Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Dalton Community Nursing Unit
Centre ID:	0643
Centre Address:	Castlebar Road Claremorris, Co. Mayo
Telephone number:	094-9362727
Fax number:	094-9362740
Email address:	mary.cotter@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive West
Person in charge:	Mary Cotter
Date of inspection:	13 and 14 April 2011
Time inspection took place:	**Day 1: Start:** 09:00 hrs **Completion:** 21:45hrs **Day 2: Start** 07:40 hrs **Completion:** 18:00 hrs
Lead inspector:	Mary McCann
Support inspector(s):	Catherine Rose Connolly -Gargan
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **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.

Registration inspections are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.
In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is

a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.

About the centre

Description of services and premises

The Dalton Community Nursing Unit is a purpose-built, single-storey facility operational since 1974. The centre provides accommodation for up to 39 residents requiring long term or respite care.

The entrance opens into a reception area with an administration office to the right. Corridors lie to the left and right of reception. The right corridor accommodates the female residents and a sitting room, the left corridor mainly accommodates male residents. Directly opposite the front door is a large day room which is used as a sitting/dining room and this space is also used for day care. To the left lie the kitchen and a specific dining room. There is a small oratory on the male corridor.

Accommodation includes 21 single rooms with a sink (one has also a toilet), six triple rooms which have shared en suite facilities that include a shower, toilet and wash-hand basin. There are four additional toilets, three showers and one assisted bathroom. Two staff toilets and showers are also available. A physiotherapy office, a smoking room (which is also used as an art room) and various other rooms including storage, clinical, sluice, cleaning, laundry office and staff facilities complete the structural layout. The centre is rectangular in design with two enclosed courtyard style gardens.

To the side of the building there is ample car parking.

Location

The centre is located on a raised site on the N60 Castlebar Road ten minutes walk from the town of Claremorris adjacent to Mount St Michael's Convent Secondary School.

Date centre was first established:	1974
Number of residents on the date of inspection	36 (three people were receiving respite care)
Number of vacancies on the date of inspection	3

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	24	6	3	3

Management structure

The Provider is the Health Service Executive West. The person appointed on behalf of the provider is Michael Fahey, General Manager, Older People's Services for County Mayo.

The Person in Charge is Mary Cotter (her primary role since December 2010 is person in charge also at the Sacred Heart Hospital, Castlebar). She reports to Mr Fahey. He attends the centre on a monthly basis and as required and is accessible by phone.

The nursing, administration and catering staff report to the senior staff nurse on duty (it was clearly detailed on the off duty who was in charge on each shift) who in turn reports to the Person in Charge. The carers/multi-task attendants report to the nursing staff. The contract cleaning staff report to a supervisor who regularly attends the centre. Services provided include long term care of older persons, care of older persons with dementia and respite care.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	5	5	3 (includes 1 chef)	1 plus contract cleaners 1 person for 2 hours each day and 2 people for 4 hours each day	1	0

Night staff: one nurse and one carer (23:00 hrs – 06:00 hrs)

Summary of findings from this inspection.

This was an announced registration inspection and the second inspection of this centre by the Health Information and Quality Authority (the Authority). This inspection took place over two days. A scheduled monitoring unannounced inspection had previously been carried out by the Authority on 22 July 2010. An action plan detailing areas which required attention was forwarded to the provider post this inspection. As part of the registration inspection these actions were also reviewed by the inspectors.

In order to gain registration the provider has to satisfy the Chief Inspector of Social Services that he/she is a fit person and will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and show a willingness to comply with the Authority's standards. The person in charge confirmed to inspectors that she had completed the fit person self assessment document and discussed it with the provider. He agreed in interview that he supported the areas identified for review in the document. Following completion of the Fit Person Entry Programme, the person in charge had identified areas for development. Inspectors spoke with the person in charge in relation to these identified areas which she has designated as requiring review. Many of these issues identified for improvement in the fit person's self assessment had not been completed, for example no evidence was made available to inspectors that the following had been reviewed:

- review of the complaints register quarterly
- discuss outcomes and opportunities to improve service at team meetings
- personalise bedrooms to make the residents room easily identifiable
- develop audit policy

Documents reviewed by inspectors prior to the inspection included the fit person self assessment document, a pre-inspection questionnaire (which had been completed by the person in charge), the statement of purpose for the centre, resident and relative questionnaires (14 resident, 8 relative) and notifications of serious incidents. Other documents reviewed during and post-inspection included residents' care plans, accident and incident records, the residents' guide, the record of complaints, staff duty rotas, policies, procedures and staff training records. Inspectors spoke with residents, relatives and staff during the inspection and observed care practices and the quality of the environment.

Inspectors carried out separate fit person interviews with the designated provider and the person in charge. There were no key senior management identified in the application for registration. However, inspectors also spoke with staff nurses who were in charge of the centre for considerable periods of time as the person in charge (PIC) had been appointed to the role of person in charge at the Sacred Heart Hospital in Castlebar in December 2010. She was currently working as the PIC to both centres but the provider assured the inspectors that this was a temporary arrangement.

Staff interviewed for the purposes of fitness were knowledgeable of and committed to meeting 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. They demonstrated a working knowledge of the relevant legislation and standards.

Inspectors found the centre to be adequately managed and all policies and procedures required by current legislation were in place and residents and relatives were complimentary of the staff and positive in their comments regarding the care provided. However, in order to progress matters identified in the fit persons entry programme and to devise systems in relation to the review of care and drive forward safe quality care based on evidenced-based practice the inspectors were of the opinion that a full time person in charge was required at the centre.

Some improvements had been made since the last inspection. The last inspection report contained twenty actions and five recommendations. Nine actions were completed, four were partially completed and seven were not completed. The five recommendations were enacted. Those partially completed or not actioned are repeated with further actions at the end of this report. There were some improvements in the provision of meaningful activities. However, it was noted by inspectors that the activity schedule on the days of inspection were much better attended by the day care clients rather than the residents. A second person had been nominated in the centre to ensure complaints are appropriately responded to and recorded. The centre-specific risk management policy had been developed. Staff had been trained in basic life support and a defibrillator was available.

The Action Plan at the end of this report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. The improvements included for example, review of night staffing levels, appointment of a person in charge solely responsible for the centre, involvement of residents and relatives in care planning, review of environmental issues, further development of meaningful activity programmes for highly dependent residents and development of audit and review of service provision.

Comments by residents and relatives

The residents the inspectors spoke with stated that they were well cared for and they spoke highly of the staff. Residents commented on how much they enjoyed people coming in and some residents knew some of the day residents prior to coming into the centre.

A number stated that they were well looked after, on resident stated that there were “plenty of people around to look after me, one other lady who due to her increasing frailty was spending long periods of time in bed stated ‘love to see staff coming in to talk’. All residents spoke with stated they felt safe in the centre and if they had a concern they would talk to the staff.

Residents described the staff as being “caring and kind’. Questionnaires supported the view that they all agreed that the building was clean and well maintained and the food served was “good quality”. Both residents and their relatives knew the nursing and care staff. Relatives stated they were kept informed of changes and developments in relation to their relative’s health and this was confirmed in the questionnaires.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

Inspectors reviewed the procedures for managing residents' finances and spoke to the administrator with responsibility for maintaining residents' finances. Transparent records were maintained to provide an audit trail of each resident's finances. A policy and procedure was in place which was reflected in practice by staff. There was an independent monitoring system in place which ensured that clear financial and accounting procedures are followed. An external audit of the accounts procedure is undertaken annually. Signed records and receipts of monies were maintained. The provider assured inspectors that there was a contingency budget would be made available if necessary if in unforeseen circumstances significant expenditure was warranted.

The provider and the person in charge demonstrated a working knowledge of the relevant legislation. Records required by the regulations were available and stored securely.

A policy on prevention of elder abuse had been developed which clearly stated that the welfare of the residents was paramount. Staff interviewed were knowledgeable of what constitutes elder abuse and of their responsibility to report same. Residents stated that they always felt safe and this was reflected in the resident questionnaires received. They confirmed if they wanted to discuss issues with staff they felt able to do so.

A register of residents who were currently accommodated in the centre was available. Information requested by the legislation was recorded, for example, personal details of residents, next of kin, and general practitioner (GP), the dates of admission, discharge or transfer outside the centre. This was reviewed by the inspector and found to be up to date, easily accessible and well maintained**.**

A signing-in register was available on entering the centre. Visitors signed on entry and exit which ensures everyone is accounted for in the event of the building having to be evacuated. This also allowed the person in charge to monitor the movement of persons in and out of the building to ensure the safety and security of residents.

A centre-specific complaints procedure was on display in the centre. A summary of the policy/ procedure was available in the resident's guide.

A suggestion box was available in the reception area. Verbal complaints were recorded. Residents confirmed that if they had a complaint they would talk to the person in charge or the nurses. All residents spoken with confirmed that they were satisfied with the service provided and had no complaints at the current time. The complaints log was made available to the inspectors. It contained details of the complaint, action taken as a result of the complaint and the outcome, the investigative process was detailed and written evidence of whether the complainant was satisfied with the outcome was recorded.

Safe work practice sheets were available for example information on avoidance of aggression, clinical waste, hoist, and pesticides. A health and safety statement was also available. An emergency plan was available which detailed procedural guidelines in relation to utility failure and fire. It specified the control measures to manage these risks and contingency arrangements were in place, where the centre could relocate to should the need arise. Hand gels, gloves and aprons were available throughout the centre and inspectors observed staff using these.

The inspectors reviewed the process for recording incidents and accidents. Staff spoken with relayed a positive attitude towards reporting incidents. A high percentage of incidents related to falls. Neurological observations were recorded routinely to monitor residents.

Some improvements required

While staff were aware of reporting structures and could explain their roles and responsibilities, the management structure described in the statement of purpose was not reflected in practice at the centre. The management chart in the statement of purpose detailed that that the clinical nurse manager two (CNM2) reports to the person in charge. However, the CNM2 post is vacant at the current time. Also nursing staff have to report to senior nursing staff who in turn report to the person in charge. This is not reflected in the statement of purpose.

A major emergency plan was in place to manage untoward incidents. This was comprehensive in nature and provided guidance to staff. The centre had developed a centre- specific risk management policy which was one of the actions from the last inspection. A missing person's policy was in place which included clear procedures to guide staff should a resident go missing. Photographic identification was available for each resident. Templates were available to complete should a resident go missing. These were completed for all residents who were mobile.

The Authority had received notifications of accidents and/or serious incidents and quarterly returns from the centre. While a grade two wound had been reported, this was not reported within the prescribed timescales.

Significant improvements required

A statement of purpose was available describing the philosophy of care and objectives of the centre. While the statement of purpose was comprehensive, it required further review in order to comply with current legislation, for example the professional qualifications of the nominated registered provider were omitted, and the type of nursing care provided required further detail.

The person in charge demonstrated a commitment to provide a quality service and had commenced audits in relation to medication administration charts and care plans in February 2011. An analysis of the information had been completed to guide quality improvements, for example, the audit showed that the rationale for the use of restraint was absent or inadequate, staff were not using the assessment scores to assist decision making, and it was documented that there was a need for training in relation to care plan documentation. However, these problems were still evident in the care planning documentation at the time of inspection and there was no evidence available that any changes had occurred. This may be contributed to the fact that the person in charge was only available for very limited periods at the centre since December 2010 and the CNM2 post has been vacant at this centre for a considerable period of time. Areas such as complaints and meaningful activities had not been audited to identify trends and enhance outcomes for residents.

A detailed risk assessment was in place in relation to all risks related to the centre. This had been updated in April 2011 and detailed the hazard, the risk, existing control measure and a risk rating using the 'traffic light system' and the person responsible for monitoring and ensuring controls were in place to minimize the risk. This was very well completed and gave a good assessment of the risk and the controls necessary to minimise the risk. One significant risk that was identified by the inspector at the last inspection remained as a high risk on this assessment. This risk was in relation to the levels of staffing on night duty and the implications this poses to meet the adequate care needs of residents and for staff to be confident that they will be able to safely evacuate all residents swiftly should the need arise. The inspector was concerned that the number of staff on duty from 23:30 hrs until 06:00 hrs was not appropriate to the assessed needs and dependencies of the residents and the design and layout of the centre. One staff nurse and one care assistant are rostered to work during this time period to meet the needs of up to 39 residents, many who were highly dependent. This was discussed with the provider and person in charge who both acknowledged that this posed a risk to residents and that they had informed senior management of this risk.

A copy of the providers insurance was made available to inspectors. This did not detail what cover was provided for residents' property.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

Inspectors observed the staff interacting with the residents and how they provided care and support to them. Residents told inspectors that there was flexibility in the daily routine and they could decide when to get up and go to bed.

Residents confirmed there was a choice of main meal at dinner time and the food was good and portions were adequate. The menus looked at showed a good variety and were well balanced. The cook was aware which residents had special diets, including diabetic, low fat etc. There was ample food stocked and it was stored at the correct temperatures, properly labelled and date. Catering and care staff have been trained in food hygiene. Inspectors observed a variety of drinks rounds throughout the days of inspection. They said they could have drinks or snacks at any time. On the first day of inspectors the inspectors were in the centre until 21:45 hrs. They observed many residents exercising choice over when they retired to bed.

Relatives spoken with informed inspectors that they were always warmly welcomed by the staff and could visit at any time. Inspectors observed that the tea was a social and interactive occasion.

Residents who required assistance with nutritional intake were respectfully assisted. Staff were observed to be assisting residents while allowing them time to eat at their own pace and used this opportunity to chat and check with the resident whether their needs were met. Inspectors observed residents being offered a variety of snacks and drinks. Residents and relatives told inspectors that they could have tea or coffee and snacks any time they wished. Bowls of fresh fruit were available. Jugs with a variety of juices and water were available in communal areas and staff regularly offered drinks to residents.

Residents told inspectors that staff respected their privacy and knocked on bedroom doors and waited for a response prior to opening the door. Inspectors observed this in practice. Residents were smartly dressed and their clothes looked well cared for. The clothing was discreetly labelled with a button system and no concerns were raised re clothes going missing. Residents told inspectors that their clothes were well looked after

All persons spoken with were positive in their views of the service provided and the staff who provided the service. National and local newspapers were provided. Other newspaper/magazines available included the Farmer's Journal, farm plant magazine, Bella

and Woman's Way. A cordless phone was available to enable residents to receive calls in private.

The religious needs of the residents were addressed. Mass was celebrated weekly and the sacrament of the sick was administered regularly. Confessions were also scheduled regularly. Church of Ireland minsters were available as required. The rosary was said daily. Residents spoken with were delighted with the religious aspect of the activity programme.

A residents' committee is in place. Meetings were held quarterly. This meeting is attended by person in charge at the current time but she informed the inspectors that as soon as the advocates have completed their training they will take the lead on this meeting. Minutes of the meeting of the most recent meeting which was held on the 12 April 2011 were made available to the inspectors. Issues discussed included spiritual reflection, outings, and the showing of films at the weekend.

An up to date record of residents' property was available.

Some improvements required

While a good range of activities which included art classes, passive exercise classes, bingo, quiz and card games and music was available, it was noted by inspectors that many of the residents who were highly dependent and or cognitively impaired were not engaging in any activities. Activities were well attended by the day care residents, for example one of the inspectors attended that art session and noted that all residents who attended were day care residents. The inspector also noted that eight out of the ten residents who attended the exercise class were day care clients. The day room chairs are laid out in straight lines which give an institutional impression and prevent residents from sitting face to face to enhance communication between them. There were wheelchairs stored in the day room which detracted from a homely style and also impinged on the space available for residents. One resident in particular was noted to spend long periods socially isolated in the day room area. There was poor evidence that social assessments were completed. A small number of residents spent long periods in bed and these residents were not actively stimulated throughout the day.

Significant improvements required

The inspector notes in the previous report that due to the design of the building, residents' privacy was impinged. Access to staff areas, administration offices and the female corridor was via the residents' sitting room. The doors in and out of the sitting room were open throughout the inspection making the end of the sitting room like a corridor. This area of the sitting room was used to access the right side of the building. This impinged on the resident's privacy and comfort. While another sitting/ dining/day hall was available, this area was also used for day residents. This room was also used by staff to cut through from the front of the building to the back of the building. It was also noted by inspectors that clients who were attending the physiotherapy department had to come in the front of the building and make their way through the dining room or day room to the physiotherapy room. This further impinges on residents' privacy. The response received to this action from the last inspection detailed that the provider was going to engage with the HSE estates department to review the current layout.

This was discussed with the provider and person in charge who both confirmed that while the estates department had been requested to attend the centre they had failed to do so to date.

A referral form detailing biographical data and a brief needs assessment is forwarded to the centre prior to admissions. A sample of these was seen by the inspector on the case files. When people are referred they or their significant other can visit the centre and obtain up to date information about the centre. The person in charge liaises with the general practitioner (GP) regarding medical needs and medication is always available for the resident on admission. However, the centre had not issued residents with a contract of care detailing the terms and conditions of the service provision that includes the fee payable and any extras to be paid for, such as hairdressing.

Restraints measures including lap straps, bed rails and a monitoring device were in use. While some documentation in relation to consent and review of restraint was reviewed in the case notes these did not comply with best practices. Further work was required in order to ensure best practice and protect safety and human rights of residents. Care plans in relation to restraint were not reflective of best practice, for example, risk assessments did not identify alternatives to the use of the restraint measure, and there was no supporting evidence to suggest that the restraint measure was used as a last resort. The rationale for necessitating the use of the restraint measure was not stated on all occasions. Where a resident was cognitively impaired no narrative was available in any of the case files reviewed that an assessment of the capacity of the residents' ability to consent to the restraint measure had taken place.

There was no documentary evidence of on-going review of consent for the use of restraint measure. Documentation did not support that an explanation, which was likely to be understood by the resident and/or significant other was given to explain the potential risks and benefits of using the restraint measure, not using a restraint measure and any other suitable alternatives. The case files reviewed did not clearly outline in cases where the resident was competent that the consent of the resident was obtained. It was not consistently documented on files reviewed that where a decision is made on behalf of a resident it must always be made with their best interests in mind and involve a multi disciplinary approach.

An audit on the use of restraint was not undertaken at regular intervals to inform resident's care and training needs of staff. The PIC informed the inspectors that two staff from the unit would complete the train the trainers programme on the new national policy on restraint. She stated that this policy together with the accompanying suite of forms would be enacted in the centre as soon as all staff were trained on the policy.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

Access to peripatetic services was available. A physiotherapist had been allocated seven hours per week. The person in charge described good links with the pharmacy services. There was good input from mental health services. A chiropodist attends the service every 6-8 weeks. He was at the centre on the first day of inspection. Audiology services are arranged as required. Eye checks are also arranged as required. There were also links with the local palliative care team. Pain assessment charts were not observed to be completed in files. Assessment and documentation of pain management and of residents' response to analgesia did not comply with best practices thereby ensuring effective monitored pain relief.

A selection of chilled water and squash was available in communal areas and staff were observed encouraging and assisting residents to drink fluids.

There was good evidence of infection control measures in place. Hand sanitizers were strategically placed throughout the centre and staff had received training on infection control measures. Inspectors found evidence that the health of residents was promoted. Flu vaccines were offered to all staff and residents. A staff nurse took a lead in relation to infection control training and practice. She had completed specific training in this area. She was the link person for the centre to the specialist infection control personnel.

A dedicated fridge was used to maintain a cold chain and ensure that medications which required cold storage were stored appropriately. A thermometer was available and staff recorded and documented the temperature on a daily basis. Medication no longer required by the centre is returned in a timely fashion to the pharmacy.

Some improvements required

All residents had an individual care plan, seven of which were examined in detail. While assessments of the persons needs were completed there was poor linkage to the care plans. The areas covered in the assessments included, mobility which included falls risk assessments and manual handling, risk of pressure ulcers and mental health review group to look at care documentation has been set up and there is representation on this group from older people's services. The person in charge informed inspectors that this group will be looking at care plans as a priority and the will adapt the recommendations from this group.

The medication policy reviewed by inspectors who found that it contained the procedures for prescribing, administering, recording and storing of medication.

The prescription and administration records were clear but did not include maximum doses for PRN (as required) medication. One of the inspectors accompanied a nurse during the medication round and observed her practice in administration. Recent photographic identification was attached to the each medication chart. Medication was crushed by nursing staff although it was not prescribed to be crushed by the prescribing doctor.

Since the last inspection, staff had reviewed the storage of residents' documentation. A case file containing all care documents was available for each resident. Medical records were stored in a separate file. Assessments were completed such as continence, nutritional status and mood charts. Social care assessments were not sufficiently detailed to ensure a comprehensive background was completed; no life histories or other documents were in place to support this.

Other assessments were completed but no analysis of the information was undertaken. There was contradictory assessments in the case files for example in one file it stated that that staff were unable to do mini mental state assessment but it also stated that the resident and her son wanted bedrails put in place. Fluid balance charts were not fully completed therefore they did not inform good safe quality care. There was poor linkage between residents' care plans and entries in the daily nursing kardex. Although residents reported to inspectors that they were happy with the care they received, there was a lack of formal resident and significant other involvement. Where residents had dementia or were cognitively impaired, there was no narrative detailing the assessment of the capacity of the resident to consent to the care plan.

While a GP visits the centre four days per week daily and an out of hours service is also available to the centre, there was poor evidence in medical files reviewed that medical staff were reviewing residents medication as required and in any event at three monthly intervals.

Significant improvements required

Inspectors were informed that occupational therapists services were difficult to access. Consequently many residents had not had any input from occupational therapy services. Some residents were observed in tilted assistive chairs and wheelchairs with no support for their feet.

There were records of residents being weighed. However, there was no evidence that residents were being weighed regularly, this was discussed with staff who felt they were weighing residents regularly but were not consistently recording in the weight chart. On occasions they were recording resident's weight in the daily record sheet or in the diary so it was difficult to follow through as to when people were weighed. A nutritional policy was available and the centre was assessing the nutritional needs of residents. While some files supported that weights were recorded, there were many instances where weights were not recorded regularly or frequency of weighing reviewed in response to residents changing needs.

The person in charge informed the inspectors that two residents had pressure ulcers. The case files of these two residents were reviewed by one of the inspectors. Both residents had been seen by a dietician and had a nutritional assessment. The person in charge informed the inspectors that these wounds had improved. The wound care plans did not provide adequate detailed procedure to be adapted in the management of wound care. For example, no guidance was available for wound measurement frequency. This resulted in incomplete regular assessment and consequently poor evaluation. Staff confirmed that not all staff had been facilitated with up to date training on wound prevention and management. While specialist advice had been obtained this advice was not consistently documented in the care records. There was no evidence of a multidisciplinary response to the resident's changing condition to ensure optimal care was provided and to prevent deterioration in health status. Inspectors also noted that not all nursing practices were developed from evidence-based skin care procedures. For example, sudocream/caldesene powder was used for treating some residents with pressure related skin damage. Wound care plans did document the use of assistive equipment and nutritional assessments, referral to the physiotherapist.

The wishes of residents and their significant others as to how they wanted care delivered at end of life had not been documented in many instances. The policy to guide staff on the management of end of life care did not outline procedures to advice staff how residents' privacy and dignity was maintained in shared bedrooms.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

The centre is operational since 1974 and is a single-storey construction. It was purpose-built and designed to meet the needs of dependent persons. A contract was in place for the cleaning of the premises and a cleaning schedule was available and signed on a daily basis. The driveway and immediate perimeter was covered in tarmac and the grounds were well maintained. A reception area is located inside the main entrance where a receptionist was available to assist with enquiries. The nurses' station and toilet was located in close proximity to the day room which provided a point of contact for residents and visitors. The grounds were well kept. Ramps and support rails were available on at the entrance, ensuring ease of access and safety for residents with mobility impairment. The design of the building allows freedom of movement for residents to walk around as there is a corridor around the main sitting area and the enclosed gardens. Handrails were available on both sides of this corridor to assist residents with maintaining independence. The corridors were clear and unobstructed.

A smoking room is available for residents use. The furnishings were adequate for residents. Some of the bedrooms were found to be personalised with photos but dormitory areas were noted not to be personalised. Since the last inspection lockable storage space was available to residents to securely store their personal valuables. There are two accessible courtyard garden areas, available for residents use. Since the last inspection these had been manicured and were now well maintained. Some residents commented on how 'nice it was to go out in the garden'. There was suitable lighting provided in each bedroom to meet the needs of each residents. A separate laundry room was available which contained two washing machines and two dryers. A double sink was available. No residents voiced any concern in relation to the care of their clothes.

A call bell system in place at each resident's bed which was accessible to residents. Staff were noted to respond to call bells in a timely manner during the course of the inspection. Suitable lighting was provided in each bedroom to meet the needs of residents.

A sufficient number of bathing and toilet facilities to meet the needs of residents were available. Grab support rails were fitted alongside all toilets and showers. An emergency call system was located in all bathrooms. Showers were level with the floor finish providing ease of access. The bathrooms were tiled, maintained in a clean condition and were ventilated mechanically.

Inspectors found there was suitable and sufficient equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. The was a service contract in place which covered breakdown and repair for all beds, air mattresses and other equipment, used by residents. Inspectors reviewed the records of servicing to electric beds and hoists. Equipment was serviced in November 2010. The person in charge told the inspector she had access to an on call maintenance department to undertake emergency and routine repairs.

Smoke detectors were located in all bedrooms and general purpose areas. Emergency lighting was provided throughout the building. An inspector viewed contracts of the servicing of fire alarms, smoke and heat detectors. These were serviced by a professional four times a year. Fire extinguishers were serviced annually. The fire alarm was tested routinely. Regular inspection of the automatic fire door closers were undertaken to ensure they were operational. Fire escape routes were checked frequently to ensure they were unobstructed. Notices to indicate the procedure to be followed in the event of a fire were in place throughout the building. Escape route plans displayed around the building to show the designated means of escape from the building to the nearest fire exit door.

There was a contract for the collection of clinical waste which was viewed by the inspector. All clinical waste was tagged to ensure traceability. General clinical waste was stored in a locked bin located externally.

A cleaning room with a sink was available with a designated washing machine to wash the cleaning mops.

There were separate staff changing and toilet facilities provided for nurses, catering and support staff. A staff dining area was also available and a further staff toilet.
No suitable private area which is separate from the resident's bedroom was available to meet with visitors. The person in charge informed inspectors that the physiotherapy department are going to relocate and part of this space will be allocated to a private visitors' room.

A fire drill to reinforce the theoretical training provided to staff to ensure they are confident of the procedure to be followed in the case of a fire was carried out on the 24 March 2011. Duvets were used to evacuate immobile residents. This was confirmed by the person in charge. She informed the inspector that this was the advice of their fire safety personnel.

There are two spacious enclosed gardens for the residents to enjoy in the good weather. There is a ramp to the garden areas to assist residents with mobility problems. There are hoists and adaptations in toilets and bathrooms to assist people with mobility problems. Pressure relieving equipment, e.g. air mattresses and cushions are provided for residents who are at risk of pressure ulcers.

Maintenance issues were well managed and inspectors were informed that tasks indentified were carried out in a timely manner. Maintenance matters gave no cause for concern throughout the inspection.

There was evidence of food safety management systems in place, and staff had completed training in Hazard Analysis Critical Control Points (HACCP) in the last year. The kitchen staff have changing facilities separate to those provided for all other categories of staff.

Some improvements required

Adequate storage space was not provided for equipment and assistive devices so that these did not intrude on resident areas or impinge on residents' safety. Wheelchairs were stored in the day room.

Significant improvements required

The hot water at the point of contact to residents was above 43 degrees and presented a scald risk to residents. It ranged from 49.5 degrees to 54.9 degrees centigrade.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

Staff worked closely with residents and relatives. Residents and relatives confirmed in person and on the completed questionnaires that staff communicated regularly with them and they were kept updated in relation to the care of their relative. Residents and relatives confirmed that 'nurses' were regularly available. Relatives confirmed that staff updated them regularly in relation to their loved one. One relative said that she could either visit or phone at any time for information about their relative's condition or progress.

Daily staff handover meetings which informed the incoming staff group of the health and wellbeing of the residents took place at every change of shift. All staff wore name badges. Each staff grade wore a different coloured uniform.

The daily menu was displayed in the dining room. There were notices boards located around the building containing information on the activities planned for the day and the complaints procedure. A residents' guide was available which contained information to assist prospective residents to make a decision regarding with regard to the services available at the centre. This complied with legislation. A suggestions box was available on entry.

A cordless phone was available which enabled residents to take calls in the privacy of their own bedrooms. Staff wore name badges. Each staff grade wore a different coloured uniform. Residents were able to tell the inspectors who they would talk to if they had a complaint or a concern and were available to identify the person in charge. Staff meetings were held and minutes indicated a range of topics were discussed which included polices and procedures and the process for handling complaint. Staff handover meetings which informed incoming staff of the health and changing needs of residents took place at the changeover of each shift. A diary detailing specific appointments and chores due was in operation.

Some improvements required

While there was a written operational policy and procedure on communication and the policy described the different modes of communicating and the ways that residents could

be encouraged to express their needs. The policy outlined the procedure for communicating with residents with sight or hearing impairment.

There was a communication observation chart available as part of this policy. However, there was no evidence on any of the files that this chart was in use. This was discussed with staff who confirmed it was not in use but they gave a firm commitment to commencing using same. A similar situation was occurring in relation to a challenging behaviour monitoring chart. These charts if utilised correctly would provide valuable assessment tools to inform care and discussion in relation to appropriate interventions.

Pictorial signage was not in place on all bathroom and toilet doors to help guide residents around the building.

No non verbal communication system which would be accessible to residents who had difficulty verbally expressing themselves was available. This would enable residents to participate more fully in the life of the centre. This action was detailed in the last inspection report.

Minor issues to be addressed

Care assistant staff were not involved in the process of documenting their care with residents.

While a comment's box was available relative and resident satisfaction surveys were not undertaken to provide information to ensure ongoing improvement and development of the service.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs.

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

There was a relaxed atmosphere in the centre during the inspection and from discussion with staff and observations during the inspection the staff team appeared to work well.

A comprehensive recruitment policy was available outlining the recruitment practices to employ staff. The person in charge informed inspectors that job descriptions outlining the reporting relationships, the purpose of the post and the principal duties and responsibilities were available for each staff grade. All staff were provided with an employee handbook on commencement of employment. While no staff had recently been employed, the person in charge confirmed and evidence was available on staff files reviewed that an induction programme was in place on commencement of employment.

Staff informed inspectors that they enjoyed their work. A large proportion of the staff had worked in the centre for many years indicating a low turnover. Residents told inspectors that staff had sufficient time to meet their needs. A key worker system was in place at the centre.

The provider employs 43 staff in total which includes a whole-time equivalent of 10.75 registered nurses and 20 support staff (13 of which have Further Education and Training Awards Council [FETAC] level five). In addition, there are three administration staff. Catering staff interviewed confirmed that their Hazard Analysis Critical Control Point (HACCP) training was up to date.

The person in charge informed the inspectors that leave was planned in advance and where there were unplanned absences it is always organised that part time staff are organised to work extra shifts. This assists with continuity of care and ensures that residents are familiar with the staff.

Staff records were available to support that training was provided and staff spoken with confirmed their attendance at training, for example, staff had attended training on management of dysphasia, end of life care, and hand hygiene. Three staff were undertaking the dementia champion programme and two staff nurses were undertaking the diploma in gerontology course.

The record of An Bord Altranais personal identification numbers for registered nurses was inspected and found to be in order. Staff spoken with were able to tell what they would do if they suspected abuse and the importance of taking measures to prevent the risk of abuse. Staff members interviewed were able to explain and demonstrate the procedure to be followed in the event of fire, including how a residents would be evacuated or moved to an area of safety.

Some improvements required

A sample of staff personnel files were reviewed by inspectors. The files were organised and information was easily accessible. The person in charge had completed a comprehensive audit of the documentation and a matrix was available detailing what documents were available and absent for each staff member. While a substantial proportion complied with current legislation there were still files which required further documents to comply. Where staff had not received Garda Síochána vetting although it had been applied for a statutory declaration declaring 'good character' was available.

On-call arrangements were in place with cover provided by the person in charge at all times out of hours. When she was not available on-call was provided by the person in charge from another designated centre.

Significant improvements required

A copy of the staff rota was reviewed by the inspectors commencing Monday the 28 of February to Sunday the 17 April 2011 (7weeks). This was clear and well maintained. It clearly documented who was in charge on each shift. With the exception of the week commencing the Monday the 11 of April 2011 the PIC was charted by way of telephone availability. For the week commencing the 11 of April the PIC was charted for four shifts 08:00 hrs – 16:30 hrs and one shift 08:00 – 15:30 hrs.

A total of 43 staff were employed in the centre. Substantial amounts of staff did not have up to date mandatory training. Eleven staff required manual handling training, 18 staff required fire and four staff required elder abuse detection prevention and reporting training. The person in charge informed the inspectors that fire safety training had been booked for the 29 of April 2011.

No staff had completed training on behaviour that challenges although it was evident from a case file reviewed that a resident displayed challenging behaviour. This training would enhance staff skills and guide staff interactions and interventions to ensure the best outcome for residents.

Minor issues to be addressed

There were no formal arrangements in place for supervision or appraisal.

No personal development plan to discuss each staff members' training needs were developed and implemented to ensure their continuous professional development.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge and nursing staff. (A brief feedback had been given to the provider after the fit person's interview), 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:

Mary McCann
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

3 June 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
22 July 2010	☐ Registration ☐ Scheduled ☐ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Dalton Community Nursing Unit
Centre ID:	0643
Date of inspection:	13 and 14 April 2011
Date of response:	24 June 2011

Requirements

These requirements set out what the registered provider must do to meet 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*.

1. The provider and the person in charge has failed to comply with a regulatory requirement in the following respect:

The number of staff on duty from 23:30 hrs until 6:00 hrs was not appropriate to the assessed needs and dependencies of the residents and the design and layout of the centre.

Action required:

Provider to complete a comprehensive assessment of staffing levels required for these hours using recognised assessment tools and contemporary evidence based practice, to ensure the needs of the residents are met and the safety of the residents is not compromised.

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

Action required: Provider to ensure that they are satisfied that procedures are in place to safely evacuate the residents at all times taking into consideration the residents specific needs and dependency levels.	
Action required: Put procedures in place to ensure that the staff rota is maintained.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 9: Health Care Regulation 16: Staffing Regulation 14: End of Life Care Regulation 31: Risk Management Procedures	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An application has been made to HSE Management for funding to provide three staff on duty from 23:30 hrs until 6:00 hrs.	September 2011

2. The provider has failed to comply with a regulatory requirement in the following respect: There was no full-time person in charge at the centre.	
Action required: Appoint a person in charge who complies with current legislation.	
Reference: Health Act, 2007 Regulation 15: Person in Charge Standard 27: Operational Management	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**

Provider's response: The recruitment of a full-time person in charge specific to this unit is underway.	September 2011

3. The provider has failed to comply with a regulatory requirement in the following respect: There was no provision of meaningful, appropriate activities for residents. The inspector observed residents sitting for long periods of time in the day/sitting room and bedrooms with no social interaction.
Action required: Provide opportunities for participation in purposeful and meaningful activities for residents of all levels of dependency an on going basis.
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Dalton Community Nursing Unit activity programme includes the following: Monday: bingo, quiz, aromatherapy, reflexology. Tuesday: computer programme – with laptop, mobile phone training, bingo, Rosary Wednesday: Legion of Mary Prayer Group and Communion, card game, art work, reminiscence work, aromatherapy Thursday: sing-along, musician, storytelling – residents (self-led), Rosary Friday: CD Irish music, Rosary Sunday: Mass, Rosary, DVD programmes other activities. Annual Art Exhibition, Bealtaine, occasional outings to Knock, residents' birthday parties, Christmas party, music and dancing, entertainment provided by children from the local primary and secondary schools. A more specific programme will be developed for the more dependent residents.	October 2011

4. The person in charge has failed to comply with a regulatory requirement in the following respect:

Staff did not implement aspects of a number of operating policies and procedures such as policy and guidelines for the monitoring and documentation residents' intake, communication policy (communication observation chart) and challenging behaviour (monitoring chart.)

Missing person templates were not complete in accordance with centre's policy.

Action required:

Provide staff with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.

Reference:

Health Act, 2007
Regulation 17: Training and Staff Development
Regulation 27: Operating Policies and Procedures
Standard 29: Management systems
Standard 24 :Training and Supervision

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: Staff have access to education and training to enable them to provide care in accordance with contemporary evidence-based practice. The introduction of a new documentation system will provide a more comprehensive record that enables compliance with policies.	October 2011

5. The provider has failed to comply with a regulatory requirement in the following respect:

The sitting/day room accommodation available to residents was inadequate. The chairs were arranged around the walls or to the side which was not conducive to conversation among residents.

Due to the design of the building there the dayroom was used as a short cut through the centre and the sitting room was not conducive to privacy.

Action required:

Provide adequate communal accommodation for sitting and recreational requirements having regard to the number and specific needs of the residents.

Reference: Health Act, 2007 Regulation 19: Premises Regulation 10: Residents' Rights, Dignity and Consultation Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: The provider will engage with the HSE estates department to review the current layout/design of the sitting/day room in order to ascertain if the issues raised by the inspector can be addressed within the available resources.	October 2011

6. The provider has failed to comply with a regulatory requirement in the following respect: No non-verbal communication system was in place. It was not possible to facilitate and encourage communication with residents who could not express them verbally. Pictorial signage was not in place on all bathroom and toilet doors to help guide residents around the building.
Action required: Devise an alternative communication system that ensures that all residents are facilitated and encouraged to communicate enabling them to participate in the activities and running of the centre.
Action required: Put in place practices that facilitate and encourage each resident to communicate
Reference: Health Act, 2007 Regulation 11: Communication Standard 1: Information Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: An alternative communication system that ensures that all residents are facilitated and encouraged to communicate enabling them to participate in the activities and running of the centre is being sourced	September 2011

to facilitate and encourage each resident to communicate.	

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

The provider has failed to adapt comprehensive contemporary evidence based restraint practices which complies with current legislation. The decision to use a restraint measure was not supported by multi disciplinary decision making.

Action required:

Develop and implement a comprehensive contemporary evidence based restraint practices which complies with current legislation.

Action required:

Put processes in place whereby a risk assessment is completed on all residents subject to a restraint measure which ensures that the restraint measure is only applied in the best interests of the resident.

Ensure that the use of a restraint measure is only ever considered as a measure of last resort and is the least restrictive option for the shortest period of time.

Action required:

Where a resident lacks the capacity to give informed consent to the use of the restraint measure, a consensus view should be reached between all healthcare staff involved in the residents care and the residents' next of kin / significant other. This decision should be documented clearly in the notes in narrative format.

Action required:

Any restraint measure whether physical or chemical must be kept under constant review with documentation evidencing motion times during waking hour.

Action required:

Conduct a quality audit review of all residents subject to a restraint measure restraint and implement recommendations from this audit.

Reference:

Health Act 2007
Regulation 31: Risk Management Procedures
Standard 21: Responding to Behaviour that is Challenging

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

Provider's response: The HSE's National Restraint Policy is in place. This addresses all the actions above. Two staff have undertaken a Train the Trainer programme. Each resident will have all aspects of the policy incorporated into their assessments.	August 2011

8. The person in charge has failed to comply with a regulatory requirement in the following respect:

There was no rehabilitative care plan to support residents who spent long periods of time in bed.

The wishes of residents and their representatives as to how they wanted care delivered at end of life had not been documented in many instances.

Action required:

Implement a rehabilitative care plan for residents who spend long periods of time in bed.

Action required:

Document the wishes of residents and their representatives as to how they want care delivered at the end of their life.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Regulation 14: End of Life Care
Regulation 6: General Welfare and Protection
Standard 10: Assessment
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: Residents at end of life who spend long periods of time in bed are offered activities appropriate to their wishes.	August 2011

9. The person in charge is failing to comply with a regulatory requirement in the following respect:

There was inconsistent evidence available that the resident or their significant other had been involved in completion or review of their care plan.

Care plans were not reviewed as required by the resident's changing needs and no less frequently than at three monthly intervals.
Residents had not had a comprehensive assessment of their social care needs.

The personal and social care needs of the residents' was not reflected or detailed in the care plans.

Assessments were not effectively utilised in the implementation and planning of care.

Assessment and documentation of pain management and of residents' response to the administration of medication for pain was not in line with contemporary evidence-based nursing practice.

Residents who were subject to a restraint measure did not have a comprehensive person-centred care plan in place in all instances.

Action required:

Residents and/or their significant other should be involved in the completion and review of their care plan. Written evidence should be available of this.

Action required:

Ensure assessment findings are reflected in the implementation and planning of care and care plans are updated in light of revised assessments.

Action required:

Ensure that a resident who is subject to a restraint measure has a comprehensive person-centred care plan in place which reflects good practice.

Action required:

Implement procedures to assess and documentation of pain management in line with contemporary evidence-based nursing practice.

Action required:

Put in place process whereby personal and social care needs are assessed and reflected in the residents care plan.

Action required:

Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances as and no less frequent than at 3-monthly intervals.

Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Regulation 9: Health Care Standard 11: The Resident's Care Plan Standard 3:Consent Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The new care planning documentation has been finalised. It addresses all of the actions required. Training will be provided so that it is used appropriately to demonstrate compliance with the regulations and standards.	To commence in September 2011

10. The provider is failing to comply with a regulatory requirement in the following respect: No contract for the provision of services was provided to residents.	
Action required: Agree a contract with each resident within one month of admission to the designated centre. 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: The contract is available for distribution to residents.	August 2011

11.The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

Not all staff had up to date mandatory training in fire safety, elder abuse and manual handling.

Action required:

Make arrangements to ensure all staff has up to date mandatory training.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Regulation 17: Training and Staff Development
Regulation 32:Fire Precautions and Records
Regulation 6: General Welfare and Protection
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All staff are trained in fire safety, elder abuse and manual handling.	June 2011

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

It was unclear what insurance cover was available for residents' property.

Action required:

Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

Reference:

Health Act, 2007
Regulation 26: Insurance Cover
Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Information regarding the insurance cover provided by the States Claims Agency has already been made available to the Health Information and Quality Authority. It may be necessary to discuss this at National level.	Ongoing

13. The person in charge is failing to comply with a regulatory requirement in the following respect:

A record of residents' personal property was not kept up to date.

Action required:

Maintain an up to date record of each resident's personal property that is signed by the resident.

Reference:

Health Act, 2007
Regulation 7: Residents' Personal Property and Possessions
Standard 4: Privacy and Dignity

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There is a system in place to maintain an up to date record of each resident's personal property.	To be completed by August 2011

14. The provider has failed to comply with a regulatory requirement in the following respect:

No evidence of regular medication review by medical staff in the sample of case files reviewed.

Action required:

Ensure each resident receives a high standard of service from his/her GP/medical officer with whom he/she is registered including regular medication review which is responsive to residents' needs.

Ensure medication is reviewed as and no later than at three monthly intervals.

Review of medication to be documented in the medical records.

Action required:

Ensure medication is reviewed as required as and no later than at three monthly intervals.

Action required:

Review of medication to be documented in the medical records.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 25: Medical Records Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: GPs will be engaged with to ensure review of medication is documented in the medical records.	September 2011

15. The Person in Charge is failing to comply with a regulatory requirement in the following respect: No staff had received training on behaviour that challenges.	
Action required: Provide staff members with access to education and training to enable them to provide all residents with care in accordance with contemporary evidence-based practice.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff will be facilitated to attend training on behaviour that challenges.	December 2011

16.The provider has failed to comply with a regulatory requirement in the following respect: Further review of the quality of care and the quality of life of residents was required areas such as satisfaction surveys, medication management, restraint practices, complaints management; provision of activities had not been audited. Information collated in audits while analysed to identify trends, no implementation to ensure learning and to improve the quality of life and safety for residents had occurred.

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. Ensure analysis of the information collated and implementation of recommendations are implemented to enhance outcomes for 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: Analysis of audits will be implemented to enhance outcomes for residents.	Ongoing

17. The provider has failed to comply with a regulatory requirement in the following respect: The temperature of the water posed a potential scalding risk to residents. Wheelchairs were stored in the sitting room.
Action required: Provide a suitable storage area for equipment.
Action required: Ensure hot water at the point of contact is thermostatically controlled and at point of contact it is no greater than 43 degrees C.
Reference: Health Act, 2007 Regulation 19: Premises Regulation 31: Risk Management Procedures Standard 25: Physical Environment

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

Provider's response: Wheelchairs will be relocated when physiotherapist relocates. The maintenance department is reviewing the plumbing requirements to control water temperatures and a plan for remedial action will be put in place.	December 2011

18. The provider has failed to comply with a regulatory requirement in the following respect:

The statement of purpose did not include the qualifications of the nominated registered provider. The range of needs outlined in the statement of purpose did not clearly define the category of service provided. The management structure described in the statement of purpose was not reflected in practice at the centre.

Action required:

Revise the statement of purpose to meet the requirements of the Regulations.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The statement of purpose is revised to meet the requirements of the regulations.	Completed by August 2011

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

Staff personnel files did not comply with current legislation.

Action required:

Maintain, in a safe and accessible place, a staff personnel file that complies with current legislation.

Reference:

Health Act, 2007
Regulation 18: Recruitment
Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Staff personnel files are maintained in a safe and accessible place. Compliance with current legislation is ongoing.	Ongoing

20. The provider has failed to comply with a regulatory requirement in the following respect:

The prescription and administration records were did not include maximum doses for PRN (as required) medication.

Medication was being crushed by nursing staff without medical authorisation to do so.

Action required:

Ensure practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents comply with current legislation and best practice guidelines.

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: Practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents comply with current legislation and best practice guidelines.	Completed- June 2011

21. The provider has failed to comply with a regulatory requirement in the following respect:

Access to occupational therapy services was difficult.

Action required:
Undertake an assessment of all residents who would benefit for input from occupational therapist and make arrangements to provide same in accordance with best practice.

Reference: Health Act, 2007 Regulation 9: Health Care Regulation 6: General Welfare and Protection Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Residents are referred to an occupational therapist when necessary. Occupational therapy services are provided by the primary care occupational therapy for the area.	Ongoing

22. The provider has failed to comply with a regulatory requirement in the following respect: The quality of healthcare promotion for pressure sore prevention and treatment was inadequate. Measures to support residents to achieve and enjoy the best possible health were insufficient.	
Action required: Ensure that appropriate healthcare is facilitated and that each resident is supported on an individual basis to achieve and enjoy the best possible health.	
Action required: Put procedures in place to ensure pressure area care is managed to a high standard based on evidence-based risk assessment tools, multidisciplinary input and informed by contemporary wound care guidelines	
Reference: Health Act, 2007 Regulation 9: Health Care Standard 12: Health Promotion Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Procedures are in place to ensure pressure area care is managed to a high standard based on evidence-based risk assessment tools, multidisciplinary input and informed by contemporary wound care guidelines. Additional training for staff is planned.	December 2011

23. The person in charge has failed to comply with a regulatory requirement in the following respect:

Specialist training in the areas of wound care and behaviour that challenges, end of life care, restraint and medication management had not been completed to guide staff and ensure the delivery of safe quality care.

Action required:

Provide staff with training in wound care.

Action required:

Provide training to staff on restraint.

Action required:

Ensure nursing staff are trained in medication management.

Reference:

Health Act, 2007
Regulation 17: Training and Staff Development
Standard 24:Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A plan is in place to facilitate access to additional training in wound care and behaviour that challenges, end of life care, restraint and medication management.	December 2011

24. The provider has failed to comply with a regulatory requirement in the following respect:

The wound care specialist did not document advice in the care records. Resident's weights were not consistently documented in the sample files reviewed to provide safe quality care.

Action required:
Ensure documentation practices promote communication, consistency and maintain clear records of decision making processes to ensure the delivery of safe quality care.

Reference:

Health Act, 2007
Regulation 25: Medical Records
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The new care planning documentation has been finalised. It addresses all of the actions required. Training will be provided so that it is used appropriately to demonstrate compliance with the regulations and standards. It is particularly focused on ensuring documentation practices promote communication, consistency and maintain clear records of decision making processes to ensure the delivery of safe quality care.	Commencing September 2011

25. The provider has failed to comply with a regulatory requirement in the following respect:

There was no suitable private area separate from the resident's own private room for residents to meet their relatives/visitors.

Action required:

Put in place a private visitors' area for residents separate from their own private room.

Reference:

Health Act, 2007
Regulation 19: Premises
Regulation 12: Visits
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 20: Social Contacts
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Plans in place to facilitate a reorganisation of space utilisation.	To commence September 2011

Any comments the provider may wish to make:

Provider's response:

None supplied.

Provider's name: Health Service Executive, Dalton CNU,

Person in Charge: Mary Cotter, Director of Nursing

Date: 24 June 2011