Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Cherryfield Nursing Home
Centre ID:	0213
Centre address:	Ballygarrett Gorey Co Wexford
Telephone number:	053-9427286
Fax number:	053-9482953
Email address:	larrydoylecherryfield@yahoo.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Larry Doyle
Person authorised to act on behalf of the provider:	Larry Doyle
Person in charge:	Catherine Murphy
Date of inspection:	4 August 2011 and 5 August 2011
Time inspection took place:	**Day-1 Start:** 09:50hrs **Completion:** 17:20hrs **Day-2 Start:** 10:00hrs **Completion:** 16:30hrs
Lead inspector:	Gerry McDermott
Support inspector(s):	Tom Flanagan
Type of inspection:	☐ **Registration** ☒ **Announced** ☐ **Unannounced**

About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

About the centre

Location of centre and description of services and premises

The centre is located on the periphery of a small rural village in Co Wexford. On one side of the centre there is a primary school while on the other side is the provider's dwelling. The centre provides long-term care for up to 17 residents. On the day of inspection there were 16 residents.

The centre is single storey and was purpose-built on a site adjacent to the provider's dwelling. There is a cultivated garden to the side and front of the building. There is parking for approximately eight cars in the grounds.

The small communal room, the dining room and the office all connect directly to the small reception/entrance area. The main communal room is entered through the dining room. A corridor from the reception/entrance area leads to all bedrooms, toilets, the assisted bathroom and the shower room.

There are nine single bedrooms and four twin bedrooms. None are en-suite. The community dining room is adjacent to the kitchen and two community day rooms. There is a small office used by the person in charge and nursing staff. The assisted bathroom also contains a toilet. There is a shower room and a separate toilet. There is also a toilet located in the sluice room.

Date centre was first established:			1989	
Number of residents on the date of inspection:			16	
Number of vacancies on the date of inspection:			1	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents	0	2	10	4
Gender of residents			**Male (✓)**	**Female (✓)**
			6	10

Management structure

The Person in Charge is Catherine Murphy and she reports to the Registered Provider, Larry Doyle. A specified nurse who is key senior management (KSM) deputises for the Person in Charge when she is absent. Care staff, nursing staff, catering staff and cleaning staff report to the Person in Charge.

Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This report sets out the findings of an inspection, which took place following a registration inspection and previous follow-up inspections, following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007.

This was the fourth inspection undertaken by the Authority. Inspectors met with residents, relatives, management and staff members over the two day inspection. Inspectors had lunch with residents. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The findings of the inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Residents' comments are found throughout the report.

The last inspection took place on 14 January 2011, reference 1385. It was a one day unannounced follow-up inspection on 14 outstanding actions from a previous inspection. On that date, inspectors found that improvements were required in the following areas:

- reviewing quality of care
- providing meaningful activities for residents
- providing sufficient storage space for equipment and communal space
- providing adequate documented fire safety training
- developing centre-specific policies and procedures required by law
- providing a Residents' Guide in compliance with legal requirements
- obtain the mandatory information required when employing staff
- develop agreed care plans with residents
- insufficient staffing
- providing suitable staff facilities
- ensuring staff work different shifts
- providing health and safety training for staff
- providing the necessary notifications to the Chief Inspector.

On this inspection inspectors found that management and staff showed a respectful, caring attitude to residents. Relatives and residents confirmed this view. The centre was clean, tidy, comfortable and well furnished. Residents' bedrooms were personalised. Staff were generally attentive to the health care and wellbeing of residents. Food was good.

However, the centre did not adhere to all of its own policies. While staff training was provided, not all staff had all the training required by law. Management required further training in elder abuse detection, response and prevention. Record keeping relating to medication management needed improvement.

Inspectors found an inadequate level of compliance with the Care and Welfare Regulations and the National Standards. Improvements are required to enhance the care provided to residents. Areas requiring attention to enhance the findings of good practice are discussed under the outcome statements and the related actions are set out in the Action Plan under the relevant outcome. Thirteen out of 18 outcomes required 36 actions in total. Improvements are required in the following areas:

- statement of purpose
- reviewing quality of care
- detecting, responding to and preventing abuse training
- providing adequate documented fire safety training and testing of fire safety equipment
- documenting centre-specific procedures for medication management
- developing centre-specific policies and procedures required by law
- consulting with residents in an organised way
- providing meaningful activities for residents subject to their needs
- providing sufficient storage space, communal space and sanitary facilities
- keeping the necessary records required by law.

Section 50 (1) (b) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. Statement of purpose and quality management

Outcome 1

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.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

The statement of purpose described the service that was provided in the centre. However, it did not meet all the requirements of Schedule 1 of the Health Act 2007

(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).
The statement of purpose set out the aims and ethos of the centre. It did set out the facilities and services provided. It stated that:

- the centre caters for 17 male and female residents over 65
- under 65 if requested by a general practitioner (GP) or hospital
- the range of needs intended to be met in the centre are care of the elderly and adults up the high dependency, but, not residents with severe forms of dementia
- the type of nursing care to be provided coveres a wide range of conditions such as Parkinson's, diabetes, stroke and mild forms of Alzheimer's
- the criteria used for admission is normally by referral from doctor, hospital or the Health Service Executive (HSE)
- Emergency admissions are not encouraged.

However, it stated that there was an activities coordinator when there was none. It stated that there was an extensive policy and procedure on admission. However, in practice this was not always observed. The facilities and services described did reflect the diverse needs of residents. See outcome 7.

The statement did not meet all the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Omissions included the dimensions of communal rooms and the number and categories of whole time equivalent (WTE) staff employed in the centre. The statement was last reviewed in February 2011. It was stored in a plain folder beside a notice board in the main hallway. The notice board and the folder were clearly visible. However, the folder was not clearly labelled to indicate its contents to a resident or a relative.

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

The quality of care and experience of the residents was not sufficiently monitored and developed on an ongoing basis.

An external pharmacy had recently audited medication management in the centre. Inspectors viewed a record of a discussion between the pharmacist and the person in charge. There was a recommendation to change recording sheets and this had been implemented. Inspectors viewed details of an appointment made with a visiting GP

scheduled for the week following the inspection to review the needs of eight residents. The documentation was comprehensive. The person in charge stated to an inspector that she planned to work with other GPs in the same way. The person in charge stated to an inspector that a consultant had visited the centre in the week before the inspection to provide training and documentation in reviewing quality of care provided to the person in charge. The inspector viewed audit templates supplied. However, the person in charge was not specific as to when she planned to undertake audits.

Inspectors viewed records of residents' committee meetings. However, the records were very limited and did not provide sufficient information on residents' opinions or suggestions. Apart from these meetings there was no formal consultation with residents or relatives such as by surveys or questionnaires. There were no formal meetings of management personnel where the results of audits could be discussed. Inspectors viewed the accident/incident book. Only in some of the reports were the details of learning that took place and measures in place to prevent recurrence.

Outcome 3
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.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

There was a clear complaints process which was effective. There was a written policy and procedure for the management of complaints. It was prominently displayed on a notice board in the hallway. It was also included in the statement of purpose.The procedure described how a person could make a complaint and to whom. The person in charge was the nominated person to deal with all complaints. There was an appeals process and a named external advocate. The advocate confirmed to inspectors that he was available for this process. The person in charge was readily available to residents and relatives in the centre and was seen by inspectors to interact with them. The nominated advocate also frequently visited the centre and chaired residents' meetings.

There was a standard complaints book with sequentially number pages. Information consisted of date/time, details of the complaint, the action required to resolve the complaint/problem and the date the complaint was closed. There were five records of complaints and all were signed by the complaint taker and the person in charge. The policy stated that the person in charge investigates complaints and provides feedback to complainants as soon as possible but no longer than 28 days. The person in charge stated to inspectors that she discussed the outcomes of complaints with the complainants to ensure that they were satisfied with the outcomes. The

provider stated to inspectors that all new residents received a copy of the complaints procedure following admission.

2. Safeguarding and safety

Outcome 4
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.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings

Sufficient measures were not in place to protect residents being harmed or suffering abuse. Appropriate action was not taken in response to allegations, disclosures or suspected abuse. The person in charge and the key senior management (KSM) did not demonstrate an awareness of elder abuse in all its forms and require further training.

Residents and relatives when interviewed by inspectors expressed the view that Cherryfield Nursing Home was a safe place. The front door was kept locked and staff were seen to be vigilant. Inspectors viewed a policy on elder abuse, prevention detection and response. It was dated February 2010 and was signed by the provider and the person in charge. It was not centre-specific. The person in charge stated to an inspector that training had been provided in the previous year by an external consultant. However she was not able to locate details of the training, the date and who attended.

Inspectors were not satisfied that the issue of the protection of residents from abuse was adequately dealt with by the provider and the person in charge.

In the case of a resident who had been admitted to the centre, the issue of suspected abuse of the resident before he/she came to the centre and the measures in place to protect the resident while in the centre were not adequately outlined in the resident's care plan.

In the case of another resident, the person in charge notified the Authority that the resident had fallen a number of times, that these falls were alcohol related and that the family of the resident had been supplying alcohol to the resident. The person in charge said that some members of the resident's family were spoken to by the provider and the GP but that other members of the family continued to supply alcohol to the resident. Inspectors found that the provider and the person in charge did not provide sufficient protection to the resident in this regard.

The person in charge stated to an inspector that no incidents, suspicions or allegations of abuse have been recorded in the centre.

The provider stated that he would be arranging training on elder abuse, prevention detection and response, with an external contractor, immediately after the inspection.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

While the general health and safety of residents, visitors and staff was promoted in areas such as infection control, health and safety and risk management, it was not sufficient in the area of fire safety. Suitable records were not presented to inspectors to show that all staff were adequately trained in fire safety.

There were policies on health and safety and a health and safety statement was available. It was reviewed and signed by the provider and the person in charge in June 2010.

There was a policy for the control of infection. It was signed by the provider, the person in charge and staff. Staff interviewed by inspectors demonstrated an understanding of good practice. There were wash-hand basins, soap and towels in all bedrooms, toilets, the assisted bathroom and the sluice room. Beside wash-hand basins in communal areas there were dispensers of liquid soap, paper towels and instructions on effective hand washing. There was a hand sanitizer dispenser adjacent to the main entrance door.

Clinical waste was initially stored in designated bins in the centre. There was a locked clinical waste bin outside the building to store larger quantities for a longer term. Inspectors viewed a contract with a specialist contractor and viewed statutory consignment documentation to verify collection of the clinical waste from the centre.

Records viewed by inspectors indicated that there was a documented food safety management system in place.

There was a risk management policy in place signed by the provider, the person in charge and staff. There was an identification of risks, hazards and controls including the risks specified in the regulations. Arrangements were in place for responding to

emergencies, including lack of an electricity supply. The centre had a stand-by electricity generator. Inspectors viewed the service record undertaken by an external contractor in June 2011. Inspectors viewed the accident/incident book and found that the records kept were comprehensive.

There were three identified means of escape from fire which inspectors observed to be unobstructed. However, only at the main entrance to the centre was the procedure for safe evacuation prominently displayed. Suitable fire fighting equipment was provided. Inspectors viewed records which indicated that the equipment was serviced by an external contractor on an annual basis to ISO standards 291, 2002. The last service record was dated May 2011. Records viewed by inspectors indicated that the fire alarm was being serviced four times per year by an external contractor. The last recorded service was 10 May 2011. Records viewed by inspectors indicated that eleven named staff attended training in the use of fire fighting equipment in July 2011 and that 13 staff attended a similar course in 2010; a record signed by the provider stated that staff attended fire safety training in June 2010 but did not specify who had attended.

A record signed by the provider stated that twelve named staff attended a fire drill on 22 April 2011. However, of four night staff on the roster to work during the week of the inspection only one attended the fire drill. All staff should attend fire drills twice per year. Two members of staff, when interviewed, demonstrated adequate knowledge on how to respond in the event of fire. There was no evidence presented of routine internal reviews of fire precautions such as alarm checks or fire exits, outside of external servicing.

Records viewed by inspectors indicated that thirteen staff attended training in manual handling in November 2010.

There were handrails in the main hallway to aid residents' mobility. Floor finishes in wet areas such as the assisted bathroom and toilets were non slip.

Outcome 6
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings

The processes in place for handling drugs, including controlled drugs, were generally safe and secure in accordance with current guidelines and administration. Nurses demonstrated appropriate practice and an adherence to professional guidelines and regulatory requirements. However, record keeping of prescriptions and administration of drugs was not adequate.

There were written policies relating to the ordering, prescribing, storing and administration of medicines; however, they were generic and did not reflect the good practice in the centre, which is in line with professional guidelines. While there were centre-specific procedures for medication management, these were not written down. An audit of medication management by an external pharmacy recently took place as described in Outcome 2.

Inspectors observed a nurse administering medications and were satisfied that she did so according to professional guidelines. Prescription sheets were generally well maintained. However, discontinuation of some medicines was not signed by a GP. Prescriptions of individual medicines were generally but not individually signed by a GP in one instant. One prescription sheet had no prescription date for all the medicines prescribed. One administration sheet had an administration time of "lunchtime" (with 13:00 written by hand) whereas the template on the prescription sheet said 14:00hrs.

Medications requiring refrigeration were stored in a locked fridge which had a service label indicating that it was serviced in July 2011. Otherwise, medication for residents was stored in the locked drugs trolley. Medicines prescribed to be used as necessary, (PRNs), were stored in individualised bottles in the drugs trolley. There was an appropriate double-locked cabinet for the storage of drugs controlled by the Misuse of Drugs regulations. There were appropriate records in place for such drugs. However, there were none currently prescribed for any resident.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

Residents received appropriate GP and nursing care. Care planning needed further improvement. While residents had opportunities to participate in planned communal activities, sufficient activities were not planned to cater for individual needs. The centre did not adhere to its own admissions policy.

There was a choice of GPs from four different practices visiting residents. Where a new resident wished to retain their existing GP, but, due to distance from the centre was unable to do so, the resident was offered a choice of GP. There was an out-of-hours GP service. Residents had timely access to GP services and appropriate treatment and therapies.

Inspectors viewed a sample of care plans. There was evidence that residents signed care plans if they were able. Otherwise relatives signed the care plans. This was confirmed by residents and relatives. Standard, recognised assessment tools were used. Care plans and residents' medication were reviewed at three-monthly intervals. Problems were identified. While the majority of problem identification sheets had been re-evaluated in May 2011, in the case of one resident the last review was March 2011. In the case of another resident, staff did not know what to do or recognise an instance as abuse (see outcome 4). Care plans were not always comprehensive. In some there were not adequate references to activities, spirituality or wishes for end-of-life care. Daily progress notes were not comprehensive or informative and usually written as "care as per plan".

There was a policy on behaviour that is challenging. It was signed by the provider, the person in charge and staff.

Inspectors viewed the timetable of activities, and observed the activities in the centre at the time of the inspection and spoke to residents. While there were planned communal activities which were meaningful and popular with residents over four to five hours per week, there were not sufficient individual activities. Some residents liked to read the national and local newspapers. One resident read a lot and told an inspector that a member of staff had provided her with a box of books. A staff member told an inspector that a travelling library visited the centre regularly and lent books to residents. A staff member was seen by inspectors reading to a resident. Staff members were seen to take three residents out into the garden.

There were no planned one-to-one activities for a resident with Alzheimer's disease. Other residents commented that days were long and hard to fill if you did not read. One care plan viewed by inspectors contained no reference to the resident's love of reading. The person in charge stated to an inspector that no staff were trained in the provision of activities.

Restraint was not used in the centre except for the use of bedrails for one resident who had requested them. In this situation there was evidence of discussion with the resident and relatives. The consent form was signed by the resident.

The centre's admission policy signed by the provider and the person in charge in February 2010 states that: "where possible, a health professional from the nursing home will visit the resident at home/hospital prior to admission. Emergency admissions will be avoided. All information regarding residents' health, personal and social needs are obtained prior to admission". However, none of these were implemented. An inspector asked the person in charge for pre-admission assessments and received a book with the heading: "Enquiries". One entry, (an emergency) in the book detailed a six line record of a phone call from the HSE and the promise of a fax. A bed was offered and admission took place.
Another resident was first seen by a GP in the centre 20 days after admission.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings

Caring for residents at end of life was regarded as an integral part of the service provided in the centre. There was a policy on end-of-life care signed by the provider and the person in charge, dated February 2010. However, it was not centre-specific. One member of staff was trained in palliative care and the KSM had also attended a one-day course at a hospice. The KSM outlined the procedure to an inspector; she stated that the resident's wishes were respected. The resident's family met the staff and the GP. A single room was offered for the resident. Family had access to the centre during the day and at night by visiting or by phone. Staff had frequent contact with the resident and their family. Regular visits were organised. Clergy were informed. The person in charge reviewed the care plan as necessary. The KSM also stated that the HSE palliative care team were contacted if necessary. No residents were at end of life at the time of inspection.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings

Each resident was provided with food and drink at times and in quantities adequate for his/her needs. Food was properly prepared, cooked and served. It was

wholesome and nutritious. Assistance was offered to residents in a discreet and sensitive manner. The centre's policy on nutrition did not address monitoring of nutritional intake.

Inspectors had lunch with residents and observed other meals and snacks being provided. Inspectors viewed the range of foods in stock. Mealtime was a pleasant, unhurried affair and residents were offered choices. The food was well presented and tasted good. Residents requiring assistance at mealtimes were assisted in a dignified and relaxed way. Water was available readily throughout the day in bedrooms, at mealtimes and in the communal rooms. Snacks, including washed and cut fruit, were provided during the day to residents in communal rooms and in bedrooms. An inspector noted that there was an ample supply of fruit in the kitchen. A resident told an inspector that he was normally offered fruit as a snack.

The centre's cook stated to an inspector that she speaks to the person in charge each morning and it is then and on the admission of a new resident that the special dietary requirements of residents are communicated verbally to her.

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

Not all residents had agreed contracts detailing services provided and fees charged. Inspectors viewed a sample of five residents' contracts. One person was admitted for respite 24 days previously but had no agreed written contract. There were contracts for the other four residents detailing services provided. However, only three had details of fees. None had contracts agreed within a month of admission.

Outcome 11
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.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation

Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings

Each resident's privacy and dignity was respected. Residents did have choices in daily living issues; however, consultation with residents in the organisation of the centre was limited.

Staff were observed by inspectors to address and communicate with residents in a dignified and relaxed way. Residents told inspectors that they felt treated with respect and relatives confirmed this. Residents told inspectors when interviewed that they had choices of when they got up and when they went to bed. They had choices of food.

Inspectors observed that visitors came to the centre at different times. Some relatives visited residents in their rooms while others visited residents in communal rooms. One relative stated to an inspector that he had visited at different times of the day and had felt welcomed by staff. Residents were facilitated to vote in the most recent general election. A polling station was located next to the centre. A resident told an inspector that a candidate for election had visited the centre and had spoken to him.

The centre, because of its location, is part of the local community. A local priest visits regularly, says mass, chairs residents' meetings and acts as residents' advocate. Newspapers including local newspapers are available and delivered each day. An inspector heard a conversation between a carer and a resident. The carer spoke of her involvement in the local sports club and what went on there. The resident was quite interested. Television and radio were also available to residents.

Because of the size of the centre there were restrictions for recreation as described in outcome 15.

Inspectors viewed documents which stated that residents' meetings occurred each month from February 2011 to the present. The local priest confirmed to inspectors that he chaired these meetings. However, the records were very limited. They did not record details of residents' views or feedback to or from residents.

Activities as described in outcome 7 were planned on a monthly basis and set out on the notice board located in the main hallway.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings

Adequate space was provided for residents' clothing and personal possessions. However, records of residents' personal property were not adequate. Appropriate and adequate storage space for clothing was provided for residents. Laundering was adequate.

All bedroom doors had locks enabling residents to safely lock their rooms from the inside. Some bedside lockers had locks and keys.

Inspectors viewed the centre's policy on property and possessions. A record of residents' property in the centre was kept in a bound hardback book. It detailed the name of the resident, the items in question and the date. The record was usually signed by one witness, or sometimes two witnesses who were members of staff. However, it was not signed by the resident or their relatives. Good practice would indicate that it should always be signed by two members of staff and the resident or their representatives. The person in charge stated to an inspector that the centre did not hold any money on behalf of residents.

There was sufficient space in residents' bedrooms to provide for residents' personal possessions. Inspectors observed that rooms were personalised with residents' possessions. A sample of four items of resident's clothes indicated that they were clearly marked with the resident's name. Residents told inspectors that clothes were never lost.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings

The centre was managed by a suitably qualified and experienced nurse who was the person in charge with authority, accountability and responsibility for the provision of the service.

The person in charge is a nurse registered with An Bórd Altranais. She works full time over five days per week. Of that time, 11 hours are stated on the roster as being for administration. She has sufficient experience having worked in the care of older people for 22 years in this centre. She was recorded on the roster for having done night duty on one occasion since the last inspection. The person in charge stated in writing that she attended training in risk management and audit, infection control and prevention, care plans, medication management, incontinence management and wound management.

The KSM is a registered nurse. She previously worked for eight years in a care centre for people with Alzheimer's disease. She has worked in this centre for four years. The person in charge stated to an inspector that regular informal meetings were held with the provider concerning staffing, equipment and all issues pertaining to the centre. However, no minutes of these meetings were recorded.

Outcome 14
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.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

There were appropriate staff numbers to meet the assessed needs of residents. Not all staff had up-to-date mandatory training. Record keeping was inadequate. There was provision for access to education and training to meet the needs of residents. Appraisal of staff needed improvement. Staff were not recruited, selected and vetted in accordance with best recruitment practice.

Staff were observed by inspectors to be kind and caring. This view was supported by the feedback received from residents and relatives. Inspectors viewed staff rosters and records. There was sufficient staff on duty at all times. Since the last inspection extra nursing time has been provided to ensure the person in charge would have more time to carry out management duties. The registration details of all nurses employed were maintained in the centre and were up to date.

Inspectors viewed a sample of five staff files. All contained the necessary references, proof of identity, birth certificates, evidence of qualifications, registration where necessary and full employment history. However, only one of the five files contained the required evidence of Garda Síochána vetting. All five records contained self-declarations of physical and mental health which did not fulfil the requirements of the regulations.

Rosters showed that all nursing staff who normally worked day shifts had worked night shifts since the last inspection. At the two changes of shift each day there were handover meetings between nurses coming off duty and nurses going on duty where staff were briefed. Nurses in turn briefed care staff. This practice was verified by staff to inspectors.

Records viewed by inspectors showed that staff had signed all relevant policies and procedures to indicate that they had read the documents.

Inspectors viewed the centre's policy on recruitment which was signed by the provider and the person in charge in 2010. It was not centre-specific and was not implemented in full. The policy stated: "All staff will undergo a medical check as necessary". The file of one member of staff viewed by inspectors showed no evidence that this had been done. The policy stated "At interview, the person in charge will satisfy themselves that new staff are competent." A new nurse in the centre was interviewed by the provider alone. There was no formal induction system. The nurse stated that she worked alongside another nurse on one shift for her induction. A care assistant working in the centre for the summer months was inducted by working alongside other staff.

The centre's policy on volunteers regarding Garda Síochána vetting, references and written aggreements was not implemented. No file on volunteers was maintained.

Inspectors viewed the annual appraisals of staff in staff files. There was no evidence of staff involvement, except for their signatures.

As described in outcome seven, there were inadequate meaningful activities for residents which indicated a need for a full-time or part-time activities coordinator who could plan, organise, operate and review a comprehensive, meaningful activities programme for all residents.

The person in charge and the KSM stated to inspectors that staff had received training required by the regulations in manual handling and in elder abuse, prevention detection and response. However, the person in charge could not provide any specific records regarding this training. One member of staff stated during an interview with an inspector that she had not received training in elder abuse, prevention detection and response. Because of the lack of records, including a training matrix, it was not possible to verify that all staff had received mandatory training.

Inspectors viewed records indicating that a member of staff had received training in risk management and audit as well as essential palliative care. Evidence was seen in the files of two care staff indicating that they had completed training modules of

level 5 Further Education Awards Council training (FETAC). However, the final certificates of completion were not seen by inspectors. Staff told inspectors that the provider supported them to pursue FETAC training by allowing them time off to do so.

6. Safe and suitable premises

Outcome 15
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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

While the centre was well maintained, the design and layout of the centre was not suitable for its stated purpose, and it did not meet the individual and collective needs of residents.

The garden at the front of the centre was well maintained. It had seating and was accessible to all residents. While these grounds were free from significant hazards that could cause injury there was easy access to the rear of the provider's house and the service area at the rear of the centre where there could be potential hazards. The garden was also not safe because there was direct access to a public road through an open gate.

The centre was kept clean and suitably decorated. Inspectors viewed records which indicated that a range of devices such as a hoist, a thermometer, a standby electricity generator, a bed-pan washer, a suction machine, a chair scale, and a nebuliser had all been serviced within the last twelve months.

There was a lack of adequate storage facilities for equipment. A hoist and a chair scales were stored in a bedroom. As described in Outcome 12 there was adequate space for residents' belongings.

Lighting and ventilation were adequate. Since the last inspection, a new staff room had been provided where staff could change clothes and store items.

There was a functioning call-bell in place however; it was excessively loud and unpleasant.

There were wash-hand basins in all bedrooms.

Necessary sluicing facilities such as a bed pan washer, a sluice and a wash-hand basin were provided in a sluice room which was normally closed and locked when not in active use.

There was sufficient equipment in the kitchen for catering.

The office space was extremely limited. It was not ventilated to the external air and did not facilitate staff in the performance of their duties.

There were an insufficient number of suitable toilets for residents. There was a toilet in an assisted bathroom, a separate toilet and a toilet in a sluice room which was not suitable for residents' use.

There was insufficient communal space for residents. The larger communal room had seating for ten residents; the smaller room had seating for four residents. Therefore there were not sufficient facilities to cater for all residents at the same time. In addition it was not of adequate size to cater for residents with wheelchairs and other mobilisation aids.

The dining room had seating for 14 residents and therefore could not cater for all residents at the same time.

7. Records and documentation to kept at a designated centre

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Part 6: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings

** Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's guide

Substantial compliance ☐ Improvements required* ☒

There was not a specific document containing all the information specified in the regulations. All documents were available separately in a single plain folder on a display rack beside a notice board in the main hallway. They appeared as a large quantity of plainly typed paper. They were not easily retrievable for a resident or relative who might wish to independently gain information.

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required* ☐

General records (Schedule 4)

Substantial compliance ☐ Improvements required* ☒

There was no Resident's Guide as previously mentioned.
There were no comprehensive records retained of every fire practice, drill or test of fire safety equipment.

Operating policies and procedures (Schedule 5)

Substantial compliance ☐ Improvements required* ☒

There were not adequate policies and procedures on monitoring and documentation of nutritional intake, provision of information to residents and the creation of, access to, retention and destruction of records.

Directory of residents

Substantial compliance ☒ Improvements required* ☐

Staffing records

Substantial compliance ☐ Improvements required* ☒

Evidence of Garda Síochána vetting was not provided for all staff. Suitable evidence was not provided that staff were physically and mentally fit for the purposes of the work they performed as required by the regulations.

Medical records

Substantial compliance ☐ Improvements required* ☒

There was no centre-specific policy for medication management. There was no GP's signature for each medication. There was not a space to record comments on

withholding or refusing medication. The times of medication did not match the template on the prescription sheet.

Insurance cover

Substantial compliance ☒ Improvements required* ☐

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings

A record of all incidents occurring was maintained and, where required, notified to the Chief Inspector. The person in charge has submitted quarterly notifications to the Chief Inspector since February 2011. Inspectors viewed the record book for accidents and incidents. One injury was recorded since the last inspection and the Chief Inspector was notified within three working days as required by the regulations.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings

There was no need for the Chief Inspector to be notified as the person in charge had not been absent for more than two weeks, which is within the period of 28 days specified by the regulations. In the event of a prolonged absence the named KSM would assume the role of person in charge. A document stating this was viewed by inspectors.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider and the person in charge to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

REPORT COMPILED BY

Gerry McDermott
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

11 August 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Cherryfield Nursing Home
Centre ID as provided by the Authority:	0213
Date of inspection:	4 August 2011 and 5 August 2011
Date of response:	21 September 2011

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

Outcome 1: Statement of purpose and quality management

1. The provider is failing to comply with a regulatory requirement in the following respect:

The statement of purpose did not meet all the requirements of schedule 1 of the regulations.

Action required:

Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

* 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 with timescales:	Timescale:
Provider's response: A new Statement of Purpose in compliance with schedule 1 of the regulations has been completed and is being forwarded to the Authority.	Immediate

Outcome 2: Reviewing and improving the quality and safety of care

2. The person in charge is failing to comply with a regulatory requirement in the following respect: The quality of care and experience of residents was not sufficiently monitored and developed on an ongoing basis.
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.
Action required: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.
Action required: Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.
Reference: Health Act 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A weekly collection of data in relation to quality of care has commenced. This will be analysed on a monthly basis and the report made available to both the Chief Inspector and residents. A questionnaire is being prepared for distribution to residents and their relatives, it will be collected twice a year.	1 October 2011

Outcome 4: Safeguarding and safety

4. The provider is failing to comply with a regulatory requirement in the following respect: Sufficient measures were not in place to protect residents being harmed or suffering abuse. Appropriate action was not taken in response to allegations, disclosures or suspected abuse.
Action required: Put in place all reasonable measures to protect each resident from all forms of abuse.
Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.
Action required: Maintain a record of all incidences where a resident is harmed or suffers abuse.
Reference: Health Act 2007 Regulation 6: General Welfare and Protection Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff training was provided by an external consultant on 23 August 2011. Our policy and procedures have been adapted to reflect local conditions. Our complaints procedure and accident book is always available and will be closely monitored.	1 October 2011

Outcome 5: Health and safety and risk management

5. The provider is failing to comply with a regulatory requirement in the following respect: The health and safety of residents, visitors and staff was not promoted through sufficient fire safety precautions and training.

Action required: Make adequate arrangements for reviewing fire precautions, and testing fire equipment, at suitable intervals.	
Action required: Provide suitable training for staff in fire prevention.	
Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.	
Action required: Maintain, in a safe and accessible place, a record of all fire practices which take place at the designated centre.	
Action required: Maintain, in a safe and accessible place, a record of all fire alarm tests carried out at the designated centre together with the result of any such test and the action taken to remedy defects.	
Action required: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.	
Reference: Health Act 2007 Regulation 32: Fire precautions and records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A maintenance policy is in place for the inspection of fire fighting equipment and the fire alarm system. Current signage is being amended and updated. I am seeking professional assistance and guidance to conduct a complete review of the existing policies and procedures and will amend them as requested to ensure complete compliance with all regulations.	31 October 2011

Outcome 6: Medication management

6. The person in charge is failing to comply with a regulatory requirement in the following respect: Centre-specific procedures for medication management were not written down. Record keeping of prescriptions and administration of drugs was not adequate.
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.
Reference: Health Act 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines. Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A site specific medication management policy is in place. All nurses are familiar with it, having read it and agreed to operate it. It is proposed that all nurses complete an online course with An Bórd Altranais, on medication management. GPs have been advised that all drugs must be individually signed for, on prescription.	1 October 2011

Outcome 7: Health and social care needs

7. The person in charge is failing to comply with a regulatory requirement in the following respect: The centre's admissions policy was not adhered to. Residents did not have sufficient opportunities to participate in meaningful activities. Care planning was not comprehensive.
Action required: Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Action required: Provide a high standard of evidence based nursing practice.	
Action required: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.	
Reference: Health Act 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As far as possible residents' social needs will be identified and responded to in an appropriate manner. All nurses have been informed that daily notes must be comprehensive and provide a high standard of evidence based nursing. A meeting of residents and their families has been called to determine how efforts can be made to improve our activities programme. A diary will be maintained to record daily activities. We will adhere to our admission policy with immediate effect. A pre-admission assessment of client form has now been put in place. Extensive evidence-based assessment will be carried out on each resident at least four times per year which will identify individual dependency needs and care will be provided to meet these identified needs. We must point out that residents' needs are being met at present. For example, one resident states that she reads four or five books per week.	1 October 2011

Outcome 9: Food and nutrition

9. The person in charge is failing to comply with a regulatory requirement in the following respect: The policy on nutrition did not address monitoring of nutritional intake.

Action required: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.
Reference: Health Act 2007 Regulation 20: Food and nutrition Standard 19: Meals and Mealtimes

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A daily flow chart No 2 identifies and records nutritional intake. This policy has been in operation for over a year. The MUST tool is in use for over a year, and completed on a monthly basis. Each resident is weighed and this is recorded on a monthly basis.	Immediate

Outcome 10: Contract for the provision of services

10. The person in charge is failing to comply with a regulatory requirement in the following respect: Not all residents had agreed contracts detailing services and fees charged. No residents' contracts were agreed within a month of admission.
Action required: Agree a contract with each resident within one month of admission to the designated centre.
Action required: Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.
Reference: Health Act 2007 Regulation 28: Contract for the Provision of Services Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions

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

Provider's response: All contracts of care will be reviewed to ensure that they are completed properly.	1 October 2011

Outcome 11: Residents' rights, dignity and consultation

11. The person in charge is failing to comply with a regulatory requirement in the following respect: There was insufficient consultation with residents in the organisation of the centre.
Action required: Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.
Reference: Health Act 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The current system of monthly meetings with recorded minutes will be expanded in order to promote a more inclusive consultation in the organisation of Cherryfield.	1 October 2011

Outcome 12: Residents' clothing and personal property and possessions

12. The Person in charge is failing to comply with a regulatory requirement in the following respect: Records of residents' personal property were not adequate.
Action required: Ensure records of a resident's property are signed by the resident.
Reference: Health Act 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The current system will be reviewed in an effort to have residents or their families sign the residents' property book already in existence.	1 October 2011

Outcome 14: Suitable staffing

14. The person in charge is failing to comply with a regulatory requirement in the following respect: The skill mix of staff did not meet assessed needs of residents. Not all staff had mandatory training as required by the regulations. Staff were not supervised in an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.
Action required: Ensure that the numbers and skill mix of staff, specifically in relation to activities co-ordination, are appropriate to the assessed needs of residents, and the size and layout of the designated centre.
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.
Action required: Supervise all staff members on an appropriate basis pertinent to their role.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.
Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.

Reference: Health Act 2007 Regulation 16: Staffing Regulation 17: Training and Staff Development Regulation 18: Recruitment Standard 23: Staffing Levels and Qualifications Standard 24: Training and Supervision Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The registered provider will ensure an appropriate activities programme is in place. A training matrix will be developed to identify required training. All new staff will be interviewed by two members of management and a record of all inductions will be maintained. All recruitment will be done in accordance with our Human Resources (HR) manual. A policy to ensure that all staff are physically and mentally fit for the purposes of the work they are to perform will be introduced on an incremental basis commencing October 2011.	1 October 2011

Outcome 15: Safe and suitable premises

15. The provider is failing to comply with a regulatory requirement in the following respect: There was insufficient communal space. There were an insufficient number of toilets for residents. External grounds were not safe and secure for all residents. Storage facilities for equipment were inadequate. Office space was inadequate. The call bell system was excessively loud.
Action required: Provide adequate private and communal accommodation for residents.

Action required: Provide sufficient numbers of toilets and wash-basins which incorporate thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.
Action required: Provide and maintain external grounds which are suitable for, and safe for use by residents.
Action required: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents. Provide sufficient Storage space and office space. Ensure call bells and other automated sounds operate at a comfortable level.
Reference: Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Major reconstruction work will be completed in accordance with derogation. No unsupervised access is allowed to the garden area, so therefore risk is minimal. I must emphasise that residents value their independence and look forward to sitting outside on the seat provided at the entrance, to engage with village life. We would not like to see Cherryfield develop a gated community atmosphere. Rather, we promote an open and inviting atmosphere. Our communal area allows for 12 seats in our sitting room, 8 in our sun lounge, and our dining room is capable of servicing all 17 residents.	25 May 2014

Outcome 16: Records and documentation to be kept at a designated centre

16. The person in charge is failing to comply with a regulatory requirement in the following respect: There was no Resident's Guide. Related documentation was not maintained in a manner that was easily retrievable to residents. There was not an adequate record of every fire practice, drill or test of equipment. Evidence of Garda Síochána vetting was not provided for all staff.

Suitable evidence was not provided that staff were physically and mentally fit for the purposes of the work they performed, as required by the regulations.

There was not a centre-specific policy for medication management. There was not a centre-specific procedure for self administration of medication.

There was not a GP's signature for each medication. There was not a space to record comments on withholding or refusing medication.

The times of medication did not match the template on the prescription sheet.

There were not adequate policies and procedures on monitoring and documentation of nutritional intake, provision of information to residents and the creation of, access to, retention and destruction of records.

Action required:

Produce a Resident's Guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.

Supply a copy of the Resident's Guide to the Chief Inspector.

Supply a copy of the Resident's Guide to each resident.

Action required:

Put in place written operational policies and procedures for the provision of information to residents.

Action required:

Put in place written policies and procedures relating to the creation of, access to, retention of and destruction of records.

Action required:

Maintain, in a safe and accessible place, a record of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.

Action required:

Put in place all of the written and operational policies listed in Schedule 5.

Reference: Health Act 2007 Regulation 22: Maintenance of Records Standard 32: Register and Residents' Records Regulation 25: Medical Records Standard 13: Healthcare Standard 14: Medication Management Standard 15: Medication Monitoring and Review Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: SOP007 Residents Rights is currently available. SOS001 Governance and Management is currently in operation. All operational policies listed in schedule 5 of the regulations are currently in place.	Implemented

Any comments the provider may wish to make:

Provider's response:

None given.

Provider's name: Laurence Doyle
Date: 21 September 2011