) was in place in the centre and was actively involved in the management and organisation of the service. The PIC was well known to residents who identified her as being accessible and approachable. The PIC was an experienced nurse manager and was found to be committed to providing person-centred-care to the residents. She was engaged in regular continuing professional development activities and demonstrated sufficient clinical knowledge and knowledge of her statutory responsibilities.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
There was an up to date policy in place for the prevention, detection and response to elder abuse in the centre. Training on the prevention of elder abuse was provided by one of the CNMs in the centre, who has the necessary qualifications. Some training gaps were identified when records of staff training on elder abuse were viewed and this was also identified on the last inspection. The CNM outlined to the inspector that these staff members are scheduled to complete this training in the centre over the coming weeks.

There was evidence that allegations of abuse in the centre were investigated in accordance with the centre's policy. The staff that were spoken to were all aware of the types of abuse, the importance of reporting any allegations of abuse and informed inspectors that they had attended training on elder abuse. However, some staff were unable to describe what to do if allegation of abuse arose over a weekend or when the PIC was not on duty.

The centre had an up to date policy on the use of restraint. Bed rail assessments were in place for residents that were using bed rails and were signed by the resident. However, in one care plan that was viewed by inspectors the bed rail assessment form did not make it clear that the resident only used a bed rail on one side which was their

personal preference and not to prevent a risk of falling.
The centre had an up to date policy on behaviour that challenges and a restraint free environment was promoted by staff.

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:
The centre had an up to date health and safety statement. The centre had a risk management policy which did not address the risks of abuse, unexplained absence of a resident, accidental injury, aggression and violence and self-harm, as required by Regulation 26(1). This was also a finding on the last inspection. This was addressed during the course of the inspection and the policy was up dated to address these risks.
The inspectors viewed the risk assessments for the centre which identified hazards to staff, residents and visitors. Since the last inspection the doors of the kitchenettes and sluice rooms were fitted with coded locks. However, some risks were identified by inspectors that were not risk assessed.
On the day of inspection an unaccompanied resident was observed smoking in the outside doorway of one the unit day rooms and no safe system was in place for the disposal of used cigarettes. This resident had not been risk assessed for smoking. The policy on smoking required updating as it stated that a no-smoking policy was in place and that when residents were smoking they must be accompanied by a staff member.
Since the last inspection the residents access to unlocked doors leading outside was risk assessed. However, the risk posed by the railings outside, behind which there was a considerable drop to the ground level was not risk assessed.
The last inspection also identified the risk posed by unlocked doors leading to a car park, posing a risk of accidents. However, no actions had been taken to mitigate this risk.
Inside the centre the railings around a stair well with a considerable drop to the basement level were identified by inspectors as a risk to residents however, this hazard had not been risk assessed.
In addition, inspectors noted in the activities room there was a very hot radiator was in place however, it was not covered, posing a burn risk to residents.
Inspectors noted unsecured latex glove and apron holders were in place in the corridors and were not risk assessed.
There was a kettle in the visitors sitting room and kitchenette was not risk assessed.

Loose electrical cables and a window blind cord were observed in a residents day room and needed to be tied up to minimise a trip and choking hazard.
Four walking frames and two wheelchairs were stored inappropriately in a residents day room.
In two units the doors to prevent access to the water-heating systems were open on the day of inspection which posed a potential risk of injury to residents.

Hand washing and sanitising facilities were available throughout the centre. Staff were observed adhering to best practice procedures in infection prevention and control. However, there were no paper towels available for use after hand-washing in one sluice room. Not all sluice rooms were fitted with an air drying rack to minimise the risk of contamination. The inspectors spoke with laundry staff regarding the procedures in place. Inspectors were informed that the alginate bags were washed at 40 degrees Celsius, however the centre policy on laundry stated that clothing soiled with blood or bodily fluids should be washed at or above 60 degrees Celsius.

The centre had CCTV in place which was recording both inside and outside the centre. However, the policy for CCTV did not address the use of CCTV inside the centre and did not adequately state who was responsible for the retention, access and disclosure of images.

Staff property was stored safely in staff lockers in a designated staff changing area.

Fire equipment service records were up to date. Staff were familiar with the fire panel with the safe evacuation of residents out of the centre. Records of the daily checks of fire escape routes and regular fire drills were viewed by inspectors. However, two door wedges were in use to hold fire doors open on the day of inspection; these were removed immediately by the PIC. Since the last inspection an emergency plan was developed and outlines the procedures and plan for the safe placement of residents in the even of an emergency.

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:
A centre-specific policy for medication management was in place and outlined safe procedures for the administration, recording and disposal of medication. The centre

maintained an accurate and up to date register of controlled drugs. Two nurses checked and recorded the controlled drugs balances at the start of each nursing shift. Nurses did not transcribe medications in the centre. There was evidence of the review of residents medications by the General Practitioner on a three monthly basis and residents had a choice of GP.

The prescription sheets clearly identified the medications, the signature of the nurse administering the medication, the times of administration matched the prescription sheet and any medications for crushing were prescribed by the GP. Photographic identification for residents was present. Medications were stored and administered securely in the centre. Medications that were refused by residents were clearly documented in the prescription sheet.

Evidence of a monthly medication audit of the prescription sheets was seen by inspectors to ensure that all prescription sheets were up to date and accurate. Medication errors are recorded in a medication incident form and reviewed by the Clinical Nurse Managers.

Residents did not have a choice of pharmacist in the centre. The PIC informed inspectors that the pharmacist provided educational sessions for nurses.

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:
Care plans were in place for residents and were developed on the residents admission to the centre. Residents were consulted on the development of care and signed them where appropriate. Regular review of the care plan assessments were conducted. Appropriate clinical assessments were in place to address the residents needs. Residents had a choice of GP and most residents were under the care of one GP who visited the centre regularly three days a week and available to visit more frequently if necessary. A daily record of nursing care was recorded in the care plans.

There was evidence in residents care plans of timely access to allied health care professionals. Dental and physiotherapy services were provided in the centre through a referral system. There was evidence of chiropody, speech and language therapy, and dietician services in the centre. The dietician provided regular support to staff in the care of residents with swallowing difficulties or nutritional needs. The Clinical Nurse Managers reported that the incidence of pressure sores in the centre was almost nil over recent years due to on-going monitoring and improvements in mattresses and residents' assessments.

A hair dresser was available at the centre several days a week and residents were observed throughout the days of inspection availing of this service. Beautician services are also available in the centre.
The residents social care needs were facilitated in the centre. An activities coordinator planned a detailed timetable which outlined a wide variety of activities such as reminiscences, bridge, bingo, music, fitness, piano and monthly mobile library. Residents were facilitated to meet their religious and spiritual needs in the centre with daily mass, rosary and other services being provided in the chapel. Residents were observed participating in these activities. Inspectors also noted that residents were assisted to walk around the centre and to the dining room, if that was their choice. Healthy dining choices were facilitated in the dining room and a nutritious choice of meals was on offer to residents. Visitors were observed throughout the days of inspection and there was ample space for them to visit with residents in private.

Judgment:
Compliant

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:
St Joseph's hospital is a purpose built residential centre caring for the needs of 65 residents. The main entrance to the centre was bright and spacious and the dining room, administrative offices, hairdressing and beauty room, chapel and activities room were easily accessible for residents. The centre had 55 registered single bedrooms and five registered double bedrooms. All bedrooms in the centre have an en-suite and there

are two assisted baths in the centre. There was sufficient storage space and lockable storage for residents in their bedrooms. Toilet facilities were available near the dayrooms in each unit and near the dining room and other communal areas. Residents bedrooms were personalised and the dayrooms in each unit were decorated individually and in a homely manner.

The centre was well maintained and clean throughout. Inspectors spoke with staff who were knowledgeable on the cleaning, infection control procedures and the correct use of the colour coded bags for clinical and domestic waste.

There were issues identified during the inspection in relation to risk and these have been addressed under outcome 8: Health and Safety and Risk Management. This was an action outstanding from the last inspection whereby Regulation 19 (3) external grounds must be suitable for, and safe for use, by residents.
- There was unrestricted access to an outside garden area leading to the car park.
- An unlocked external door leading to a garden area where a steep drop was present and located behind a wooden railing.

The provider had made an application to vary the conditions of registration in relation to two new single bedrooms that had been added to the centre to increase the resident occupancy from 65 to 67. As part of this inspection inspectors reviewed these bedrooms and one room was found to be compliant with the Regulations and standards. However, the design and layout of the second bedroom did not provide sufficient space for a resident to move about the bedroom safely. Nevertheless, inspectors noted that this issue was addressed immediately and by the second day of the inspection the bedroom was modified and complied with the Regulations and standards. The new bedrooms were fit for purpose, décor, furnishing, fittings were of a high standard; size of the bedrooms were suitable as were the full en suites. Lights were fitted over the beds, a spacious double wardrobe, a bed side locker and a comfortable chair were in place. Both single rooms were bright with sufficient storage space for residents belongings and a hoist rail and a television was in place. Both rooms had a spacious en-suite with a hand-basin, toilet and shower facilities, with hand rails in place. Call bells were in place in the bedrooms beside the bed and in the en-suites beside the toilet and in the shower.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
The inspectors viewed the policy and procedure for making, investigating and handling complaints. The complaints process was displayed in an accessible format in the reception. The name and contact details of an independent appeals person was provided on the complaints process.

The inspectors reviewed the complaints log and found that complaints were responded to promptly. The details of the investigations into the complaints were provided, however, in some cases the satisfaction or otherwise of the complainant was not recorded. The person in charge was asked to revise the step of the complaints process which recommended that the Health Information and Quality Authority could be contacted for clarification on complaints, as this is not within the remit of the Authority.

Improvements to practice had been implemented in response to some complaints.For example, in order to prevent items of clothing being mixed up in the laundry a new identification button system was in place on all items of clothing to ensure their return to the resident.

Judgment:
Substantially Compliant

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

Theme:
Workforce

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

Findings:
Throughout the course of the inspection residents outlined to the inspectors that they were well cared for kind staff who treated them with respect.

On the morning of the first day of inspection there were two CNMs, four staff nurses, 11 care staff, five catering staff, four cleaning and laundry staff and one administration staff on duty. The sisters of the Bon Secours were also available in the centre. The inspectors reviewed the planned and actual staffing rotas and were satisfied that there were sufficient staff and skill mix in place to meet the needs of the residents. The

inspectors were informed that there was always a CNM on duty seven days a week, and the PIC was present in the centre five days a week, providing a clear and accountable management structure.

Staff training records were viewed during the inspection. Some gaps were identified in the mandatory training in areas such as elder abuse but these staff were scheduled to complete this training in the weeks after the inspection.

A sample of staff files were viewed by inspectors and they contained all the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2013 (as amended). All relevant staff had up to date an Bord Altranais registration. Inspectors spoke with several staff members throughout the inspection and they reported that they were well supported in their roles with clear lines of accountability and duties set out for all staff. The centre has a policy to guide the recruitment and induction of staff into the centre in accordance with best practice.

The centre had volunteers participating in the centre and while they were all Garda Vetted, their duties were not set out in writing as required by the Regulations.

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:

Aoife Fleming
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	St Joseph's Hospital
Centre ID:	OSV-0000284
Date of inspection:	24/03/2015
Date of response:	15/04/2015

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 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some training gaps were identified when records of staff training on elder abuse were viewed. The CNM outlined to the inspector that these staff members are scheduled to complete this training in the centre over the coming weeks.
However, some staff were unable to describe what to do if allegation of abuse arose over a weekend or when the PIC was not on duty.

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

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:
As per factual inaccuracy - There were two staff members who have had full Elder Abuse training, their updated training had to be rescheduled due to sick leave, and we scheduled to do updated training the week after this inspection. This has been completed.
All staff have been reminded to re read the Hospital policy on Elder Abuse which is available on the floor for them at all times. This policy is given at initial Elder Abuse training also which all staff have been fully trained in. Our policy clearly sets out the handling of all allegations.

Proposed Timescale: 15/04/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
However, some risks were identified by inspectors that were not risk assessed.
On the day of inspection an unaccompanied resident was observed smoking in the outside doorway of one the unit day rooms and no safe system was in place for the disposal of used cigarettes. This resident had not been risk assessed for smoking. The policy on smoking required updating as it stated that a no-smoking policy was in place and that when residents were smoking they must be accompanied by a staff member.
Since the last inspection the residents access to unlocked doors leading outside was risk assessed. However, the risk posed by the railings outside, behind which there was a considerable drop to the ground level was not risk assessed.
The last inspection also identified the risk posed by unlocked doors leading to a car park, posing a risk of accidents. No actions had been taken to mitigate this risk.
Inside the centre the railings around a stair well with a considerable drop to the basement level were identified by inspectors as a risk to residents but this had not been risk assessed.
In the activities room a very hot radiator was in place and was not covered, posing a burn risk to residents.
Unsecured latex glove and apron holders were in place in the corridors and were not risk assessed.
A kettle in the visitors sitting room and kitchenette was not risk assessed.
Loose electrical cables and a window blind cord were observed in a residents day room and needed to be tied up to minimise a trip and choking hazard.
Four walking frames and two wheelchairs were stored inappropriately in a residents day room.
In two units the doors to prevent access to the water-heating systems were open on the day of inspection which posed a risk of injury to residents.

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:
Re: Lady on Respite who was smoking, she had been asked to call a staff member to go with her on admission. She was here for one week and is no longer here. We have amended our policy and also informed Respite Liasion Officer to ensure if any smokers are sent here on respite that they are aware of our smoking policy.
Re: unlocked doors – this is an open facility, which all potential residents are made aware of & are assessed prior to admission to ensure they are suitable. We discussed this with the Inspectors on the day and with Inspectors at the previous inspection that we allow our residents the freedom of movement and if we feel they are not suitable for our facility we do not admit them. We feel the risk is minimal and will not be locking the doors. All exit doors have been risk assessed. These will be monitored, and evaluated regularly as required and any actions required will be taken to, at all times ensure the safety of our residents is a priority. The following are more detailed steps we have had in place.
• All residents are assessed pre admission to assess their suitability to our open door facility. If there is a high risk of wandering/ absconsion and we are not the most suitable facility to meet their needs , they are not accepted for admission.
• Any of our current residents at risk of wandering are monitored regularly. A whereabouts chart is used and security bracelets are provided whereby an alarm sounds to alert staff if the resident passes certain points in the building.
• Some of our doors are alarmed.
• Plans are in place to erect a secure fence around each garden to enclose them and minimize any risk .This will ensure all residents can avail of our gardens and are safe.

The railings outside that are mentioned were risk assessed in Feb 2014. They meet Building Regulations and Safety Standards. We put a caution sign there last year and do not feel this is a risk to our residents. Risk assessments completed, are monitored and evaluated regularly as required and any actions required dealt with.
New Signs ordered to say' Beware of steep drop' . These will be erected as soon as we get them on all railings.
None of our current residents have been assessed as at risk.
Plans are in place to amend our railings, to raise them higher and ensure they can't be climbed on, thus reducing any risks.

We have risk assessed the internal railings which also meet Building Regulations and Safety standards. These have been risk assessed and have a low risk rating. This will be monitored and evaluated regularly and any actions needed will be undertaken.
None of our current residents are identified as high risk at present.
Plans are in place to alter these railings to ensure the risk to our residents, staff and visitors is zero.

The radiator in the Activities room is operated under the same heating system and thermostatic control as the rest of the building, it will not reach a temperature for

burning. However we have ordered a radiator cover for this.
The Dani centres which store aprons and gloves in the corridors have been risk assessed. They will be monitored and evaluated regularly .
We have risk assessed the kettle in the visitors room. As this room should be kept locked we have reminded staff of this practice.
Electrical cables that were loose & window blind cord were secured on day of inspection. We are always on the look out for anything like this.
Walkers & wheelchairs that were in one of our six dayrooms were there to be in close proximity to the residents and had been taken from their room for cleaning by night staff these were returned to residents rooms once they were up.
Re: water heating systems doors – these were fitted with locks last year and staff who are accessing the linen press in the mornings have been reminded they need to lock the door behind them each time.
CCTV – this policy has been updated and signs have been put in place.
Re: Wedges in two doors – Staff have been reminded not to use wedges on any doors as is our strict hospital policy.

Proposed Timescale: Complete (Radiator cover & Signs 20th May 2015) (Review railings July 2015)

Proposed Timescale: 15/04/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no paper towels available for use after hand-washing in one sluice room. Not all sluice rooms were fitted with an air drying rack to minimise the risk of contamination. The inspectors spoke with laundry staff regarding the procedures in place. Inspectors were informed that the alginate bags were washed at 40 degrees Celsius, however the centre policy on laundry stated that clothing soiled with blood or bodily fluids should be washed at or above 60 degrees Celsius.

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:
Re: Paper towels in sluice room – Holder has been put back on wall.
Re: Air drying rack – Modified, has been put back on wall
Re: Alginate bags at 60 degrees – It is our hospital policy to wash all soiled clothes in alginate bags at 60 degrees regardless of what type of clothing is in the bag. We have gone through the Hospital policy again with this member of staff and our Infection Control team will speak to all staff regarding the use of alginate bags.

Proposed Timescale: 15/04/2015

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were issues identified during the inspection in relation to risk and these have been addressed under Outcome 8: Health and Safety and Risk Management. This was an action outstanding from the last inspection whereby Regulation 19 (3) external grounds must be suitable for, and safe for use, by residents.
- There was unrestricted access to an outside garden area leading to the car park.
- An unlocked door leads out to a garden area where a steep drop is present, behind a wooden railing.

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:
This has been discussed in Outcome 8

Proposed Timescale: 15/04/2015

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The details of the investigations into the complaints were provided, however, in some cases the satisfaction or otherwise of the complainant was not recorded.

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

Please state the actions you have taken or are planning to take:
Complaints book has been amended as per above.

Proposed Timescale: 15/04/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff training records were viewed during the inspection. Some gaps were identified in the mandatory training in areas such as elder abuse but these staff were scheduled to complete this training in the weeks after the inspection.

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:
As per factual inaccuracy - all our staff have had Elder Abuse training. There were two staff who had to have their refresher training rescheduled due to sick leave, this was scheduled for the week after this inspection so is now complete.

Proposed Timescale: 15/04/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The centre had some volunteers participating in the centre and while they were all Garda Vetted, their duties were not set out in writing as required by the Regulations.

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:
Our volunteer duties were amended to be more specific for the current volunteers we have here. All long standing volunteers have been given these more detailed duties for their roles. All recent volunteers already had the appropriate role description.

Proposed Timescale: 30/04/2015