Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Friar's Lodge Nursing Home
Centre ID:	0342
Centre address:	Convent Road Ballinrobe Co. Mayo
Telephone number:	094 9542474
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Email address:	friarslodgenursinghome@yahoo.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	G & T Gallen Limited
Person in charge:	Pamela Connor
Date of inspection:	3 and 4 March 2011
Time inspection took place:	**3 March Start:** 09:00 hrs **Completion:** 18:30 hrs **4 March Start:** 09:00 hrs **Completion:** 17:00 hrs
Lead inspector:	Mary Mc Cann
Support inspector(s):	PJ Wynne
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 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.

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

About the centre

Description of services and premises

Friars Lodge Nursing Home is a purpose-built single storey building, which is operational since 2004. The centre provides long term residential care for dependent persons over 18 years, respite and convalescent care.

On entry there is a lobby which has a fireplace and seating area. There is a nurses' station, treatment room, kitchen, dining and living room all located off the entrance lobby. The 60 single and two twin bedrooms are laid out in corridors branching off from this central reception area. All the rooms (with the exception of one single bedroom) have en suite toilet, wash-hand basin and shower facilities. Small seating areas are located at various junctions along the corridors. A recreation/ relaxation room, two sitting rooms, a smoking room and an oratory are also located along these corridors. Staff facilities, storage areas, cleaning, and laundry and sluice areas complete the structural layout. A further five toilets and two assisted bath/shower areas are available for residents use.

On the first floor, there is two bedded self – contained apartment which currently provides accommodation for two staff nurses. A staircase leads from the ground to the first floor. This does not form part of the designated centre's application for registration.

A large enclosed garden is located to the rear of the centre. There is ample parking to the front and side of the building. The site is well maintained.

Location

Friars Lodge Nursing Home is located on Convent Road, Ballinrobe, Co. Mayo. It is 5 minutes walking distance from the town of Ballinrobe. The nearest train station is Claremorris and daily buses are available from Castlebar, Westport, Claremorris and Galway.

Date centre was first established:	14 February 2004
Number of residents on the date of inspection	62 and two in hospital
Number of vacancies on the date of inspection	0

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	0	20	20	22

Management structure

The Provider is G & T Gallen Limited. This is a family business. The delegated provider on behalf of the company is Tanya Gallen. Her husband Gerry Gallen assists her in this post. The person in charge is Pamela Connor (known in the centre as the Director of Nursing).She reports directly to the provider. In her absence, one of the nurses on duty deputises as Person in Charge. Care assistants report to the staff nurses who in turn report to the person in charge. Catering staff report to the Person in Charge or her deputy. The maintenance person and administrator report to the provider.

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	2	8	3	4	1	3*

*providers and maintenance man.

Summary of findings from this inspection

This was an announced registration inspection and the third inspection by the Health Information and Quality Authority (the Authority). This inspection took place over two days. The first inspection by the Authority of this centre was an unannounced triggered inspection which took place on 20 January 2010. The second inspection took place on the 5 May 2010. The report from both inspections is available on the Authority's website, www.hiqa.ie. Post the inspection on 5 May 2010 an action plan was sent to the designated provider and person in charge detailing areas which required review. 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 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 the fit person self assessment document had been completed jointly by the provider and herself.

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 provider), the statement of purpose for the centre, notifications of serious incidents and quarterly returns. Other documents reviewed during and post-inspection included residents' care plans, resident and relative questionnaires, accident and incident records, the Residents' Guide, the record of complaints, staff duty rotas, policies, procedures and staff training records. Inspectors spoke with residents, a relative and all grades of staff during the inspection. They also observed care practices, the daily routine and the quality of the environment.

Inspectors carried out separate fit person interviews with the designated provider, her husband as he assists her in this role and the person in charge. Inspectors also interviewed the staff nurse who primarily deputises for the person in charge in her absence. Staff interviewed for the purposes of fitness was 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. The providers in conjunction with the person in charge had completed the fit person self-assessment document and submitted this to the Authority in the agreed timescale.

The provider and person in charge had adapted a quality conscious approach to developing and improving the service and the quality of life for the residents. Inspectors highlighted minor issues in relation to the statement of purpose and these issues were actioned and resolved prior to completion of the inspection. The inspectors reviewed the action plan from the previous inspection and found that the majority of the actions had been addressed within the agreed timescales.

The person in charge was supernumery and there were usually two staff nurses on duty in addition to her during the day shifts. This gave her sufficient time to complete her supervision, operational and management functions. The person in charge had completed the Diploma in Gerontology and developed her clinical training in line with contemporary evidence based practice.

Residents' healthcare needs were adequately met. General practitioners (GPs) attended to residents on a regular basis and carried out three monthly review of medication. The care planning process had been reviewed since the last inspection and care plans were in place to guide person centred care. Documentation in relation to restraint had been developed and work in this area was on-going. Peripatetic services such as physiotherapy and occupational therapy (OT) were available and there was evidence on case files that residents were seen by these services.

The premises were clean with fittings and equipment including fire safety equipment was well maintained. A risk management policy and health and safety statement was in place. The risk management policy requires review to ensure it complied with current legislation.

Residents and relatives were complimentary of the staff and generally positive in their comments regarding the care provided. Staff were knowledgeable of individual residents' needs and were observed interacting with them in a respectful and caring manner. A significant number of staff knew the residents for many years.

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 mandatory training for all staff to be kept up to date, involvement of residents and relatives in care planning, continuing review and development of policies.

Comments by residents and relatives

Inspectors received 11 completed questionnaires from residents and two from relatives. Inspectors also met with residents and a relative during the inspection. They were complimentary of the service provided and felt that the care delivered was of a high standard. One lady described how she enjoyed sweeping the dining room. Another gentleman described how he liked to watch the ducks in the garden from his bedroom window.

Residents could clearly identify the person in charge and the provider and described the provider as 'the owner'. They were positive in their comments in relation to her commitment to providing a quality service. They described how she was available on a daily basis in the centre and "a caring person". They said the person in charge was "approachable" and they could "talk to her if they had a problem". Some residents were unable to verbally express their views due to communication difficulties and confusion associated with dementia.

Residents were of the view that there was adequate staff on-duty to meet their needs. They told inspectors that when they rang the call bell it was answered promptly. They were happy with the care of their clothes. Residents were smartly dressed and their clothes looked well cared for on the days of inspection.

Residents spoken with stated that they felt safe in the centre. They said they could talk to staff at any time and the fact that there was ‘bells in all areas made them feel secure’.

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

A clear organisational structure was in place and this corresponded with the statement of purpose. There had recently been a change of person in charge at the centre. The person in charge has the required knowledge and experience to fulfil the role. She was enthusiastic and knowledgeable of the residents' background and their specific needs. The provider was actively involved in the day-to-day operation of the centre providing ongoing support to the person in charge. This was confirmed by the person in charge.

At the opening meeting of the first day of inspection which was attended by the providers and the person in charge they had a quality conscious approach and wanted to provide consistent high quality care and stated they wished to "continually improve their service".

Staff interviewed were knowledgeable about their roles and responsibilities. They were aware of the staff structure and the reporting mechanisms in place, to ensure appropriate delegation, supervision and competence in the delivery of care to residents. They confirmed that the provider and person in charge were easily accessible and onsite daily at the centre. Staff described an open working relationship with the providers.

The centre had a Statement of Purpose available. It set out the objectives and philosophy of the service to be provided. The person in charge informed the inspector that a copy of the statement of purpose was made available to each resident. Admissions are not made to the centre until an assessment of their needs has been undertaken by the centre. This assessment involves the individual, their family or significant other and phone contact with any professionals involved in their care. The person in charge or provider complete a pre-admission assessment in person prior to admission to the centre.

Valid insurance cover was in place. Mail was observed to be hand delivered unopened by staff to residents. Residents informed the inspectors that staff assisted

them when requested to do so. Inspectors noted that residents and staff files were maintained confidentially. Records required by the legislation were stored securely and accessible when requested.

Evidence was made available by way of email confirming that the person in charge and the provider were to attend training on risk management on the 29th of March 2011.

Since the last inspection the provider had reviewed risk management procedures. A missing person's profile including photographic identification was available for each resident who was assessed as at risk of wandering. The person in charge confirmed that missing persons drills were carried out on a regular basis. A signing-in register was available on entering the centre. This 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 procedure is in place on display for staff to follow if a resident absconds from the building. The centre also has a missing person's box available at the centre which contains essential items such as a torch, relevant phone numbers and a high visibility vest. Hazardous chemicals were stored in locked cleaning trolleys and cleaning staff have been educated on practice of leaving equipment safely stored. Alarms on fire exit door had been changed, if they are opened the emergency bell sounds thereby alerting staff. A major incident plan was in place and information is clearly available of the senior on call structure out of hours.

A system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre had been developed since the last inspection. Monthly audits on medication management are carried out by the provider. As a result of these the provider had changed their pharmacy supplier. Regular medication audits in conjunction with the pharmacist are now planned. An audit of falls had been completed. This was reviewed by the inspectors which stated 'from a review of falls risk and falls risk action plans it was advised that a system of exercises needs to be devised' consequently the centre employed a physiotherapist one day per week. An audit of the environment was also completed. This revealed that a contributing factor to one resident who was a frequent faller was that her room contained lots of person items in a disorganised fashion. The person in charge sought the consent of this resident to tidy up her room which the resident agreed too. This coupled with a tactile alarm mat has resulted in a significant decrease in her falls. A quality of life survey is undertaken bi-annually. A copy of this was made available to inspectors. This was last completed in September 2010 and is due for completion in March 2011. The person in charge and provider informed the inspectors that any suggestions for example to bring in specific musicians would be acted upon.

Some improvements required

The inspectors reviewed the directory of residents which was up to date and complied with current legislation however deleting fluid was used to correct some errors.

A complaints log was available in the centre. The provider and person in charge confirmed that where residents made suggestions for change they acted upon these swiftly. The person in charge described an example of this. She stated that the residents stated they liked a certain type of food she would ensure it was made available. The provider was clear of the necessity of a transparent easily accessible complaints procedure. Dates were recorded so it was clear to see the timescale of each complaint. Verbal and written complaints were recorded. It contained details of the complaints, action taken as a result of the complaint and the outcome. However, written evidence of whether the complainant was satisfied with the outcome was not recorded. Residents spoken with displayed an awareness of their right to voice any complaint that they wished. They told inspectors that they would talk to the person in charge or the owner or the nurses if they had a complaint. All residents spoken with confirmed that they were satisfied with the service provided and had no complaints at the current time.

A centre-specific complaints procedure was on display in the centre. This document required revision in so far as, it did not include details of a nominated person in the centre, independent of the designated person responsible for complaints to ensure that all complaints are appropriately responded to and records maintained thereof. It also failed to include timescales for investigation or timescales in relation to response and acknowledgement times. A summary of the policy/ procedure was available in the residents' guide.

The elder abuse policy did not detail the contact details of the local dedicated abuse officer. The policy was not centre specific for example it stated 'outside office hours referrals should be made to the duty social worker '. The policy also failed to clearly outline an adequate safe procedure to be adapted to investigate an allegation of abuse, for example it stated 'an in-house investigation must occur within 24-72 hours.

An individual, record of each resident's personal property was recorded on admission; however, this was not updated to reflect changes throughout the residents stay. Inspectors confirmed with residents that there were no instances of missing items. The complaints log also did not contain any complaints re clothes going missing.

Significant improvements required

A written contract of care which detailed the terms and conditions of the occupancy including services provided was available for each resident. However, they were not complete in many cases. They were not valid as they were not all signed or witnessed by the appropriate persons. They also failed to detail fees to be charged or the cost of services not included in the fee such as hair dressing.

An emergency policy was available. However, it did not detail arrangements for responding to a medical emergency or contingency arrangements should the centre need to evacuate the residents.

While there was a transparent system in place in relation to the management of the residents finances this did not comply with best practice. Six residents had money accruing in the business account of the providers. They obtained a statement in relation to these monies on a regular basis, however no individual interest was payable in respect of these monies to the residents. The provider was an agent to manage pensions on behalf of some residents. A separate file was available for each resident, which clearly documented the financial transactions. Where the resident had capacity, their signature was documented and where they were incapacitated, the signature of the resident's significant other was available.

A system was in place to in relation to risks. This identified clinical and environmental hazards and controls to minimise these risks. The provider and person in charge confirmed that they reviewed risks and hazards on a day to day basis. This document required further work as it was not centre specific, for example although the providers and person in charge were clear that they did specific risk assessments in relation to falls and these were completed in the residents files the procedure for completion of these was not documented in the risk register. Hand gels, gloves and aprons were available throughout the centre and inspectors observed staff using these. Large window openings were filled with restrictors. The temperature of the water at point of contact did not pose a risk to residents.

The Authority had received notifications of accidents and/or serious incidents and quarterly returns from the centre, however, a resident who had a grade 2-pressure sore had not been reported. The provider confirmed that she would submit the required documentation as soon as possible.

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

There was a relaxed pleasant atmosphere on entry. Inspectors observed that the building was of a comfortable temperature, clean bright and well furnished. A buddy system was in place for each resident on admission, the person in charge informed the inspector that she had completed a literature review in this area and had enacted a policy of allocating a carer to a resident as a buddy to ensure support in the transition period into the centre. She felt this was working well and the residents were complimentary of this system.

Residents were smartly dressed and their clothes looked well cared for. Residents told inspectors that their daily personal care needs were met to a high standard.

All residents interviewed indicated that they had privacy in all aspects of personal care and this was observed by inspectors. The manner in which residents were addressed by staff was appropriate and respectful. Staff knocked before entering residents' bedrooms and curtains were used in semi-private rooms to ensure that privacy and dignity was maintained. Staff provided residents with choice in many aspects of their lives. Residents told inspectors that they could decide how to spend their day. Residents told inspectors that they if they wished to spend time in their own room staff respected their wishes. Residents spoken with described how happy they were in the centre and how 'staff was great and always at hand to help'. Another resident said 'they will get you anything you want'.

Where a resident for any reason wished to remain in their bedroom a carer was allocated as the primary person responsible for that person from 9am to 16:00 hrs. This ensured that the resident knew who their primary carer was and provided continuity of care. An inspector spoke to one of the residents who choose to spent long periods in her bedroom. She informed the inspector that this was her choice and the staff supported her to do as she wished. Her room was personalised and she had an individual programme as to how she wished to spend her time throughout the day.

A call bell system was in place which was accessible from the bed and a chair by the bed. Call bells were also available in all communal areas and toilets. Staff were observed to respond to call bells promptly. Residents informed inspectors that if you rang the bell "someone will come quickly".

Bedroom and bathroom doors could be locked from the inside thereby ensuring privacy. One resident with poor eyesight had a visual aid in front of her television to assist her.

Transition year students from the local secondary school attended the centre. They were currently working with six residents completing their life stories. They planned on completing two copies one for the resident and one for the resident's significant other. Three residents' life histories have been completed to date. These were viewed by the inspectors and were found to be detailed and included many photos. It was clear that the resident, relatives and staff were involved in their completion which should give greater insight into the person, their life and interests and inform person centred care planning in relation to meaningful activities.

Residents' religious needs were met. Mass was celebrated weekly, the rosary is said daily and the sacrament of the Sick is administered monthly. Eucharistic Ministers attend three times per week to distribute Holy Communion. Copies of the Parish bulletin are brought to the centre each. A copy of the latest one was displayed on the residents' notice board. There are currently three Church of Ireland residents; their Minister attends the centre every Thursday. There was a policy for end-of-life care which provided direction to staff on the care of residents who were dying. Case files reviewed contained individual end of life care wishes.

An activities co-ordinator is in pace and care staff also assist with activities. A lap top is available for residents use. One resident who chooses to spend her day in her room was having computer classes. The provider is looking into providing mobile internet access throughout the centre. Audio and large print books were available in the library.

The hairdresser attends the centre as required. There was a well established laundry system in place. Residents expressed satisfaction with the service provided.

A food safety system was in place which is supported through a cleaning and temperature control checking system. The kitchen staff were aware of who was on special diets. The menu was on display in the dining room and all kitchen staff had undertaken food safety training. The kitchen was clean with separate areas for dry food storage and a vegetable store. There was a good supply of various juices and these were available to residents at various times throughout the day. Separate kitchen staff changing facilities together with a separate cleaning room was available to ensure good infection control procedures. The most recent environmental health inspection had occurred on the 17 November 2010. A report from this inspection was viewed by the inspectors which stated that there was "a good standard of operational hygiene".

Staff were knowledgeable about residents needs and could describe how they were enabling them to maintain their independence. Handrails had recently been erected to support residents maintain their independence.

An inspector joined the residents for lunch. All food portions were individually plated and residents were asked which food they wished to have. Residents were seated around circular tables in clusters of three to four.

Some improvements required

Inspectors observed that the dining room was small for the amount of residents the residents the centre accommodated. 28 residents were in the dining room for the second sitting at lunch time on the first day of inspection. The inspector observed that conditions were cramped and there was very little space to move between tables.

Significant improvements required

Restraints in use included bed rails, tilt chairs and lap straps. The provider stated that some of the bed rails were in place at the request of residents or relatives as some of the residents had got used to using these prior to admission. While the centre had made an effort to address documentation and practice in relation to the use of restraint further work was required in order to ensure best practice and protect safety and human rights of residents. A risk assessment in relation to the use of restraint and a consent form were in use. 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, 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. Knowledge gained from this review process must be used to inform the resident's care and training needs of staff.

While an activity co-ordinator was in post and a programme of activities was in place on the days of inspection, these were attended by the more independent

residents. Inspectors observed that there was limited social engagement and stimulation for residents who were more dependant and/or cognitively impaired.

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 on-going 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

Prior to an admission the centre receives a referral form detailing the factual details of the resident together with a brief needs assessment. The provider or person in charge follows up on this by phone and will assess the resident in person prior to admission to the centre to ensure the centre will be able to meet the needs of the resident.

Since the last inspection the centre had appointed a physiotherapist one day per week. She takes a lead on two exercise classes on a Wednesday for residents who have a medium to high dependency. This forms part of the falls management programme. She also reviewed individual residents and developed specific programmes for staff to implement. There was evidence on case files reviewed that the physiotherapist was monitoring some of the residents. Access to an occupational therapist was available. Two residents had recently been seen by this service. One resident had obtained a new wheelchair and the other was awaiting a new type of bed. The provider assured the inspectors that all residents who required occupational therapy input would obtain same, and would be provided with appropriate assistive devices and equipment to promote quality of life and promote independence. Dietician and speech and language therapy assessments were available via referral to Mayo General Hospital. A chiropodist attends the service as required. Ophthalmic services attend the service yearly and all residents have an eye test. Eye check ups are also arranged as required. The person in charge stated that the centre had developed good links with community mental health services. Clients were reviewed by the community mental health services. Evidence was available in case files of mental health service involvement. One resident had recently been transferred to the psychiatric unit for review.

A policy on medication management was available. It included sections on ordering, prescribing, storing and administration of medication. The person in charge described a good working relationship with the pharmacist. They had recently changed pharmacy supplier and the pharmacist was actively engaged in audits of medication and assisting and advising the staff. Medicines can be obtained swiftly once prescribed. The medication trolley was locked and stored in the clinical room. The only key holders were the registered nurses. The medication administration charts were clear. The prescription for regular and PRN (as necessary) medication was

written separately. Allergies were recorded and photographic identification of the resident was attached to the chart. Notices warning of possible drug interactions were in place on medication charts. The system for storing controlled drugs was reviewed and was compliant with An Bord Altranais guidelines. A proportion of residents were prescribed sedatives and psychotropic medication. The person in charge stated that she had completed a review of sedative and psychotropic prescribing at the centre. This had been discussed with the pharmacist and the general practitioner and had resulted in decreased prescribing of these medications.

A rolling menu was in place. Inspectors joined residents for lunch. A varied and nutritious diet was offered and all residents said they were offered a choice. The food was served plated. Gravy, sauces and condiments were available on the table. Residents were encouraged to assist themselves but where unable to do so were assisted by staff. Special diets were available. Where residents required a soft diet or to have their food pureed, this was presented in individual portions. The variety, quality and presentation of all meals were of a good standard. Residents expressed satisfaction with the food and the dining experience. There were adequate staff in the dining area and good interaction was observed between staff and residents.

Residents and relatives could access tea/coffee and other drinks throughout the day as they wished. Staff could access a variety of food from the kitchen day or night for residents who required snacks outside regular meal times. Water and squash was freely available throughout the day and there was a variety of drinks and snacks available at drink rounds. Staff were observed assisting residents with fluids.

When a resident returned from an admission to the General Hospital an assessment sheet was available and was seen to be completed in the notes detailing any changes and the current needs of the resident.

A form was available with each medication chart detailing review of the medication by the general practitioner. This was to ensure that each resident medication was reviewed at three monthly intervals.

Significant improvements required

A sample of six care records was reviewed by the inspectors. While assessments, care plans and daily nursing notes were filed together and the narrative in the case file gave a good current clinical picture of the resident, some files contained assessments that had not been updated within the preceding three months but this was not the case in all files. An assessment of residents' activities of daily living had been completed on all files reviewed following admission. Some care plans were found to be generic in nature as on many occasions no deletions had been made to the typed copy. Some care plans were handwritten and were person centred. There was evidence that an assessment of social care needs had been undertaken, however there was limited evidence that this was linked to the development of meaningful activities. Many care plans did not reflect any contribution from residents or from others involved in their care.

While pain charts were available and in use in some cases, they were not fully complete. They did not reflect the adequacy or inadequacy of the analgesia prescribed.

Minor issues to be addressed

It was noted on restraint forms that staff were using 'cot sides' as opposed to bedrails which is inappropriate terminology.

Entries in residents' care plans showed that residents had access to a GP as required and an emergency on call service was available. There was good evidence of regular reviews by the general practitioner on some case notes inspected. However this was not consistent in all cases.

While there was a pressure area care policy this did not reflect contemporary evidenced based practice.

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 was purpose built and is operational since 2004. The physical design and Layout of the premises was appropriate for use as a designated centre. The designated centre was clean and suitably decorated. Adequate private and communal accommodation was provided for residents use.

The premises were kept in a good state of repair externally and internally. An external well maintained garden which was suitable and safe for use by residents was available. Adequate assistive equipment was available. The equipment provided at the designated centre for use by residents or persons who work at the designated centre was maintained in good working order. Inspectors viewed the maintenance records for equipment such as beds, hoists and pressure relieving mattresses and noted that these were last serviced on the 17 February2011. A maintenance log was also maintained to record any day-to-day faults.

Since the last inspection infection prevention and control procedures have been reviewed. Hand hygiene sanitizers had been increased and posters to highlight good hand washing technique were in place. All en-suites had antibacterial soap via a wall dispenser and paper towels. Infection control training which included hand hygiene techniques had taken place for staff. In addition 5 members of staff have passed the FETAC Level 5 Module on infection control. A flat mop colour coded system was in place. Cleaning schedules were in place within the centre and these were signed and up to date. All furniture is covered in washable fabric that is impervious to liquids, and can be cleaned. Infection control policies have been reviewed. Job descriptions have been reviewed with a clear defined responsibility for infection control. Policies for responding to an outbreak of infection have been redrafted and staff inducted on these. It was noted by the inspectors that bed linen was clean and staff were observed to be changing the bed linen on many of the beds in the centre. Staff stated that disposable sheets and incontinence wear were changed as required to meet the comfort and well-being of the residents. This was confirmed by residents and relatives. In order to ensure proper disposal of all disposable items such as swabs and incontinence wear a contract for bi-monthly collection of clinical waste was in place.

Showering and changing facilities for catering and non catering staff are separate.

A visitors' room was available for residents to meet visitors in private. The room was furnished domestic style.

Bedroom sizes complied with national standards. There was adequate sitting and recreational space provided separately from the resident's private accommodation. The communal space provided for residents was suitable for the provision of social, cultural and religious activities. For example the room where Mass was celebrated was able to accommodate all residents should they wish to attend. Other rooms were available for recreational activities and they contained suitable furniture. A quiet room was available for relaxation and small group activities for residents with dementia.

The corridors were wide and unobstructed which enabled residents to mobilise in a safe environment. Handrails were in place to promote residents' independence. Suitable storage facilities were provided for the use of residents, each resident had a wardrobe and locker. The locker had a secure drawer to ensure storage of valuable or private items. Equipment was suitably stored and did not infringe on the safety of residents.

A kitchen was with suitable and sufficient cooking facilities was available with a dry stores area and cold room. All food was stored in hygienic conditions. The kitchen was spacious, clean and bright. It was well equipped and was well- stocked with fresh and frozen vegetables, fresh fruit, bread, milk and meats. The chef kept up to date records of any special dietary requirements of residents.

En-suites to include shower toilet and wash- hand basin was provided in each bedroom.(with the exception of one) A sufficient number of toilets, bathrooms and showers were available taking into consideration the level of dependent persons accommodated in the centre.

Bedrooms were personalised with residents' belongings including photographs. Residents told inspectors that they were encouraged to bring in personal belongings. The centre had sufficient storage areas for equipment and supplies. Equipment such as hoists, wheelchairs and mobility aids were appropriately stored. This decreased risk of slips, trips and falls to residents and ensured emergency exits were kept clear. Radiators could be individually controlled and were found to be of a comfortable temperature.

Since the last inspection, the provider had reviewed fire safety management arrangements. All fire equipment had been serviced, records inspected were found to be up to date. An individual fire evacuation assessment has been developed for all high dependency persons at risk. An assessment of equipment necessary to safely evacuate has been completed by the provider and evacuation blankets were obtained for residents assessed as requiring same. Fire alarms and emergency lighting are checked quarterly. Signage detailing the nearest fire escape route is in place. All staff had been trained in fire safety and evacuation. The provider informed the inspector that there is daily monitoring of fire exits and records were available to support this. The provider has increased staffing levels- there is an extra care assistant on duty in the afternoon up to 22:00 hrs and the person in charge is now always supernumery. The provider and person in charge informed the inspectors that they were confident

that there is adequate staffing, both day and night time, taking into account the dependencies of residents and purpose of centre to safely evacuate residents. The local fire officer has attended the centre for a familiarisation visit.

Some improvements required

With the exception of the dining room which was small, the size and layout of rooms occupied and used by residents were suitable for their needs.

Adequate laundry facilities were provided however, there was inadequate space for folding clothes.

While appropriate sluicing facilities laundry facilities and a cleaning room were available, secure access to these rooms to ensure they did not pose a risk to residents was not in place.

It was noted by inspectors that while bedrooms were numbered there was not appropriate signage to guide an orientate residents around the centre.

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

The person in charge had put a number of mechanisms in place to support good communication between staff members and staff and residents to enhance the smooth operation of the centre. A notice board in the nurses' station had updates on education opportunities and other changes to practices. The person in charge holds regular meetings with staff and minutes of minutes indicated that they were a forum to discuss items such as the national standards, regulations, and practices to promote person centred care
and team working. Regular nurses meeting were also held. Minutes were made available to the inspectors of these meetings. Issues such as clinical practice and general housekeeping duties were discussed at these meetings Views of the residents in relation to the daily activity programme were documented in the communication book. This gave staff who may not have been involved in the activity programme on the day a good overall view of the residents' participation in the activity programme.

Communication between residents and staff was positive. Some residents stated that they enjoyed the interaction with staff and felt that they would be able to raise any issues with staff. Inspectors observed staff speaking calmly and respectfully towards residents thereby empowering residents to make their own lifestyle choices. From talking with staff it was clear that they knew residents very well.

Residents informed the inspectors that they obtained newspapers on a daily basis. Inspectors observed the availability of daily newspapers on the days of inspection. The provider informed the inspectors that three copies of daily national and local newspapers were purchased by the centre for residents' use and residents who wished to order their own copy could do so. One resident described to the inspectors how she enjoyed obtaining the newspaper because she liked to keep up with politics. Magazines that reflected the specific interests of the residents for example Ireland's Own and the Farmers Journal were available.

A pictorial communication book was available for residents. This was particularly important as an aid to residents who had difficulty expressing themselves verbally. This had been devised by the PIC and was of a good standard. The person in charge

has developed a pictorial communication tool to assist residents to express their needs. Individual books were available for two residents who were assessed as requiring same. This was viewed by the inspectors and staff informed the inspectors that this was of great benefit when communicating with residents.

All residents have the option of a phone in their bedroom and a cordless phone was also available for residents use. A communication book was in place in which family members requests were documented so that all staff were informed of these. This was viewed by the inspectors and found to be up to date.

The provider informed the inspector that in future new resident will receive an information pack on admission. This will include the resident's guide, the statement of purpose and a contract of care. Currently the statement of purpose and residents guide is stored in a folder on the back of each resident's bedroom door. An independent advocacy service was available to residents. The centre also had a policy on advocacy services.

A resident's guide was displayed in the entrance foyer. This contained all the information required by the legislation. All staff wore name badges. Photographs of staff detailing their name were available in the centre. All staff wore badges and different coloured uniforms. A quarterly newsletter was produced by the centre. This detailed any changes to the centre and updates re events etc.

Large clocks were available in communal areas. A Leaflet display stand and advice on falls prevention was available in the foyer area. Photos were displayed of recent events enjoyed by residents throughout the centre. The complaints policy was on display and suggestions box was also available in the foyer area.

Significant improvements required

While a communication policy was available this was very general in nature and did not address the area of alternative means of communication and communication strategies for dealing with different resident groups.

While all the polices required in order to comply with current legislation were available , the policies required review in order to ensure that the procedures are sufficient to guide inform and support staff in the delivery of good quality safe care and ensure positive outcomes for residents.

Resident meetings were held regularly, however, these were not independently chaired. A care assistant chaired these meetings. Minutes were available of these meetings. A copy of the most recent minutes was displayed on the sitting room notice board.

Minor issues to be addressed

While staff and the person in charge confirmed that there was a handover at the change over of each staff shift there was no formal time built into the staff rota to reflect this. Given that this is a 64 bedded unit and the importance of the handover to ensure provision of safe quality care it is recommended that this policy is reviewed to reflect a formal handover period on the staff roster.

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

Comprehensive written policies and procedures relating to recruitment, selection and vetting of all staff are in place. An induction programme was in place on commencement of employment. This was confirmed by staff. One staff nurse told inspectors that she worked alongside the person in charge and more experienced staff prior to doing night duty.

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.

All staff who worked in the centre was rostered detailing their position and full name. The inspector viewed the staff rota for a two week period and found that it was legible. A registered nurse was on duty at all times. Where there were more than one staff nurse on duty during the day time it was clear from the off duty who was the designated person in charge. The senior on call structure was outlined in the emergency plan for the centre. Adequate on-call arrangements were in place with cover provided by the providers and in their absence the person in charge. Staff were aware of out of hours contact numbers for the providers and person in charge. Their telephone numbers were clearly on display in the nurses' office.

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 ensures that residents are familiar with the staff and staff are knowledgeable of the needs of the residents. A staff handover occurred at the commencement of the morning and night shift.

Staff records were available to support that training was provided and staff spoken with confirmed their attendance at training, for example, 34 staff had attended training on Nutrition and Dysphasia on the 28 February 2011. Staff had also attended training on continence care and infection control. A training needs analysis was recently conducted by an external consultancy company. The provider informed the inspectors that she was in the process of reviewing the recommendations of this.

Currently the centre has 24 care staff of which 11 have Further Education and Training Awards Council [FETAC] level five training or above in the care of older people. 10 staff are currently completing this course. Staff wore identification badges detailing their name and position.

The record of An Bord Altranais personal identification numbers for registered nurses was inspected and found to be in order.

Some improvements required

While all staff had received training on elder abuse – recognition reporting and prevention and fire safety training, not all staff had up to date mandatory manual handling training. The provider informed the inspectors that this was booked for the end of March 2011.

A sample of staff personnel files were reviewed by inspectors. Most contained the required documentation to comply with current legislation. A small number of omissions were noted which included for example, proof of the centre's Garda Síochána vetting and evidence of mental and physical fitness.

Significant improvements required

The person in charge informed inspectors that approximately a quarter of current residents had a diagnosis of dementia or cognitive impairment and some also had communication difficulties, however, staff had not received dedicated training in these areas to ensure they provided care in accordance with contemporary evidence based practice. Training on Managing Challenging behaviour had not been delivered but planned.

No staff had received training at the centre on basic life support to ensure that they would be able to respond to a medical emergency. The provider informed that the inspectors that she was liaising with a company in relation to the provision of this for all staff.

There were no formal arrangements in place for supervision or appraisal. The person in charge told inspectors that she is in the process of developing this.

Closing the visit

At the close of the inspection visit, a feedback meeting was held with the providers 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 co-operation 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
21 April 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
20 January 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced
5 May 2010	☐ Registration ☒ Scheduled ☐ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report

Centre:	Friar's Lodge Nursing Home
Centre ID:	342
Date of inspection:	3 and 4 March 2011
Date of response:	17 May 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 and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

1. 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 person centred. Pain charts were not in use for all residents who were administered analgesia to ensure the analgesia administered was effective and controlled the pain. Residents who were restrained did not a comprehensive person-centred care plan in place.
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: Review all care plans to be person centred.

Action required: Ensure a pain chart is accurately completed for all residents who are administered analgesia	
Action required: Ensure that residents who is restrained has a comprehensive person-centred care plan in place which reflects good practice.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 11: The Resident's Care Plan Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All residents care plans are under review ensuring that the resident or their significant other are involved. All care plans are in the process of been personalised. Pain charts are been included for all residents receiving regular analgesia. Comprehensive care plans and assessment tools are being developed and put in place as part of our new restraint reduction programme.	March - September 2011

2. 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 comply 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 complied 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 residents best interest and is the least restrictive option necessary. 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 to maintain the care and welfare of the resident.

Action required:
Where residents lacks 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.
Implement procedures and documentation practices in line with legislation and best practice restraint management to take into account of residents' human rights.

Action required:
Any restraint measure whether physical or chemical must be in the best interest of the resident and under constant review.
Conduct a quality audit review of all residents in 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: Restraint Reduction Team has been developed which consists of Nurses, Care Assistants, Residents, GP, Physio and relatives. The HSE policy for restraint for designated centres is being implemented in Friars Lodge. Assessment tools have been further developed including "Restraint Free Periods". PIC and S/N are attending Train the Trainer Course in June (HSE). Residents who are on restraint Reduction Programme are having progress monitored daily and same documented weekly. Consent forms have been revised in line with best practice. Resident Restraint booklet has been published to assist residents to make informed choice. Audit on restraint changes (using HSE Audit Tool) due in November 2011.	March - November 2011

3. The provider is failing to comply with a regulatory requirement in the following respect:
The contract of care provided to residents did not comply with current legislation

Action required:
Provide each resident with a contract of care that is legally binding and includes details of the services to be provided for the resident and the fees to be charged.

Reference:
Health Act 2007
Regulation 28: Contract for the Provision of Services
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 residents Contracts of Care to be reviewed ensuring they meet with current legislation.	March-June 2011

4.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 on manual training.

Action required:
Make arrangements to ensure all staff are trained in the moving and handling of residents.

Reference: Health Act, 2007
Regulation 31: Risk Management Procedures
Regulation 17: Training and Staff Development
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 within Friars Lodge Nursing home have attending Manual Handling Training and are up to date. Training booked for 27 January 2012 for next years requirements	March 2011

5. The provider is failing to comply with a regulatory requirement in the following respect:
There were no plans in place to relocate residents to a place of safety should an evacuation of the building be required.

Action required:
Update written procedures in relation to evacuation of the premises to include details of a place of safety for residents

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: Major Incident Plan updated to include details of where to relocate residents in the event of such incident.	April 2011

6. The provider and person in charge are failing to comply with a regulatory requirement in the following respect: Residents who were highly dependent and/or cognitively impaired were not observed to engage in meaningful activity.	
Action required: Provide opportunities for all residents to take part in meaningful activity in accordance with their needs, preferences and capacities.	
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Regulation 6: General Welfare and Protection Standard 18 : Routines and Expectations Standard 20: Social Contacts	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Evidence is available to show that dependent and cognitively impaired residents do interact with the activity co- ordinator and are offered, or do partake in meaningful activities. Activity co-ordinator was on sick leave during the Inspection but has returned to work now and works 4 days per week.	March 2011

7. The provider is failing to comply with a regulatory requirement in the following respect: Confirmation of Garda Síochána clearance had not been obtained for staff working the centre. Verification that the staff member was physically and mentally fit for the purposes of the work which they were to perform at the designated centre was not available on all files.
Action required: Ensure Garda clearance is obtained for all staff and evidence of this is kept on personnel files.

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: All Staff files have Garda clearance applied for.	March 2011

8. The provider is failing to comply with a regulatory requirement in the following respect: The complaints policy did not detail identification of a nominated person (independent of the person responsible for investigating the complaint), to ensure that records were appropriately maintained and that all complaints were appropriately responded to in accordance with relevant legislation. Timescales were not detailed in the complaints policy. A procedure to ensure that the complainant was satisfied with the outcome of the complaint were not contained in the policy.	
Action required: Revise the complaints procedure to ensure that the centre has written operational policies and procedures relating to the making, handling and investigation of complaints that complies with current legislation.	
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Complaints Policy reviewed and updated to include current legislation requirements.	June 2011

9. The person in charge is failing to comply with a regulatory requirement in the following respect: Not all assessments or care plans had not been updated within the preceding three months. Not all residents had an assessment of social care needs undertaken.	
Action required: Ensure that assessments and care plans are updated and reviewed at a minimum of three monthly or more frequently as required to reflect the changing needs of residents.	
Action required: An assessment of social care needs to be carried out for all residents.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Regulation 9: Health Care Standard 11: The Resident's Care Plan Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All Care Plans have been updated and will continually be reviewed to meet the best practice standards.	April 2011

10. The person in charge is failing to comply with a regulatory requirement in the following respect: Deleting substances was used on the Directory of Residents' to correct errors	
Action required: Ensure deleting substances are not used on the Directory of Residents to correct errors.	
Reference: Health Act, 2007 Regulation 23: Directory of Residents Regulation 22 : Maintenance of 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: Deleting Substances (Tippex) have been removed from all clinical areas with immediate effect. Staff made aware of same.	March 2011

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

The dining room accommodation available to residents was inadequate. Due to the size of the dining room compared to the amount of residents in the centre it posed a potential risk of accidents to residents.

Action required:

Provide adequate dining space having regard to the number and specific needs of the residents.

Reference:

Health Act 2007
Regulation 31: Risk Management procedures
Regulation 19: Premises
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: Risk Assessment carried out on Dining Room. Dining Room is supervised at all meal times. Two/Three meal setting in place to avoid congestion. Residents' views taken into consideration and any improvements to the dining experience will be made as per request.	April 2011

12. 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 and two members of staff.

Reference:

Health Act, 2007
Regulation 7: Residents' Personal Property and Possessions
Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All resident Inventories were updated in April 2011 and this will continued on a twice yearly cycle or as required in the event of new items been brought into the nursing home.	April 2011

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

Ensure all polices available in the centre are available to guide and inform staff on practices.
A number of policies for example ,elder abuse policy, communication policy, wound care policy and emergency policy did not inform and support staff in the delivery of good quality safe care.

Action required:

Develop polices to ensure that guidance and information is available to staff in practices and procedures to enhance the delivery of safe quality care to residents.

Reference:

Health Act, 2007
Regulation 6:General Welfare and Protection
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: Policies are under development and review to ensure that guidance and information is available to staff in practice.	September 2011

14. The provider is failing to comply with a regulatory requirement in the following respect:
The risk assessment completed for the centre did not include all information on risks and control measures in the centre.

Action required:

Review the recently completed risk assessment and ensure it details all risks and control measures in the centre.

Action required: Ensure the risk assessment is centre specific.	
Reference: Health Act, 2007 Regulation 31: Risk Management procedures Standard 26: Health and safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Risk Assessment training received in March 2011. Risk Assessments developed and continuously reviewed.	May 2011

15. The provider is failing to comply with a regulatory requirement in the following respect: A system was not in place to ensure that residents were obtaining interest on their person finances.	
Action required: Put in place procedures for individual bank accounts for each resident so as to ensure that residents obtain any and all benefits of having a personal bank account.	
Reference: Health Act 2007, Regulation 7: Residents' Personal Property and Possessions Standard 9: The Residents' Finances	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 6 residents' finances have been reviewed and are_no longer managed by G & T Gallen Ltd but by the resident or their nominated person. All financial transactions within the centre continue to be transparent and readily available at any time.	May 2011

16. The Person in Charge is failing to comply with a regulatory requirement in the following respect: Not all notifications were submitted to the chief Inspector as required by the regulations.
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

Reference: Health Act 2007, Regulation36: Notification of incidents Standard 29: Management systems.	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All notifications will be sent as per best practice.	March 2011

17. The Person in Charge is failing to comply with a regulatory requirement in the following respect: Not all staff had received dedicated training on dementia care or on the management of residents with behaviour that challenged to ensure they provided care in accordance with contemporary evidenced –based practice. No staff had training on basic life support to ensure that they would be able to respond to a medical emergency.	
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: Provide staff members with access to education and training on basic life support in accordance with contemporary evidenced 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: Friars Lodge has reviewed staff training requirements and are currently planning basic life support training in conjunction with the Ballinrobe Order of Malta. Staff training in regards in Challenging behaviour has commenced and all staff will have an opportunity to avail of training.	March - October 2011

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 2: Consultation and Participation	Complete a life history/life story for each resident and use the information gathered to plan and personalise the activity programme. **Provider's response** Life Story projects in place in conjunction with Ballinrobe Community School. 8 residents just completed current program May 2011.
Standard 8: Protection	Dedicated elder abuse officer details to be added to protection policy **Provider's response** Dedicated Elder abuse Officer details have been added to protection policy.
Standard 2: Consultation and Participation	Residents Committee to be chaired by independent person **Provider's response** Residents to vote on who they want to chair residents committee.
Standard 26: Health and Safety	Secure sluice, laundry and cleaning room to ensure safety of residents. **Provider's response** Cleaning Store Room and Laundry already secure. Sluice not appropriate to be secure due to risk of cross infection. This will be continually reviewed.
Standard 25: Physical Environment	Provide suitable space to facilitate folding of laundry. **Provider's response** Laundry area assessed for space, laundry assistant feels that she has enough room to fold laundry. This will be continuously reviewed.

Standard 13: Healthcare	Ensure regular review by the general practitioner for all residents. **Provider's response** All GP's are contacted re 3/12 reviews same is documented. Some GP's are more compliant than others in attending their 3/12 checks.
Standard 30: Quality Assurance and Continuous Improvement	Ensure pressure area care policy reflects contemporary evidenced based practice. **Provider's response** Pressure Area policy to be reviewed ensuring contemporary evidenced based practice is included.
Standard 17: Autonomy and Independence	Signage was inadequate to orientate and assist residents as they walked around the centre. Provide appropriate signage to assist and orientate residents in the centre. **Provider's response** We will reassess our signage and act on our findings.
Standard 2: Consultation and Participation.	Terminology such as 'cot sides was used as opposed to bedrails Ensure that terminology used is respectful of residents and age appropriate. **Provider's response** All terminology has been changed to meet best practice.
Standard 24:Training and Supervision	Commence a process of staff appraisals **Providers response** Staff appraisals are already insitu and will continue.
Standard 29:Management Systems:	There was no formal time built into the staff rota to reflect handover at the change of each shift. **Provider's Response** Handover has always been included in Friars Lodge it occurs 3 times a day morning, afternoon, night.

Any comments the provider may wish to make:

Provider's response:

The Management and Staff of Friars lodge Nursing Home would like to thank the inspectors for their courtesy and respect shown to staff and residents during the registration inspection on 3rd and 4th March 2011. We felt that both inspectors were approachable, fair in their judgment, objective and a pleasure to work with.

We were very pleased that the inspectors acknowledged the vast amount of hard work carried out by the management and staff since the last visit and also their acknowledgment of the commitment given by the provider and the person in charge to continuously improve the service provided.

We were delighted that many of the positive projects which we have developed for our residents were highlighted, and the staffs overall knowledge and commitment to the residents was acknowledged.

We will endeavour to complete our action plan by stated dates and feel that the overall experience enhanced our own learning experience and was very positive.

Provider's name: Tanya & Gerry Gallen
Date: 17 May 2011