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 Luke's Home
Centre ID:	OSV-0000290
Centre address:	Castle Road, Mahon, Cork.
Telephone number:	021 435 9444
Email address:	info@stlukeshome.ie
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Lukes Home (Mahon) Limited
Provider Nominee:	David O'Brien
Lead inspector:	Mairead Harrington
Support inspector(s):	Mary Costelloe;Michelle O'Connor
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	127
Number of vacancies on the date of inspection:	1

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. 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:
15 February 2016 10:30	15 February 2016 17:15
16 February 2016 09:00	16 February 2016 14:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs		Substantially Compliant
Outcome 02: Safeguarding and Safety		Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation		Non Compliant - Moderate
Outcome 04: Complaints procedures		Compliant
Outcome 05: Suitable Staffing		Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises		Substantially Compliant

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. Inspectors followed the experience of a number of residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia, using a validated observation tool. As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide providers on best practice in dementia care and the inspection process. The provider had submitted a completed self assessment on dementia care to the Authority with relevant policies and procedures prior to the inspection. This return summarised a review of dementia services in the centre as commenced in July 2015. Actions in progress included the further development of a dementia specific unit in the centre with a capacity for 38 residents. Areas for attention included review of policies, education and training programmes and environmental initiatives such as orientation signage, layout and colour design.

The inspection assessment focused on the delivery of care in this dementia specific unit. As part of the process inspectors met with residents, visitors, staff nurses and care staff, the person in charge and members of management and administration staff. Inspectors observed practices and reviewed a sample of care plans including health and medical records. Documentation reviewed by the inspectors on-site included staff rosters and training records, meeting minutes, policies and related protocols.

Issues identified on previous inspection had been addressed. Overall the inspection established that a very good quality of care was delivered by this service. Actions required to further comply 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 included improvements in environment, documentation and person-centred care practice. These issues are covered in more detail in the body of the report.

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, assessment and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

Based on observations, feedback and a review of documentation and systems, inspectors were satisfied that there were suitable arrangements in place to meet the health and nursing needs of residents with dementia or cognitive impairment. Members of staff and management spoken with explained that a dementia focused strategy had been developed and was being implemented to improve provisions around care, facilities and training in place to meet the needs of residents with dementia or cognitive impairment. Residents could retain the services of their own general practitioner (GP) and had regular access to the services of allied healthcare professionals or as required; these included a speech and language therapist, dietician, optician and chiropodist for example. The centre retained the regular services of a physiotherapist with arrangements being developed for on-site access to the services of an occupational therapist. Inspectors tracked a sample of resident care plans and found that, overall, timely and comprehensive assessments were carried out and appropriate care plans were developed in line with the changing needs of residents. The centre implemented an effective admissions policy which included a pre-admission review and assessment by the resident social worker, as well as a comprehensive health and welfare assessment by a qualified nurse. A dementia care policy was in place dated January 2016 that referenced the need to pay particular attention to the assessment of clinical issues for residents with dementia such as weight loss, changes with appetite, constipation, urinary tract infections, pain, skin and pressure area care. A care plan monthly checklist was in place to monitor and review these assessments which included a section for recording specific issues to be addressed and any corrective or preventative action to be implemented. Care planning management had recently transferred to an electronic process. Records on those plans reviewed by inspectors indicated that residents and their families, where appropriate, were involved in the care planning process. Care plans reviewed contained relevant information to guide the care of residents and were updated routinely on a four monthly basis or to reflect the residents' changing care needs. The care planning process involved the use of a range of validated tools

including those to assess residents' risk of falls, nutritional status, level of cognitive impairment and skin integrity for example. Regular referrals for dentistry took place if required. Of the files reviewed correspondence relating to hospital transfer arrangements was in place. These included relevant information about the residents' health, medications and communication needs and, where available, advance care plans.

Residents either diagnosed with dementia or presenting impaired cognition had appropriate assessments around communication needs in place. The inspectors found that nutritional needs were well met in the centre. Residents were seen to be provided with a regular choice of freshly prepared food. Menu options were available and residents on a modified diet had the same choice of meals as other residents with appropriate consideration given to the presentation of these meals. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. A record of residents who were on special diets such as diabetic and fortified diets or fluid thickeners was available for reference by all staff and kept under review. Service systems were in place to ensure residents had access to regular snacks and drinks. All residents were appropriately assessed for nutritional needs on admission and were subsequently reviewed regularly. Records of weight checks were seen to be maintained on a monthly basis and more regularly where significant weight changes were indicated. Nutritional and fluid intake records were appropriately maintained where necessary and records indicated weight gains for residents subject to monitoring.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised, medications reviewed and care plans were updated to include interventions to mitigate the risk of further falls. Of the care plans reviewed inspectors noted that discussion with residents and their families about end of life care arrangements had taken place and were recorded. There was also evidence of advance care planning with arrangements in place around hospital transfers to ensure this information was available for reference. Measures were in place to prevent unnecessary hospital admissions and included regular attendance and review by the GP, informed advance care plans and access to palliative care as well as hospice services. As part of the review inspectors spoke with family members following recent bereavement and information in this regard indicated that care and consideration was person centred and of a high standard with appropriate consideration given to the wishes and preferences of residents where expressed.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were implemented in practice and staff were observed to follow appropriate administration practices. However, the policy did not reference 'pro re nata' (as required) medications.

Judgment:
Substantially Compliant

Outcome 02: Safeguarding and Safety

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 policy dated April 2015 was in place for the protection of vulnerable adults which outlined procedures and appropriately referenced current national guidelines and policy and included guidance on protected disclosures. Records indicated that regular training on safeguarding and safety was provided. Staff members spoken with by inspectors had received training and understood how to recognise instances of abuse and were aware of the appropriate reporting systems in place. A programme of training in safeguarding was in place supported by the resident social worker. Where allegations had been made inspectors noted that the recording and management of this information was in keeping with related procedures and statutory guidance.

A comprehensive policy dated 8 September 2015 was in place on person-centred approaches to dementia and support for persons who present with responsive behaviours. This included guidance on input by a multi-disciplinary team and the use of behavioural charts. Through observation and review of care plans the inspectors were satisfied that staff were knowledgeable of their residents' needs and provided support that promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD). Staff were seen to reassure residents and divert attention appropriately to reduce anxieties. There was a policy on restraint dated June 2015. However, information around the definition of an enabler in this policy did not reflect national guidance and required review. The policy promoted a restraint free environment and the use of alternatives such as ultra-low beds and crash mats in the first instance. Inspectors noted that this approach was observed in practice. Where restraints such as bed-rails were in use assessments had been undertaken and nursing notes reflected regular monitoring and review. Action on the recording and reporting of the use of restraint had been addressed since the last inspection which was now in keeping with statutory requirements.

There was a current policy and procedure in place on the management of residents' accounts and personal property. The inspector spoke with an administrator who explained that most residents were responsible for the management of their own finances with the support of families. There were no cash transactions for services on-site and charges for such services were included in the regular billing and invoice system. Where the centre operated as an agent for residents' pensions appropriate protocols and safeguards were in place including an internal and external audit.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
The centre had adopted a pro-active approach in developing initiatives around dementia care and a dementia strategy group was in place that had convened four times since July 2015. A dementia care policy was in place effective from January 2016. The centre was seen to promote a culture of advocacy and consultation through a number of initiatives and practices. For example the services of a resident social worker were retained with responsibilities around ensuring the voice of the resident is heard and that the rights of the individual were observed. A comprehensive admissions policy described processes for pre-admission assessments by the social worker around life history, preferences and social rights. Appropriate supports were in place to facilitate residents in voting. Processes for consultation were in place with resident councils convening monthly and the minutes of these meetings were displayed on notice boards in each unit. Topics covered included mealtimes, outings and activities. Records of consultation with families were in place and those relatives spoken with by inspectors reported regular communication and update around the circumstances of care. The services of an independent advocate were available who was identified by photograph with contact details also clearly displayed. Inspectors saw completed survey results and questionnaires around how services were delivered in the centre and improvements that could be made.

There were no restrictive visiting arrangements and on the days of inspection a good number of visitors were observed spending time with residents in all areas of the centre. In Maguire House visitors were variously present throughout the day and there were areas for residents to receive visitors in private should they so wish. The centre provided access to a chapel on-site and pastoral services were available with religious service at the centre on a daily basis.

Maguire House was a secure unit and its layout was based on a 'household' model with homely fixtures and furnishings. Consideration had been given to colour co-ordination and contrast. The space had good natural light and was well laid out with access from three points to secure outside space. All flooring was level with no trip hazards at access points. Residents were seen to wander freely through the unit and individual preferences were observed with residents able to take naps when and where they chose. There was also a good sensory room (snoezelen) with ambient lighting and water features that residents could access unrestricted. However, as outlined in Outcome 6 of this report, the design and layout of multi-occupancy bedrooms that were in use in the wider centre did not provide adequate privacy and dignity in relation to use of space for personal hygiene and information and communications of a private nature.

The centre had a dedicated full-time activities co-ordinator who managed a programme of activities and also organised special events and celebrations and was resourced with

four activity leaders and two volunteers. Inspectors saw that effort was made to mark relevant cultural occasions and during the inspection for example, there were brightly designed displays and decorations throughout the centre themed around Valentine's Day. The centre provided a wide range of activities such as art, Sonas, Boccia, film night and cookery and residents also had the opportunity to go on regular bus outings. As part of the dementia strategy initiated by the centre the activities co-ordinator had undertaken a review of the provision of meaningful activities in Maguire House and an observational study had taken place in October 2015. Recommendations from this review included enrichment of the living environment and increased awareness and training around sensory based living and activities. On the days of inspection a musician was present for a time on both days doing musical activities and singing which residents partook in and clearly enjoyed.

Aside from routine observations, as part of the overall inspection, a standardised tool was also used to monitor the extent and quality of interactions between staff and residents during discrete 5 minute periods in a block of 30 minutes. Three episodes were monitored in this way. One episode returned a positive result with notes that staff had engaged positively and meaningfully with residents on a regular basis. The other two episodes also returned a positive result but notes indicated less frequent interaction between staff and residents with some residents experiencing no interaction at all throughout the timeframe. In general, residents with dementia were seen to receive care in a dignified way that respected their personhood. Inspectors observed staff interactions with residents that were appropriate and respectful in manner. However, an inspector observed poor practice around assisted eating at one mealtime with members of staff talking over a resident's head and not providing adequate attention or consideration to the person they were supposed to be assisting. Inspectors noted that comment on this kind of practice had also been made in the minutes of a recent resident meeting.

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There was a complaints policy in place dated April 2015 and the complaints procedure was displayed prominently in the centre. In keeping with statutory requirements the procedure for making a complaint included the necessary contact details of a nominated complaints officer and also outlined the internal appeals process and the nominated individual with oversight of the complaints process. Contact information for the office of

the Ombudsman was also provided.

The inspectors reviewed the complaint records on file and noted that records were maintained about each complaint with details of any investigation into the complaint and whether or not the complainant was satisfied with the outcome. Inspectors were satisfied that the system for dealing with complaints was in keeping with statutory requirements. Staff members spoken with could explain how complaints were reported and logged and also how learning from complaints was communicated through regular staff and management meetings. Further information on advocacy is recorded against Outcome 3 on Rights, Dignity and Consultation.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
The inspector reviewed recruitment and training records and procedures and spoke with staff and management in relation to both these systems. Staff spoken with demonstrated an appropriate knowledge of evidence based good practice and were competent to deliver care and support to residents. Staff were also familiar with the Standards and Regulations and were aware of their statutory duties in relation to the general welfare and protection of residents. A regular programme of training was in place that captured all mandatory training and also addressed the specific needs of the resident profile. The dementia strategy group had identified a programme of education to be implemented for all staff at the centre on better understanding dementia and an awareness around communication issues in relation to dementia. The person in charge explained that staff members had been nominated for the next national dementia champion programme. Training delivery was supported by on-site resources such as the physiotherapist and resident social worker. Staff spoken with confirmed that they were supported to attend training as required. The planned and actual staff rota was reviewed and, overall, inspectors were satisfied that the staff numbers and skill mix were appropriate to meet the needs of the residents having consideration for the size and layout of the centre. An additional clinical nurse manager had recently been rostered at night to improve cover. However, inspectors were told that enough staff were not always available to support residents from Maguire House in attending the daily religious service and residents could often only attend if visitors were available to take them.

At time of inspection the system of supervision was directed through the person in

charge with designated administrative support. Management systems were in place to ensure that information was communicated effectively and minutes of staff meetings were available for reference. There was a clearly defined management structure that identified the lines of authority and accountability. A schedule of staff appraisals was in place. Supervision was also implemented through monitoring and control procedures such as audit and review. An appropriately qualified, registered nurse was on duty at all times. Copies of the Standards and Regulations were readily available and accessible by staff.

Recruitment and vetting procedures were in place that verified the qualifications, training and security backgrounds of all staff. A sample of staff files was reviewed and documentation was appropriately maintained as per Schedule 2 of the Regulations. A record of current professional registration details was in place. The centre engaged a number of volunteers and arrangements in this regard around vetting and supervision were in keeping with statutory requirements. However, some residents at the centre retained the services of a personal assistant for companionship and policy and procedures on staffing required review to address appropriate provisions in relation to these arrangements.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The centre was a split level two-storey, purpose-built facility. Administrative facilities were located on the first floor with a separate training/education centre in an adjacent building on campus. Facilities throughout the premises included a main kitchen, laundry facilities, a restaurant/dining area, communal areas such as a large conservatory, an activity room, chapel, physiotherapy space, art room and library. There was also a family meeting room with computer access for residents. There was an on-site pharmacy facility. Residential accommodation for a maximum 128 residents was located throughout the ground floor. Overall there were 84 single bedrooms, 10 twin bedrooms and six four-bedded rooms all with toilet, shower and hand-wash basin en suite facilities.
Accommodation was arranged over four nominated 'Houses' – each house had appropriate facilities in keeping with requirements including staff facilities, sluice facilities, kitchenette, storage areas, treatment room, additional shower and toilet facilities. Actions identified on previous inspection in relation to design, layout and storage had been appropriately addressed. However, the continued use of multi-occupancy rooms for up to four residents in three of the four houses impacted on the

privacy of these individuals and action in this regard is recorded against Outcome 3 on Rights, Consultation and Dignity.
Whilst inspectors undertook a general review of the premises, the focus for the purpose of this inspection was on Maguire House – a unit configured with the needs of residents with dementia and cognitive impairment in mind. The design and layout of this unit was in keeping with its dementia-specific purpose. The strategy for this house included its separation into a north and south unit, to accommodate residents with advanced and new onset dementia respectively; this process had commenced in January 2016. Colour contrast was used appropriately on floors and along hand-rails. Communal areas were furnished in a homely style with dressers and soft furnishings; one area had a traditional fire place and armchairs. Wall spaces were decorated with large photographs of local areas and amenities, settings familiar to many residents from previous times. There were two dining areas with ample space and seating to meet the needs of residents. The central area of the unit was open plan with direct and unrestricted access to an enclosed patio garden area with seating and shade. Secure outside space could be accessed freely from other exits within the unit also. Two nursing stations were located adjacent to communal areas in the unit. Facilities included an accessible and appropriately risk assessed kitchen and dining area where residents could participate in baking activities and also sit and eat if they so wished. There was a well equipped multi-sensory room with soft seating and low lighting. Hand rails were provided in circulation areas and grab rails were in bath/shower/toilet areas. Specialist assistive equipment was available where necessary and appropriately stored. Individual rooms were appropriately furnished and decorated with ample storage space. Resident rooms were personalised to varying degrees with individual belongings and memorabilia. Orientation signage both in this unit, and in some areas of the wider premises, did not fully support the needs of residents with cognitive impairment. Some signage was set too high and was out of line of sight. In Maguire House although there were printed names on residents' room doors, all doors were the same colour and there was little to assist residents with cognitive impairment to identify their own rooms. As outlined in the introduction to this report a dementia strategy group was in place that had identified a "household model" as the adopted approach in developing the physical environment in Maguire House and the person in charge confirmed that signage had been identified as an issue to address.

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:

Mairead Harrington
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 Luke's Home
Centre ID:	OSV-0000290
Date of inspection:	15/02/2016
Date of response:	16/03/2016

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on medication management did not provide practice guidance and procedure around the administration of 'pro re nata' (as required) medications.

1. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them

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

in accordance with best practice.

Please state the actions you have taken or are planning to take:
All Medications including PRN medications are administered in accordance with NMBI Guidance to Nurses and Midwives on Medication Management, which is reflected in the Policies of the Home.

The policy has now been amended to state PRN Medications, and appendix 15.4 updated to reflect the monitoring and practice as was in place at the time of inspection.

Proposed Timescale: 16/03/2016

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Information around the definition of an enabler in the restraint policy did not reflect national guidance and required review.

2. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The wording of the policy has been amended.

Proposed Timescale: 16/03/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of multi-occupancy rooms rooms that were in use in the wider centre did not provide adequate privacy and dignity in relation to use of space for personal hygiene and information and communications of a private nature.

3. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
All multi-occupancy (2 and 4 bedded) rooms have appropriate separation and screens between Residents to protect their privacy and dignity. The 2 bedded rooms in Gregg House and Wise House have been renovated following the registration inspection in May 2015, and this was confirmed to HIQA on completion.

We have asked our Architects to look at alternative layouts for the 4 bedded rooms in Gregg House and Wise House.

Proposed Timescale: 04/08/2016

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was poor practice around assisted eating at one mealtime with members of staff talking over a resident's head and not providing adequate attention or consideration to the person they were supposed to be assisting.

4. Action Required:
Under Regulation 09(4) you are required to: Make staff aware of the matters referred to in Regulation 9(1) as respects each resident in a designated centre.

Please state the actions you have taken or are planning to take:
The incident has been raised to all Clinical Nurse Managers in the Home; all staff have been re-instructed on the appropriate communication for Residents during meal times.

Additionally, the staff members concerned have been re-instructed on the appropriate means of communication and assistance to Residents whilst eating.

Proposed Timescale: 16/03/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policy and procedures on staffing required review to address appropriate provisions in relation to arrangements around personal assistants for residents.

5. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any

event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
St. Luke's Home does not employ Personal Assistants.

When requested by a Resident or family, St. Luke's Home provides a referral to a recognised agency for the Resident.

Where a family or Resident has a private arrangement in place, St. Luke's Home will request the relevant documentation in line with the requirements for volunteers. The Home's volunteer policy will be updated to reflect this practice.

Proposed Timescale: 30/08/2016

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were times of the day when staffing levels in Maguire House did not adequately support residents to avail of services to the extent of their abilities.

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

Please state the actions you have taken or are planning to take:
St. Luke's Home maintains constant review of the staff roster, and continues to change the staffing profile and skill mix to meet changes in Residents needs on a daily and weekly basis. The Home is currently changing Maguire House into 2 separate DSU's, at which stage the staffing complement will be reviewed again to ensure suitable and adequate staffing in both units.

Proposed Timescale: 16/03/2016

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Orientation design and signage did not fully support the needs of residents with cognitive impairment.

7. 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:
The Home is procuring new signage for communal areas and also for Maguire House, suitable to the Residents need.

Proposed Timescale: 30/08/2016