Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	St Clairs Nursing Home
Centre ID:	0099
Centre Address:	Ballinderry Mullingar Co Westmeath
Telephone number:	044-9385300
Fax number:	044-9385995
Email address:	None supplied
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	VFM Healthcare (Ireland) Ltd
Person in charge:	Paula Gavigan
Date of inspection:	23 and 24 February 2011
Time inspection took place:	**Day 1: Start:** 08:45 hrs **Completion:** 17:45 hrs **Day 2: Start:** 08:00 hrs **Completion:** 18:00 hrs
Lead inspector:	Catherine Connolly-Gargan
Support inspector(s):	Brid McGoldrick
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

St Clair's nursing home is located within St Francis's Private Hospital complex, a three-storey facility in which St Clairs Nursing Home occupies a part of the ground floor.

The hospital and the centre share a common entrance and a number of other services that include the main kitchen, the maintenance department and chaplaincy provision.

St Clair's Nursing Home has accommodation for up to 43 residents. There are 25 bedrooms, of which 16 are twin rooms, eight are single rooms (one with an en suite toilet and wash-hand basin), and one three-bedded room with en suite toilet, shower and hand-washing facilities. There are two bathrooms and a shower (the shower and one of the bathrooms are wheelchair accessible). There are twelve toilets available for residents' use of which three are wheelchair accessible. Toilet facilities are located throughout the centre and within close proximity of communal areas.

There is an enclosed garden accessible from the centre. The enclosed garden known as "the peace garden" was recently refurbished and had some seating provided. A landscaped garden surrounds the exterior of the building.

The centre has two sitting rooms, one of which is designated as suitable for residents to meet their visitor's in private. Seating is also available in the lobby area of the centre and was available for residents' use. Residents had access to a dining room linked to one of the sitting rooms.

The centre is adjacent to a large church and coffee shop which are accessible through the lobby area of St Francis' Private Hospital.

Location

St Clair's Nursing Home is located on a large site in Ballinderry, which is a residential area on the periphery of Mullingar town, Co Westmeath.

Date centre was first established:	June 1968
Number of residents on the date of inspection	37
Number of vacancies on the date of inspection	6 vacancies

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	14	13	7	3

Management structure

St Clairs Nursing Home is owned by Mark Gordon of VFM Healthcare (Ireland) Ltd who took over as provider in December 2010. The person in charge is Paula Gavigan who reports directly to Noeleen Sheridan, Director of Nursing/General Manager of St Francis Private Hospital and to the provider. The person in charge is also supported by staff nurses, carers, cleaning, catering, maintenance, administrative, chaplaincy and physiotherapy. Some of these services are based in St Francis's Private Hospital and are accessible to residents in St Clair's Nursing Home. The provider has financial, risk advisory and human resource services on site which the person in charge can access to support her work.

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	6	0	2 x cleaning	1 (8 hrs per week)	activities coordinator and * See below

*Maintenance via St Francis Private Hospital staff
Catering done in St Francis Private Hospital kitchen
Laundry off-site by contractor
Physiotherapy service as part of St Francis Hospital complex service

Background

The first inspection of St Clair's Nursing Home by the Health Information and Quality Authority (the Authority) was an announced registration inspection undertaken on the 03 and 04 February 2010. Further to that inspection, on 08 February 2010, the provider was required to carry out an investigation into the large number of incidents of behaviour which challenged in which residents were being physically and verbally abused by other residents. On 24 February 2010, the Authority received a report from the provider into this matter, which was inadequate.

The provider was subsequently required to provide further clarification to the Authority in relation to this.

An unannounced visit to the centre by the inspection team to follow-up on the provider led investigation report on the 26 April 2010 identified the need for an immediate action letter sent to the provider, (letter sent on 28 April 2010) instructing urgent address of inadequate risk management procedures, staffing and skill mix levels and no full-time person in charge. The standard of the building was inadequate to provide for the care, welfare, and quality of life of residents living in it. Inspectors also found significant improvements were required in the following areas:

- general welfare and protection
- leadership and governance
- fulfilment
- risk management procedures
- staff training and supervision
- communication

The Authority subsequently met with the providers and person in charge on the 12 May 2010 to address the inadequate response by the provider. Following the meeting, the Authority was satisfied with the actions proposed by the provider to address the outstanding actions contained within the Action Plan of the 28 April 2010 inspection report. The Authority carried out a further unannounced follow up inspection on 16 June 2010.

As the centre has undergone a change in provider in December 2010, a further registration inspection took place on 23 and 24 February 2011. The Action Plan at the end of this report details all outstanding requirements from previous inspections together with any additional requirements identified during this inspection.

Summary of findings from this inspection

This was an announced registration inspection of St Clair's Nursing Home. The new provider took over ownership of the centre in December 2010 and had applied for registration under the Health Act 2007 and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009. An essential aspect of the registration process is the requirement that the provider satisfies the Chief Inspector of Social Services that he is fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Inspectors met with residents, relatives, the provider, the general manager, the person in charge, staff nurses, carers, catering staff, cleaning staff and the risk manager. Documentation examined included fire safety records, health and safety documentation, operational policies and procedures, staff files, care plans, medical notes, medication and assessment records.

The provider undertook a fit person interview during the inspection. The general manager and person in charge had previously completed fit person interviews on the 15 October 2010. A number of documents completed for the registration process were reviewed by inspectors. These included the fit person self assessment document, management-staff profiles, the statement of purpose, and other documentation associated with the registration.

At the time of this registration inspection, inspectors also evaluated the actions taken by the new provider in response to the follow up inspection undertaken on 16 June 2010. Of the 25 actions in the Action Plan, four had been fully completed and the remainder had been completed to varying levels. Those actions not fully addressed are restated in the Action Plan at the end of this report together with any issues identified during this inspection. These included:

- fire safety
- staffing levels and supervision of junior staff was not adequate
- residents access to healthcare
- residents recreational Activity
- elder abuse prevention training
- inadequate staff personnel files
- inadequate statement of purpose
- inadequate residents' guide
- inadequate complaints policy
- the number of resident baths and amount of communal space did not meet minimum standards
- cleaning and hygiene was also of a poor
- plans did nor reflect residents' needs
- policies and procedures were not adequate.

The issues identified for improvement during this inspection mirror those previously identified. However, some improvements had been made and an activity coordinator was appointed.

Information was received by the Authority in September 2010 relating to inadequate staffing levels and while staffing levels were increased, inspectors found evidence indicating that this area required further improvement.

There were improvements required in access to a balanced diet, healthcare, dietetic services and recreational activities. Rights, privacy and dignity of residents, medication management, review of quality and safety of care and staffing levels also required improvement.

The quality of service was otherwise of a reasonable standard. Inspectors also noted that three incidents of alleged elder abuse had occurred within the past six months. While two of these incidents (alleged physical and financial abuse) were still being investigated, one was satisfactorily resolved. Inspectors noted that actions taken in response to previous allegations of elder abuse were appropriate, well managed and reflected the centre's policy.

The internal garden was risk assessed and refurbished last year. However, residents did not have free access into it or did not have an input into the refurbishment. The door to the garden was locked and staff held the key.

Inspectors also identified that there were insufficient bathing facilities, there was no cleaning room and the sluicing facility was inadequate.

The Action Plan at the end of the report details the improvements 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*.

Comments by residents and relatives

Twelve residents and eight relatives completed feedback questionnaires. Inspectors spoke with many more residents and relatives during the inspection. Residents complimented staff's kindness and the caring nature of the person in charge. A number of residents told inspectors that they felt 'well cared for' and 'safe'. In the completed questionnaires, many residents commented on how busy staff appeared to be and that they had to wait sometimes. These comments were again voiced during the inspection.

Relatives commented on residents' loss of clothing and some told inspectors that they now took clothing home for laundering. While a significant number of residents and relatives thought the food was good, some felt it could be improved.

Relatives were happy that residents' healthcare needs were met and said that if there was any deterioration in their health status, they would always be informed.

Residents said they enjoyed "chatting" to their visitors, while others enjoyed watching television. Other residents were very happy that they could link into the prayer service in the church. However, as per previous inspections some residents and relatives still felt that activity provision could be better and access could be improved to outside the building when the weather was nice.

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 the provider stated he was on site four to five days each week. He informed inspectors that he starts work early in the morning and also calls to the centre at night to observe the running of the centre out of hours. He had taken over ownership of the centre as part of St Francis Private Hospital complex in December 2010. The person in charge was aware of her legislative responsibilities in the provision of clinical care and the general welfare and protection of residents. The provider and person in charge were aware of their responsibilities in relation to notifications of prescribed incidents and had submitted their quarterly notifications to the Chief Inspector as required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Staff interviewed by inspectors were knowledgeable about their roles and responsibilities were able to describe to inspectors the staffing structures and reporting arrangements in place which reflected those described by the person in charge. Staff confirmed to inspectors that they felt supported by management and that the person in charge was knowledgeable about care of the older person.

Financial controls were in place to ensure the safeguarding of residents' finances. There was a policy to guide practice. The provider did not manage pensions on behalf of any of the residents. A petty cash system was in place to manage small amounts of residents'' monies. A record of the handling of money was maintained for each transaction. Two signatures were recorded in all instances. The ongoing balance was transparently managed and explained to the resident and/or their representative. The hairdresser issued a receipt for fee. All receipts issued were maintained in each resident's financial file.

A major emergencies policy was in place to guide and assist staff in responding to untoward incidents. This detailed a clear procedure to follow in the event of utility failure, flooding or missing persons. A designated place of safety was identified in the policy should it be deemed necessary to evacuate the building. An unannounced missing person drill was a regular event in the centre coordinated by the fire safety officer. A report had been compiled following each drill. The most recent missing person drill was carried out on

the 10 February 2011. A post-drill evaluative report viewed by the inspector indicated that further practice was required which had been scheduled.

The provider had valid insurance cover against accidents and injuries to residents, staff and visitors. The insurance cover reviewed by an inspector included indemnity for the personal property of residents which was reflective of the regulations.

Inspectors reviewed the directory of residents which was up to date. It detailed when residents were transferred to hospital and the reason for transfer and contained all other information required by the regulations.

In the event of an emergency, residents could be evacuated from the centre through designated fire exit doors facilitated by an electromagnetic door locking system that disengaged on activation of the fire alarm. Door-guards were also in place to facilitate residents who liked to have their doors open. The door-guards disengaged automatically when the fire alarm sounded or manually by a foot-activated pedal. All dependant residents had evacuation sheets located under their mattresses to expedite their evacuation in the event of an emergency.

Some improvements required

The person in charge took up post in August 2010. Although she completed an induction programme, she has lacked ongoing supervision and support in this new role. Inspectors identified that the management arrangements in place within St Francis' Hospital meant that the person in charge was not adequately involved in all aspects of the governance of the centre. Furthermore, there was no single member of staff nominated to take over management of the centre in the absence of the person in charge.

All residents had been provided with a written contract which detailed the care and services provided. However, the contract of care did not include details of the agreed fee to be paid or the cost of additional services such as hairdressing and chiropody. The contract of care also did not identify the room to be occupied by the resident.

There was a policy in place to inform staff on procedures to follow in the event of residents' temporary absence or discharge from the centre. However, it required development to include procedures for medication administration, dressings and arrangements for specific care such as the prevention of pressure-related skin damage to residents assessed as being at risk.

Risk management procedures were not robust. While a falls risk assessment was completed for each resident and falls in St Clair's Nursing Home had been reviewed as part of an overall St Francis Private Hospital risk management meeting, fall prevention strategies were noted by inspectors to be weak. For example, comments noted in documentation included 'advised to ring the bell' and 'advised not to get up from chair'. Although falls were reviewed as part of the overall governance procedures of St Francis Private Hospital, they were not analysed to identify weaknesses or learning to be applied in practice.

The complaints management policy did not reference all the requirements of the legislation. Although the complaints procedure was displayed in the centre, it required

review to reflect the amended policy and ensure that complaints are dealt with in accordance with the relevant legislation.

The Statement of Purpose did not contain all information to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Significant improvements required

Although, fire safety certification confirmed that the centre was 'largely compliant with the statutory fire safety legislation' inspectors noted a recommendation to relocate the medical gases room (which supplied St Francis' Private Hospital) from St Clair's to elsewhere in the hospital had not been addressed.

Throughout the inspection, inspectors noted that the door to the smoking room had been consistently left open when residents were smoking. All staff in the centre had not participated in a fire drill twice yearly. During the inspection, the fire alarm sounded and inspectors observed that staff's response was inadequate and not in accordance with the centre's fire management policy.

There was a no system in place to review the quality and safety of clinical care. Although reviews of accidents and incidents were evaluated as part of a hospital-wide risk management process attended by the hospital risk manager where the person in charge presented data from St Clair's nursing home. However there was evidence that audits or other quality assurance initiatives had not been undertaken to address areas previously identified by inspectors as requiring improvement. These included medication management, notifications to the authority, bowel management and care planning.

While a Health and Safety Policy was in place, it was developed in 2007 and had not been updated since. All existing hazards had not been identified and risk assessed with appropriate controls in place to mitigate the risks identified. For example, there was a risk of trip due to a small step out of the sluice and from handrails which were not safe as joints were open between rails. The fault with the handrails had been previously repaired but had recurred. Only three staff signed that they had read the health and safety statement.

Minor issues to be addressed

Residents' records, care plans, medical files and other confidential information were stored in a safe and secure place in the person in charge's office. However this office was not secured at all times and inspectors noted that access to this office was not controlled.

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

Residents' privacy and dignity was respected. Inspectors observed staff knocking on bedroom doors and waiting for permission to enter. Cleaning staff were observed seeking permission to enter bedrooms. Bedroom doors were closed and screens were pulled around beds by staff when assisting residents with their personal care. Staff promoted the dignity of residents by supporting them to dress according to their individual tastes and assisting them with personal grooming. Toilet doors were fitted with locks.

Many bedrooms were personalised to resident's individual tastes and included photographs, ornaments and pictures hanging on the wall. Some residents had their own televisions.

Residents could practice their religious beliefs. A spacious church was accessible from the lobby of St Francis Private Hospital. Weekly mass was held there and a prayer service was held on a daily basis led by the religious sisters from the Franciscan Missionaries of Our Lady congregation. Residents told an inspector they were able to practise their faith and worship according to their wishes. Inspectors were told by some residents that they attended the church for weekly mass as did people from the local community, enabling residents to maintain community links. There was a chapel of repose located at the back of the main church building also available for use by the centre. The person in charge told an inspector that other religious denominations visited the centre as required. All services were transmitted via a video link to the centre. This enabled residents and staff who wished to attend funeral services of deceased residents or local people in the community to do so. Residents unable to go to the church were observed joining in with the prayer service which they were able to access via the video link to their television sets. One resident told inspectors that this arrangement enabled her to feel 'as if she was in the church'.

Residents maintained social relationships. Social interaction with families was encouraged and relatives spoken with expressed a great deal of satisfaction with how they were always welcomed by staff and that the atmosphere was friendly. Links were maintained with the local community through visitors coming into the centre. Some residents left the centre routinely to go out with family. The television in the lobby of the centre was running a slide show of still scenes from a number of local areas of natural beauty and interest, for example, Belvedere House and Lough Ennell. Two residents attended the Springfield Day Centre twice-weekly where they met and had lunch with many others from

the local community. They also had access to physiotherapy, occupational and speech and language therapy there.

Visitors primarily met with residents in the communal sitting rooms but access to a private space was available for those who wished to see relatives' and friends privately. Inspectors observed a conveniently placed coffee shop in the lobby of St Francis private hospital and just outside the doors to St Clair's centre. Some residents joined their visitors for refreshments in the coffee shop. The person in charge told inspectors that other residents go there independently for morning coffee and to read newspapers.

A computer was available for residents' use. The provider and person in charge were in the process of setting up 'Skype' for one of the residents so he could contact his relatives abroad. The resident concerned confirmed his satisfaction to inspectors regarding this development.

Residents who wished had been provided with a safe in their wardrobe to allow them to secure personal items thereby ensuring their privacy.

Inspectors observed that some residents experienced confusion or had dementia related conditions. In the dining room, an inspector observed an episode of behaviour which challenged which was skilfully diffused by staff. Inspectors observed staff gently and respectfully reassuring and responding to residents. Inspectors noted staff were attentive and respectful in their interactions, addressing each resident by his/her preferred name. In discussion with inspectors, relatives were complimentary about how staff communicated with residents.

Some improvements required

Residents who wished had completed a postal ballot in the recent general election. Although residents spoken with were happy that they had an opportunity to exercise their voting rights, none of the residents were afforded the opportunity to vote in a polling station.

Residents did not have free access to the peace garden and during the inspection; most residents remained inside the centre. While some residents told inspectors that they did not want to go outside, others were observed trying the door to see if it was open. One resident said that she would have liked to go out into the garden to feed the birds but felt unable to.

Pre-inspection questionnaires referenced some dissatisfaction with how residents' personal clothing was managed. Residents' laundry was contracted out to a local launderette. Relatives and some residents stated that clothing went missing. Clothing viewed by inspectors was not adequately labelled. Soiled clothing was put in a plastic bag with a checklist of the clothing in it completed by residents, relatives or staff and removed off-site for laundering. The provider and person in charge told inspectors that they had recently reviewed the process and were confident that this situation was improving. However, a quality review had not taken place to date to ascertain whether improvement was achieved. Furthermore, residents did not have facilities to wash, dry and iron their own clothing if they so wished.

Significant improvements required

An inspector joined residents for lunch, which took place in a bright dining room annexed with the sitting room. However, the dining experience for residents was not of an adequate standard. Although residents were offered a choice of menu, food was plated and placed on trays in the main kitchen of St Francis private hospital. A kitchen assistant delivered the meals in a large heated transport unit and residents did not have choice about portion size or an opportunity to change their choice of meal without incurring a waiting time for an alternative dish. All residents were given milk to drink with their lunch. An alternative drink was not offered.

In preparation for lunch, residents were escorted to the dining room at various times up to 13:20 hrs. Some residents were observed waiting for their lunch for significant periods and inspectors heard one resident calling out for his food. Inspectors concluded that there was insufficient staff to meet the needs of all residents requiring assistance with eating in a timely manner. Notwithstanding, those residents that required assistance were offered it sensitively and discreetly. Staff in the dining room were observed encouraging residents to be as independent as possible while eating. The activity co-ordinator described how on occasion, she had supported a number of residents to become independent with eating when they previously needed full assistance.

The tea-time meal was served to residents from 16:00 hrs. Inspectors observed care staff buttering bread and serving the evening meal. However, care staff did not have basic food hygiene training.

Residents who could not independently get up in the morning or go to bed at night were not afforded adequate choice in this regard. Inspectors noted that many residents were waiting on staff for prolonged periods to assist them with getting out of bed. One resident said “they (staff) were up to their eyes” while another resident said she was “did not like having to wait all the time”. Other residents spoken to confirmed that this caused them ongoing dissatisfaction. On the first day of inspection lunch was delayed by fifteen minutes as staff were still assisting residents to get out of bed.

Inspectors observed that 19 residents were in bed by 19:00 hrs and one resident told inspectors that ‘the night was very long’ as a consequence. There was no evidence to confirm that this practise was at the request of residents or had been assessed as appropriate at most effectively meeting their care needs.

The activity co-ordinator had collected some information on residents’ backgrounds, previous occupations and interests. This information gave an informed picture of the residents’ life experiences and captured their likes and dislikes and their past and present interests. There was a semi-structured program of activities in place which was facilitated by the activity coordinator. The program included watching reminiscence DVDs and knitting on a weekly basis. There was also a weekly exercise class led by a physiotherapist. Music sessions, visits by therapy dogs and parties although less frequent supported the semi structured programme of activities. However, inspectors concluded that there was inadequate provision of meaningful activity and a lack of social interaction for all residents. This was especially significant for residents who were unable to leave their rooms or residents who did not have regular visitors. A member of care staff had recently been appointed as an activity-coordinator but a comprehensive training

programme had not been put in place to up-skill her in this area. As many residents had varying cognitive abilities, inspectors noted that she was unable to effectively fulfil her role as activities co-ordinator. This was further compounded by the additional responsibilities placed on her to supervise residents in the sitting room, co-ordinate the lunch time meal (including the distribution of trays to residents who had their meals in their rooms) and assisting residents when eating.

A policy was available to inform staff on managing elder abuse. It did not include details of the elder abuse officer or guide staff on how to respond to an incident or allegation of abuse**.** The Authority had been notified of eleven incidents of alleged abuse to date three of which occurred since the follow-up inspection on 16 June 2010. Notwithstanding, inspectors noted that actions taken in response to allegations of abuse were appropriate, well managed and reflected the centre's policy. Two incidents of alleged physical and financial abuse were still being investigated. Inspectors were told that all staff employed by the provider had been facilitated to attend elder abuse prevention training. However, a student on work experience confirmed to inspectors that they had not attended elder abuse prevention training. This student was not adequately supervised by the person in charge or the staff nurses. Inspectors observed the student filling and distributing water jugs. The student did not know that there were at least five residents on a modified-consistency diet due risk of choking and/or aspiration. The student gave these five residents a jug of unaltered consistency water placing these residents at risk.

While inspectors were told by the person in charge that all staff had been trained in moving and handling, the practices observed by inspectors were not in accordance with evidence based principles and the centre's policies and procedures.

A visitor name-tag system was in operation on entering the St Francis Private Hospital. This allowed monitoring of the movement of persons in and out of the building to ensure the safety and security of patients and residents. However, the reception desk was not staffed on a 24-hour basis. Persons were permitted to enter St Clairs Nursing Home without initial vetting by staff or residents. The door to St Clairs Nursing Home could be disengaged by pressing a switch and therefore did not deter entry to the centre by unauthorised persons which created risk to residents. Visitors names were not copied therefore the name-tag system used was not traceable.

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

Residents had access to drinks during the day. Jugs of water were placed in residents' rooms and on side tables in the day room where residents could help themselves. Care staff offered assistance to the more dependent residents.

There was provision of emergency equipment such as oxygen, portable suction and an automated external defibrillator. A large number of staff were trained in cardiopulmonary resuscitation technique.

Some improvements required

There was evidence of pre-assessment of residents prior to long term admission. The person in charge told inspectors that admission to the centre was based on needs, safety and if the centre had the scope of services to meet the needs of the new resident. However, residents admitted on respite were not routinely visited by the person in charge.

One resident in receipt of end of life care was in a single room for privacy and to have unlimited access to his family. There was a multidisciplinary focus on the provision of care to the resident, including input from the palliative care team. Inspectors were also told that the pastoral care team was involved in his care. However, arrangements were not documented in the end of life policy and procedure to inform staff of the steps to take to meet the needs of residents in twin or three-bedded rooms. Inspectors also noted that evidence-based pain assessment tools had not been used in managing the resident's pain.

While there was a comprehensive medication management policy in place, it did not cover all aspects of medication practice, for example crushing of medications, managing warfarin administration.and administration of medications via percutaneous endoscopic gastrostomy (PEG) tubes. Medications were crushed in the absence of obtaining consent from residents and or their representative. Medication prescriptions were not regularly reviewed for all residents. There was no maximum dose documented for as required (PRN) medications.

While residents had some care plans in place, they were not kept under formal review and therefore did not reference all residents' changing needs. Residents were not involved in developing their care plans or in reviewing them. Residents spoken to by inspectors were not aware of the contents of their care plans.

Significant improvements required

Contemporary evidence-based practice was not in place to manage residents with constipation. Although fruit was available to residents, inspectors noted that 27 out of 41 residents were prescribed laxatives.

Discussion with staff and a review of the nursing documentation, confirmed that there were a number of residents in the centre with wounds. In particular the documentation referenced a resident with pressure related wounds to the skin over the mid-spine and sacral area. Inspectors were also made aware of other residents (where the skin was not broken) who had pressure-related redness and inflammation that had been treated with an application of creams. However, there was no adequate programme in place which reflected contemporary evidence-based wound care management. Not all residents had wound management charts. There was no wound management policy available to inform practice. Pressure area care management was not of an adequate standard. Inspectors noted that a resident assessed as needing two-hourly change of position had their position changed four-hourly. All residents assessed as being at risk did not have plans of care.

Restraint management was not of an adequate standard. Although restraints in use were consented for by some residents and relatives, assessment of need or most appropriate level of restraint was not documented. Risk assessments were not completed. There were 24 residents (64%) with bedrails in place and 11 (approximately33%) who had lap belts fitted. There were inadequate records of restraint use, monitoring and release schedules.

Residents had access to physiotherapy and speech and language therapy. However, discussion with staff and review of documentation including care records confirmed that residents did not always have access to all appropriate healthcare to promote their health and wellbeing. Inspectors noted that 17 residents (44%) had special dietary needs and many had been assessed using the centre's nutritional needs assessment tool as requiring referral to a dietician. In particular, one resident was receiving nutritional via a percutaneous endoscopic gastrostomy (PEG) tube and another had lost six kilograms (kg) since May 2010 and at the time of inspection weighed 42.6kg. However, there was no evidence that these and the other 15 residents assessed as requiring referral to a dietician had been appropriately reviewed. Therefore residents received a modified consistency diet for long periods without assessment. The resident who had lost significant weight did have a medical review but there was a lack of continued review and re- assessment to determine possible causes of the on going weight loss. There was no documentary evidence of tests or procedures to rule out possible causes or referrals for specialised assessment. Furthermore, there was no documentary evidence that a resident with palliative care needs had been referred to the palliative care team.

While residents had good access to the medical team in St Francis' private hospital, they had not been regularly reviewed by their own general practitioner (GP).This resulted in the medical officer attending the resident when there was an acute problem such as a fall or respiratory infection but there was no written communication done between the medical officer from the hospital and the GP. This resulted in fragmented communication and lack of continuity in residents care. Staff were more likely to contact the medical officer and not the GP as they had difficulty in accessing GP's to review residents during surgery hours. The medical officer was also the county Coroner.

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

Handrails were on both sides of corridors to assist residents when walking independently and to promote their mobility and independence.

The enclosed courtyard had paved footpaths and some seating provided for residents' use. There was a synthetic textured green area along both sides of the courtyard making it more accessible in wet weather.

Adequate precautions were in place and regular testing was carried out to detect legionella infection in the water systems. Water temperatures at point of contact were controlled and monitored and did not pose a scald risk to residents. An inspector noted that it recorded a temperature of 43 degrees centigrade.

There was adequate equipment available to meet needs of residents. Adequate systems were in place to service and maintain assistive equipment. External contractors serviced the hoists and beds and service records were up to date. There was a maintenance log and the maintenance department located in St Francis private hospital provided maintenance support for the centre.

There were large screen televisions available in each of the sitting areas.

Some improvements required

A comfortable visitor's room was located at the front door of the centre, which residents used as a sitting area. However, an area to the back of this room was used to store chairs, which created a disturbance for residents when meeting with relatives or friends in private.

While radiator guards were on most radiators to protect residents from the risk of scald injury, environmental temperatures had not been monitored. The environmental temperatures recorded in the dining room, the visitors' room, lobby area and one of the bedrooms were higher than the temperatures recommended for communal areas in the National Quality Standards for Residential Care Settings for Older People in Ireland.

Significant improvements required

Residents did not have the recommended minimal communal space available to them as referenced in the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Residents had choice of where to sit as there were three sitting areas available. One of the sitting rooms annexed the dining room. While the sitting and dining room together created an additional space for residents, this area was busy and was not conducive to rest and relaxation.

There was an absence of reserved parking close to the centre for visitors to St Clair's nursing home. Parking for disabled drivers was not established.

Inspectors left the centre after dark. The external lighting was of a poor quality and therefore presented risks for pedestrians. External directional signage was also not adequate.

A spacious seating area with a large flat screen television was provided in the entrance lobby of the centre. However this area was busy and residents were noted by inspectors to be constantly disturbed by noise from traffic in this area. This lobby area also served as the only access route to the centre and facilitated access to the medical gases room at scheduled intervals throughout the day. Inspectors observed that the door of this room was left open while cylinders were changed by maintenance persons. This practice did not restrict access by unauthorised persons and made the fire retardant function of the door redundant.

Inspectors were told that the household supervisor for St Francis private Hospital and St Clairs Nursing Home regularly carried out audits to ensure that cleaning was of an adequate standard. However, inspectors concluded that residents were placed at risk of infection due to inadequate cleaning standards in the centre. A lack of attention to detailed cleaning of equipment was evident. The surfaces of some bed tables were worn and frames were worn and rusted. The areas surrounding the wheels on commodes were also rusted. These damaged surfaces did not allow for cleaning to be done to an adequate standard. Surfaces surrounding sinks were porous and were also not of a standard that could be fully cleaned. Commodes were soiled with faeces and bedpans fitted in commodes ready for use were discoloured and damaged. There were no waste disposal outlets to empty contents of bedpans into. Stainless steel surfaces including a sink in the sluice room were visibly soiled. Cleaning schedules were not in place.

There was inadequate storage for cleaning equipment. While there were some storage cupboards for cleaning equipment, there was no cleaners' room in the centre. Cleaning staff told inspectors they used a cleaner's room in St Francis Private Hospital. A flat-mop system was in use for cleaning floors but inspectors noted that floor surfaces were dull and sticky under foot. A student gaining work experience was observed to be involved in surface cleaning. This student was not been supervised and confirmed that he had not attended training on cleaning procedures in the centre.

Although residents had access to televisions in their rooms, these were of an inadequate standard. Residents confirmed to inspectors that these televisions were difficult to view, as they were located in the top shelf of a built in wardrobe. Some residents had inadequate

and unsuitable wardrobe space for their clothes. Some residents commented on this to inspectors. The layout of rooms created difficulty for some residents who stated they had inadequate room to meet their needs Although the room size met the minimum floor space requirements residents told inspectors they did not have enough space and felt that more space would be improve their comfort.

There were an inadequate number of bathroom/shower facilities available to meet the needs of the number of residents the provider wished to be registered for. There was one three bedded bedroom with en suite showering facilities. However, there was an insufficient number of bathing/showering facilities to meet the individual needs of the remaining residents. One assisted bathroom, one independent bathroom and an assisted shower was provided to meet the bathing needs of 42 residents. This was not in accordance with the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

There was inadequate storage facilities provided for the storage of equipment, hoists, and walking frames which were stored in bathrooms and other communal areas throughout the centre. The linen collection unit was also permanently stored in an assisted bathroom. While the inspector was told that an additional area accessible from the visitors' room was available for residents use, it was used as a storage area for residents' assistive chairs and wheelchairs. The nursing office was only accessible by passing through a storeroom for continence wear. A curtain was drawn to obscure the view of this storage area.

Environmental temperatures were of a comfortable level and those measured by inspectors in the dining room and the visitor's room were within recommended levels. However, there was no temperature monitoring gauges to monitor environmental temperature levels located throughout the centre. While most windows were closed on the day of inspection, residents confirmed that they could not independently open the windows in their rooms. Inspectors noted that most of the existing windows had top openings which required a hook to open. The provider told inspectors that he was planning to install new windows in the centre.

Minor issues to be addressed

There was a key coded lock still affixed to a toilet door designated as a residents' toilet.

Some residents' beds were in a worn state although inspectors were told that of a replacement programme and some beds had been replaced with electric beds, which residents confirmed enhanced their comfort.

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

Inspectors were told by residents that the person in charge was available and they found her approachable and interested in what they had to say. Relatives also told inspectors that they were informed by staff about the wellbeing of their family members, and were notified immediately of any change in their health status. Relatives confirmed they could approach staff with questions or concerns.

Residents had the option of a phone in their room. Some residents retained their previous landline phone number and could be called directly by their families. Residents who had not availed of this option were able to use a cordless phone which enabled them to take calls in the privacy of their own bedrooms. Some residents had their own mobile phones.

Residents had access to newspapers and magazines, for which the provider paid an annual subscription.

Some improvements required

While resident's meetings were in place, there was little evidence that they were given the opportunity to become involved in making decisions which affected their lives within the centre. While inspectors acknowledged that changes to the catering contract had been made in response to residents' comments, there was no evidence that resident's views had informed other changes in the operation of the centre. For example, residents had not been involved in the refurbishment of the enclosed garden.

All policies required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were in place. Policies had been developed with the help of an external consultant. However a review of some of the policies and procedures by inspectors confirmed the need for further development to reference practices in the centre. The person in charge stated that she planned to introduce polices and procedures in stages and would provide training for staff to ensure their understanding of all policies and procedures. It was noted in the minutes of the nursing and care staff meetings that polices and procedures had been discussed. However

in discussion with inspectors, some staff were unaware of the contents or existence of specific policies.

There was a written operational policy and procedure on communication. The policy entailed 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 and interacting with residents with behaviour that challenged. Inspectors observed satisfactory interactions and communication taking place between some residents and staff. However residents with cognitive impairment and/or dementia did not have aides in place to assist them with communicating, for example, talking mats and environmental cues. Furthermore, the activity co-ordinator had not been facilitated to attend Sonas or other specific training.

Significant improvements required

There was a residents' guide available, which was reviewed by inspectors. It contained valuable information to assist prospective residents to make a decision regarding choosing a placement. The guide did not contain all the information required by the regulations and had not been made available to each resident.

All incoming calls for St Chairs Nursing Home are answered by an automated call answering service that invites the caller to select from a menu, which references various locations in St Francis hospital with St Clairs Nursing Home as the last option in the menu. Some residents and relatives complained that they could not access their relatives or the centre easily at night. Incoming call were diverted to a ward who transferred calls as requested. However, relatives reported being cut off or in some cases delayed for significant periods.

Minor issues to be addressed

There was an activity schedule displayed but in small font on the notice board.

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

Staff were approachable and able to describe their varied roles and duties and how they contributed to residents' welfare. Staff said that there was a good team spirit and they were well supported by the person in charge who was described as having an approachable management style. This team spirit and concern for each other was observed by the inspection team.

The duty roster detailed each staff member's position and full name. A registered nurse was on duty at all times. There was a system in place to provide senior nurse management cover in the absence of the person in charge. Seven care assistants had completed a module on palliative care.

Inspectors were satisfied that the person in charge and nursing staff were clear about their purpose and responsibilities. Nurses were clear about their supervisory responsibilities for care staff and inspectors observed continuous communication between care staff and nurses. There was usually another registered nurse on duty with the person in charge which provided her sufficient time for management and governance tasks and to support the staff team.

There was a record maintained of An Bord Altranais professional identification numbers (PINs) for registered nurses.

Inspectors were told that agency staff were not used and when shortfalls occurred, existing staff, particularly those who worked part-time, were able to do extra shifts. This arrangement was observed in the staff duty rota.

A review of staff training records confirmed that staff had access to training. The person in charge confirmed that all staff training was up to date on fire safety, evacuation and moving and handling. Some staff had received dementia care training and training on the management of behaviour that challenges in 2010. Two staff had attended training on medication management.

Some improvements required

There was a detailed staff recruitment policy. This outlined the principles of good recruitment practice and the steps taken by the providers when staff were being recruited for the service. Notwithstanding, while there had been a lot of work completed to ensure that staff files complied with the relevant legislation, there was no evidence available of mental and physical fitness declarations for staff.
Currently the centre has fifteen care assistants, of which two have FETAC level five training or equivalent in the care of older people. Of the remaining thirteen care assistants ten have completed a module on caring for an older person.

While there was an induction plan for new staff members, a formal induction process or preceptorship arrangement had not been implemented for the person in charge following her appointment. The provider acknowledged this deficit and agreed to put adequate arrangements in place.

Significant improvements required

There was insufficient staff and skill mix to meet the assessed needs of residents.
There had been a review of staffing following an inspection on June 16 2011. In response to that review, an additional care attendant was rostered from 17:00 hrs – 23:00 hrs daily and an attendant commenced in the role of activities co-ordinator from 11:00 hrs – 17:00 hrs Monday to Friday. Notwithstanding, from observation of care practises and discussion with residents, relatives and staff, inspectors concluded that there was still insufficient staff and skill mix to meet the assessed needs of the residents. This impacted on the service delivery namely residents did not receive appropriate assistance at mealtimes, had limited access to showers and were delayed in getting out of bed. Cleaning and disinfection practices were also poor with faeces observed on two commodes in current use.

One nurse and one carer were on duty from 23:00 hrs – 08:00 hrs. The dependencies of the residents included 25 high to maximum, 11 medium and five low. One resident had a PEG tube insitu and six residents had cognitive impairment and/or dementia. In addition, a member of staff rostered to work in St Clair's nursing home was required to work on a ward in St Francis Hospital for part of the day. Many staff has contracts to work in a 'bank' capacity within St Francis' Hospital. Inspectors noted that staff from St Clair's nursing home were redeployed to cover unplanned leave in St Francis Private Hospital. Their vacant position in St Clair's nursing home was then filled by staff who were off-duty. From discussion with staff, relatives and relatives, inspectors concluded that this arrangement was unsatisfactory and resulted in delays to the care provided to residents and adversely impacted on the care and welfare of residents within the centre.

Minor issues to be addressed

St Clair's staff training records had not been maintained separately from St Francis Private Hospital. This practice makes monitoring of mandatory training difficult.

While the person in charge had commenced an appraisal system with staff, there had been no assessment of staff skills and competencies or an evaluation of the needs of residents to inform training and development needs of staff.

Closing the visit

At the close of the inspection visit, a feedback meeting was held with the provider, person in charge and risk manager 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:

Catherine Connolly-Gargan
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

23 February 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
03 and 04 February 2010	☒ Registration ☐ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
26 April 2010	☐ Registration ☐ Scheduled ☐ Follow up inspection ☒ Monitoring Visit ☐ Announced ☒ Unannounced
12 May 2010	☐ Registration ☐ Scheduled ☐ Follow up inspection ☒ Meeting with Provider ☒ Announced ☐ Unannounced

16 June 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:	St Clair's Nursing Home
Centre ID:	0099
Date of inspection:	23 and 24 February 2011
Date of response:	11 April 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 has failed to comply with a regulatory requirement in the following respect:

The governance of the centre was not adequately completed in all respects by the person in charge.

Action required:

Put procedures in place where the person in charge is adequately supervised in her role to competently carry out the governance of the centre as required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended)

Reference:

Health Act, 2007
Regulation 15: Person in Charge
Regulation18:Recruitment
Standard 27: Operational Management

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

Please state the actions you have taken or are planning to take with timescales:	Timescale
Provider's response: 1. The person In charge and proprietor now meet on a daily basis for a daily operations meeting. Actions are formulated from this meeting and minutes are recorded. This meeting covers all aspects of governance, health and Safety, maintenance, complaints, incident/accidents, risks, training and development, HR, audit results, weekly monitoring report and action follow ups and look forward. 2. The person in charge is now 'mentored' by the proprietor in all aspects of governance, innovation, compliance and general management, including financial management, procurement and information. 3. Quarterly reviews of person in charge's performance now in place.	Commenced Friday 25 March in this format

2. The provider has failed to comply with a regulatory requirement in the following respect: The Health and Safety policy and procedures were not centre-specific.	
Action required: Develop a Health and Safety policy for the centre which is implemented and reflects the practices and procedures of all staff working in the centre.	
Action required: Provide staff with training on policies and procedures relating to health and safety commensurate with their role and function.	
Reference: Health Act, 2007 Regulation 30: Health and Safety Regulation 17: Training and Staff Development Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. The health and safety policy and safety statement for St Clair's is being updated and implemented. 2. The new policy is being communicated to all staff, who will read and sign off their understanding of the policy.	01 May 2011 01 May 2011

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

The complaint policy does not contain all the procedures outlined in the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009.

Action required:

Redraft the complaints policy to ensure all aspects of the complaints procedure are implemented and operational in the centre.

Action required:

The revised policy must be displayed in the centre.

Action required:

Ensure residents are fully informed of the complaints procedure.

Reference:

Health Act, 2007
Regulation 21: Provision of Information to Residents
Regulation 39: Complaints Procedures
Standard 1: Information

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
1. The new complaint policy is being reviewed and re-drafted to be completely centre specific.	Completed April 2011
2. A new compliments, comments and complaints booklet for residents is being published.	01 May 2011
3. A new residents' satisfaction comment card and monthly audit are being implemented.	01 May 2011
4. The new complaints policy and complaints statement will be on display in the Centre.	01 May 2011
5. The complaints log is reviewed daily at the operations meeting, and reviewed as part of the monthly Audit.	01 May 2011
6. All staff will be made aware of the new policy and procedure.	01 May 2011

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

There was no evidence of a formal review of the quality and safety of care provided to residents or use of information collated through record keeping to manage high risk areas.

The quality of residents' life in the centre did not enable independence or promote a person-centred approach.

Action required:

Establish and maintain a system for reviewing the quality and safety of care and the quality of life of residents at regular intervals.

Action required:

Utilise data collated to manage clinical risk and improved resident care outcomes.

Action required:

Draft a report in respect of these reviews and improvements and provide a copy of these reports within three months of receipt of this inspection report.

Action required:

Complete an evaluation and plan to address issues of communication, person-centred care, enablement, inclusion and involvement of residents and relatives or advocates in daily decision making and participation in their care and the organisation and delivery of services provided.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 17: Autonomy and Independence
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: 1. The person in charge will conduct a monthly assessment and review of all residents. This will involve the person in charge collating information from nurses/care-assistants and all relevant documentation in relation to the resident. The person in charge will also meet with each resident on an individual basis in privacy each month to ensure the quality of care is implemented and insure residents are involved in the decision making and participation in	April 2011

their care. This will ensure a quality assurance and continuance improvement in the quality of service St. Clair's provides. To Evaluate: Risk, health and safety, quality of Life, restraint, care plan, challenging behaviour, dementia, medication, end of life, nutrition, weight monitoring, slips trips and falls, infection control, pain management, wound care, pressure sore and catheter care in relation to all residents. This will be presented on a monthly template format. In the event the resident is unable to participate in this process a relative will be invited and encouraged to become the residents advocate to be evolved in planning their care. This will be reflected in their care plans also.	
2. The above data will be used to inform weekly risk assessments and monthly residents meetings.	01 May 2011
3. A daily communication meeting (Hand-Over) with person in charge/nurses/care-assistants where resident's individual choices, decisions and needs are voiced and shared will be in place from 01 May 2011.	01 May 2011
4. A full report will be provided to the Authority within 3 months of the date of this report.	July 2011

5. The provider has failed to comply with a regulatory requirement in the following respect: The provider failed to put a comprehensive medication management policy in place to inform all staff in the centre on all aspects of contemporary evidence based medication management procedures in the centre.
Action required: Develop and implement a comprehensive medication management policy.
Action required: Reference all aspects of anticoagulant therapy.
Action required: Reference the procedure of crushing medications to inform staff.
Action required: Revise prescribing procedures for 'as required' (PRN) medication to include maximum dose in 24 hours.

Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and administration of Medications Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. Person in charge will review and further develop the current medication policy referencing all aspects of anticoagulant therapy. In addition standard operation procedures will be developed to further safe guard and ensure good practise. A detailed SOP on crushing medications is being drafted and staff will be up-dated on same. 2. Working in close relations with Whelehan's Pharmacy new prescribing procedures including maximum dose in 24hrs currently in place. 3. Person in charge meets the pharmacist weekly/monthly to review and discuss medications with GP involvement. 4. Pharmacy training/education provided and monthly review/Audit of use of PRN medications.	08 May 2011 Completed Completed Ongoing

6. The provider has failed to comply with a regulatory requirement in the following respect: The provider failed to provide a separate cleaning room appropriate to the size of the centre.	
Action required: Provide a cleaning room appropriate to the size of the centre for use by cleaning staff in the centre to store equipment, to prepare and to dispose of cleaning solutions.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment.	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A separate cleaning room will be provided.	08 May 2011

7. The provider has failed to comply with a regulatory requirement in the following respect: The statement of purpose did not contain all the required information such as the professional registration and qualifications of the provider and the name of the current person in charge.	
Action required: Outline a statement of purpose that includes <u>all</u> the information required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The proprietor will issue a new Statement of Purpose, including Purpose and Function.	01 May 2011

8. The provider has failed to comply with a regulatory requirement in the following respect: Fire safety in the centre was not of an adequate standard.	
Action required: Put procedures in place where all staff are aware of their responsibilities in the event of a fire alarm sounding and attend fire drills twice yearly.	
Action required: Ensure the door to the smoking room is kept closed at all times.	
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: 1. Fire drills are planned for twice a year June and December 2011. 2. Snap fire drills and rehearsals will be carried out monthly. 3. Fire training date planned for September 2011. 4. Notice on smoking room door to be closed at all times currently in place/ventilation fan turned on daily and all staff and residents focussed to implement this. 5. Residents have daily access to Peace Garden, garden furniture currently in place giving the residents the choice to smoke out-doors also.	 June 2011 01 May 2011 September 2011 Completed Completed

10. The person in charge has failed to comply with a regulatory requirement in the following respect: Did not have adequate procedures in place to account for temporary absence and discharge of residents.	
Action required: Revise the policy for temporary absence and discharge of residents to take account of medication administration arrangements, dressings and arrangements for specific care such as pressure area care.	
Reference: Health Act, 2007 Regulation 29: Temporary Absence and Discharge of Residents Standard 10: Assessment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. The policy is being revised currently, to be re-published, communicated with staff and patients.	 10 May 2011

11. 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 themselves verbally.

Residents and relatives had difficulty accessing the centre by telephone outside of office hours.

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:

Provide staff with training in dementia care and managing challenging behaviour.

Action required:

Facilitate staff including the activities co-ordinator to attend Sonas training.

Action required:

Provide communication aids to enable residents to express their wishes.

Action required:

Put a suitable system in place to enable residents and relatives to contact the centre more easily.

Reference:

Health Act, 2007
Regulation 11: Communication
Standard 2: Consultation and Participation
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:	
1. The Proprietor has procured an eye gaze system for resident with difficulties with verbal communication.	02 April 2011
2. New picture cards have been introduced.	02 April 2011
3. A new range of communication/notice/activity/orientation/menu boards with magnetic icons purchased and installed. This will ensure	02 April 2011

each resident has access to information in accessible format appropriate to their individual needs. 4. New relative/resident notice board at St. Clair's new entrance/front door. 5. Direct phone line (X2) in operation in St. Clair's all relatives/residents aware of same. Intranet and new website currently up and running www.stclairsnh.com e-mail: info@stclairsnh.com 6. All staff have attended training in dementia/challenging Behaviour in 2010/2011 7. Activities Co-ordinator has attended SONAS APC workshop Friday 25 March & Friday 6 May, will also attend a third training day in December to receive FETAC module qualification. 8. St. Clair's has purchased a SONAS kit and SIMS Kit to facilitate the activity co-ordinator. 9. Weekly resident's newsletter on website and paper format commences 15 April, including encouragement of residents' input.	 12 April 2011 08 April 2011 Completed Ongoing Completed 15 April 2011

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

There were deficits in the care planning process for residents in the centre:

- the care plans in place did not consistently reflect the resident's current health status
- there was no evidence of resident involvement in developing his/her care plan or in a review of their care plan.

Action required:

Put systems in place to ensure that residents' needs are set out in an individual care plan developed and agreed with each resident.

Action required:

Keep the resident's care plan under formal review in response to the residents changing needs.

Action required:

Provide a programme of education on care planning to provide staff with the skills and knowledge to complete holistic person-centred care plans for residents.

Action required: Review input of the carers in evaluating residents care and explore ways in which they can make a contribution in this process.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales: Provider's response:	**Timescale:**
Provider's response: 1. All staff nurses have attended care plan training, the person in charge is inviting residents/relatives to meet to up-date, implement and evaluate care plans to be specific to the individuals needs on a monthly basis. 2. Person in charge will conduct a monthly review and audit of care plans, supported by other Nurses, and inviting input from care assistants, GPs and dieticians.	02 May 2011 Commencing April 2011

13. The provider has failed to comply with a regulatory requirement in the following respect: Personnel files did not contain documents detailed in schedule 2 of the Health Act 2007 (Care and welfare of Residents in Designated Centres for Older people) Regulations 2009 (as amended). All required documentation to be held in respect of persons working in the centre was not in place.	
Action required: Ensure all staff employed in the centre have the documents outlined in schedule 2 of the Health Act 2007 (Care and welfare of residents in Designated centres for Older people) Regulations 2009 (as amended).	
Reference: Health Act, 2007 Regulation 24:Staffing Records Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: 1. All documentation to be reviewed and completed to be in compliance re Schedule 2 of the Health Act 2007.	02 May 2011

14. The provider has failed to comply with a regulatory requirement in the following respect: The contract of care provided to residents did not meet the legislative requirements as it did not contain details of fees to be charged to residents.	
Action required: Revise the contracts to reflect all the terms and conditions including 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: 1. New contracts are being created to reflect all legislative requirements.	29 April 2011

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

Staff did not respect residents' rights, dignity and consultation needs by affording all residents choice about when they got up in the morning or went to bed.

Action required:

Put procedures in place where all residents are afforded choice about when they got up in the morning and go to bed at night.

Action required:

Review the suitability of use of the room to the back of the visitor's room as a storeroom with regard to the impact on the privacy of residents meeting their visitors there.

Action required:

Review the impact of the traffic entering and exiting the centre and accessing the oxygen supply room on the privacy of residents sitting in the lobby area.

Reference:

Health Act, 2007
Regulation 10: Residents Rights, Dignity and Consultation
Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
1. The person in charge will discuss all aspects of autonomy, rights, dignity and consent with all residents when meeting on a monthly basis and ensure all residents' wishes are courted and effected on a daily basis.	29 April 2011
2. Care plans will reflect resident's preference and staff will consult with residents on a daily basis ensuring freedom of choice.	Completed
3. Room to the back of visitors' room has been developed as a computer room. This was never a storeroom.	April 2011
4. Plans are in progress to re-locate oxygen room – plans to re-locate person in charges office will increase storage space and residents use in the coming months.	June 2011.
5. The front door is being redeveloped to the other side of the building, making it entirely single use, reducing traffic at the current lobby entrance. The current front door area will be extended by approximately 25m2 in order to create a rear service area.	May 2011

16. The person in charge has failed to comply with a regulatory requirement in the following respect: Did not ensure that appropriate assistance was given to residents who required assistance with eating and drinking.	
Action required: Promote residents dignity and independence by ensuring that appropriate assistance was given to residents who required assistance with eating and drinking.	
Action required: Ensure residents have control over portion sizes and have freedom to change their choice of dish if they wish.	
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. Facilities management support system in place. 2. New patient service operator catering specific to St. Clair's will deal with all aspects to food & nutrition meals and meal-times (see job description), therefore enabling Care Assistants to focus solely on the patients, especially at key times. 3. St. Clair's now has a dedicated Chef who can react to any requirements indicated by residents. 4. Daily menus are completed.	 Completed Completed Completed Completed

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

- sluicing facilities were inadequate as there was no sluice sink for emptying contents of bedpans before disinfection
- did not provide adequate bathing facilities to meet the needs of all residents in the centre
- Access to ventilation to the external air was not adequate in the communal areas and in bedrooms for most residents in the centre.
- there is a lack of suitable and safe storage space for storing chemicals, oxygen and household cleaning equipment - there was also a lack of suitable storage space for assistive devices e.g. hoists commodes and assistive equipment belonging to residents
- all residents did not have sufficient storage space for their clothes
- hand rails were not adequate and posed a risk to residents
- Inadequate disabled parking, directional signage and poor lighting increased risk of injury for residents and visitors.
- there were no temperature monitoring gauges to monitor environmental temperature levels located throughout the centre.

Action required:

Develop and implement adequate sluicing facilities.

Action required

Provide a sufficient number of accessible bathrooms/showers having regard for the number of dependent persons and wheelchair users in the centre and in line with the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

Action required

Evaluate the ventilation to the external air and put a programme in place to address deficits.

Action required

Ensure residents can access fresh air if they wish.

Action required

Put systems in place to ensure that recommended environmental temperatures are maintained throughout all areas used by residents.

Action required

Provide appropriate, safe and accessible storage facilities for all equipment.

Action required Ensure all parts of the external areas used by residents and their relatives are assessed as safe and risk free.
Action required Evaluate the suitability of residents televisions located on the top shelves of rooms.
Action required Provide a suitable cleaner's room for the centre that can also adequately store cleaning equipment.
Action required Put procedures in place to ensure that all parts of the centre are kept clean.
Action required Put procedures in place to ensure that all equipment including equipment used by residents in the centre is kept clean and in good order.

Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. A new sluice is being procured. 2. 2 x new showers are being installed. 3. New windows are currently being installed in all St Clair areas. 4. Full open access to the Peace Garden is currently in operation. 5. A new storage room is being installed for St Clair's (Household & equipment) 6. New lockers/wardrobes for residents' clothing space are being procured.	 24 May 2011 01 June 2011 02 – 29 April 2011 02 April 2011 09 May 2011 April/May 2011

7. New front-door, reception area, car-park with disabled parking specific to St. Clair's with adequate lighting works in progress. 8. Temperature reading dials will be purchased and installed. 9. A new risk assessment for use of external garden is being carried out. 10. New television sets are being procured, and re-positioned to better suit Residents' positioning when seated, or in bed.	Ongoing, completed 31 May 2011 20 May 2011 02 May 2011 14 May 2011

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

- There was no evidence of comprehensive assessment prior to respite admission to determine each residents needs and whether the centre was able to meet their needs
- the admission policy in place was inadequate.

Action required:

Assess residents' health, personal and social care needs prior to respite admission. In the case of an emergency respite admission, carry out the assessment as soon as possible and within 72 hours of admission.

Action required:

Revise and implement the admission policy to reflect respite admission procedures.

Reference:

Health Act 2007
Regulation 8: Assessment and Care Plan
Standard 10: Assessment
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. The full Admissions Policy is being re-drafted reflecting the fact that the Person in charge/Deputy Nurse carry out Pre-Assessments prior to admission of all residents according to a defined set of criteria. 2. The admissions policy will inculcate respite admissions procedures.	 10 May 2011 10 May 2011

20. The provider has failed to comply with a regulatory requirement in the following respect: The programme of activities was not adequate and did not meet the individual fulfilment needs of all the residents for in the centre.	
Action required: The activities program in the centre requires development to ensure activities are specific to individual resident's needs and that each resident including those with physical, cognitive or sensory disability are afforded opportunities for participation in purposeful and meaningful activity.	
Action required: Programmes of suitable and meaningful activities are to be developed in consultation with the residents.	
Reference: Health Act 2007 Regulation 6: General Welfare and Protection 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: 1. The person in charge and activities coordinator are preparing a strategic and personal activities plan including a structured plan / time-table taking into account the resident's choice, preferences and capabilities. 2. St Clairs have purchased new communications boards and displays for demonstration at the new entrance to the facility. 3. Activities preferences will be solicited during monthly patient reviews, patient meetings, and daily communications briefings. 4. Activities will be promulgated on the new St Clairs Residents weekly newsletter.	01 May 2011 02 April 2011 08 April 2011 15 April 2011

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

The provider is failing to provide a residents' guide that meets the legislative requirements and that it is available to residents.

Action required:

Produce a written guide "the residents' guide" that contains all the information required by the legislation.

Action required:

Provide each resident with a copy of the revised document.

Reference:

Health act 2007
Regulation 21: Provision of Information to Residents
Standard 25: Information

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. The new Residents' Guide will be in place on 15 April 2011 2. The Guide will be issued to each resident, copied to their family/relative on 15 April 2011.	15 April 2011

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

The range of policies, procedures and guidelines available in the centre had not been updated to reflect the provisions of Schedule 5 of the Health Act (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2009.

Action required:

Revise and implement polices and procedures to comply with current legislation, regulations and standards.

Reference:

Health Act 2007
Regulation 22: Maintenance of Records
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: 1. The person in charge is reviewing and revise all current policies for St. Clair's to meet the requirements of Schedule 5.	29 April 2011

23. The provider has failed to comply with a regulatory requirement in the following respect: The provider failed to put a process in place where recorded incidents, accidents and near misses were analysed to be used for learning and as a proactive risk management tool.	
Action required: Commence a process where analysis is done of all accidents, incidents and near misses in the centre identifying trends and areas where improvement can be made.	
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: 1. A new process is now in place where the person in charge discusses all accidents/incidents/near misses at the daily operations meeting each morning. 2. Risk management tools (risk assessment template) will be utilised to identify current potential risks. Person in charge will audit all of the above	29 April 2011

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

The person in charge failed to care appropriately for residents' clothing and to provide adequate facilities for storage, maintenance and use of residents' own clothing at all times.

Action required:

Put in place a comprehensive system for the labelling, laundering, ironing and management of residents clothing ensuring that clothing is returned to residents and that they always have a clean supply of their own clothing.

Reference:

Health Act 2007
Regulation 13: Clothing
Standard 26: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. A space has been allocated for laundry within the facility, to be self-delivered by Residents. This includes washing machine, dryer, and ironing facilities. 2. External laundry supplier is in place for use by Residents. 3. All residents/relatives are encouraged to label clothing. All individual laundry is documented on a laundry sheet and accompanies the laundry to laundrette in individual bags and returned in this format.	04 May 2011 In place In place

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

The numbers of staff on duty may not be appropriate to meet the care welfare and safety needs of residents at all times as residents had to wait for long periods for assistance with care and eating.

Cleaning of the centre and disinfection practices of the centre equipment used by residents was inadequate.

Action required:

Using appropriate evidence based tools, review the staffing levels on day and night duty, taking into account the size and layout of the centre, the number of residents, their dependencies, their assessed needs and ensure that residents can be safely evacuated in case of fire.

Action required: Provide the inspection team with a proposal which demonstrates that staffing levels are adequate at all times to meet the needs of residents in the centre.	
Reference: Health Act 2007 Regulation 6: General Welfare and Protection Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have analysed and modelled the entirety of this issue – not solely nurse staffing levels – and taken the following actions: 1. Staffing is rostered according to the case mix of patient, and is delivered according to the appropriate level of ration required by registered nurse, and by care assistant. We have deployed an appropriate level of modelling that is reviewed on a weekly basis to take account of variances in dependency, and activities. 2. Support Staffing has been altered with an entirely tailor-made Patient Service operation that has assumed all the tasks re delivery and operation of feeding times, in order that Care Assistants are focussed purely on patients and have nil other tasks to achieve; particularly during busy times. This has been particularly successful in maximising care time towards patients. The Patients Service Operator designated to St. Clair's already in operation for assistance with care and eating. 3. Staffing is currently delivered according to higher levels than is normal for this type of facility. However we have taken the following measures in order to improve ratio support to patients: a) Dependency levels have been re-assessed, and where inappropriate for this facility, we have assisted relatives and patients to source an acute dementia unit. b) Dependency levels are being consistently re-assessed monthly, as part of the new Monthly Patient Review. c) We have ensured that there are more than the usual levels of professional nursing support to patients (now at 1: 5.33 patients), and Care Assistant Support (now at 1: 3.44 patients). d) As described above, dedicated support staffing from Household and Patient Services are now intrinsically	01 April 2011 30 March 2011 01 April 2011 01 April 2011 01 April 2011

focussed on supporting St Clair's holistically in a manner that is patient-focussed. Planned and actual staff rota available, Bank staff are used for unforeseen contingencies and high levels of sick leave. All residents are currently assessed on a dependency system where they achieve a score on low, medium, high or max on dependency. Following the introduction of the new nursing care plan will also be assessed using the Barthel index.	

26. The provider and person in charge have failed to comply with a regulatory requirement in the following respect: The end of life policy was not centre specific as it did not adequately inform end of life care of residents in two and three-bedded accommodation. Arrangements for palliative care review of residents were not completed in all cases.	
Action required: Commence using evidence based pain assessment tools to inform care of residents who have pain.	
Action required: Put procedures in place where residents with terminal illnesses will be referred for palliative care input.	
Action required: Revise the centre's end of life policy to reflect care of residents in multioccupancy rooms.	
Reference: Health Act, 2007 Regulation 14: End of Life Regulation 6: General Welfare and Protection Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The person in charge will complete and implement the new end of life policy.	04 May 2011

Where possible all residents at end of life are accommodated in a single room. Pain assessment tool will be introduced by person in charge. All residents with terminal illness are referred to palliative care by GP. The palliative care team act on these referrals and visit and assess on the initial instruction from the GP. Once a resident is known to the Palliative care team the nurses in St. Clair's will contact the palliative care team for advise, support and to request further assessment with any changes that occur. This is currently the practise in place for new palliative care referrals.	Completed 11 May 2011 Completed

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

Did not ensure that all staff members were supervised on an appropriate basis pertinent to their roles.

Staff were not supervised in protecting residents from injury while moving and handling or providing modified consistency diet and fluid therapy.

Not all staff involved in food hygiene had access to education and training.

Not all staff were aware of the centre's policies and procedures.

Action required:

Ensure all staff are appropriately supervised at all times of the day and night.

Action required:

Put procedures in place where staff are facilitated to attend education and training on care of residents with swallowing deficits.

Action required:

Put procedures in place where care staff involved in food preparation and serving are facilitated to attend training in basic food hygiene training.

Action required:

Ensure that all staff is made aware of provisions of the Health Act 2007 and all regulations and rules thereunder commensurate with their role, the statement of purpose and with any policies and procedures dealing with the general welfare and protection of residents.

Action required: Ensure all staff are facilitated with training on the policies and procedures to enable them to provide care in accordance with contemporary evidenced-based practice.	
Reference: Health Act, 2007 Regulation 17 : Training and Staff Development Standard 25: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale**
Provider's response: All staff are now rotated day/night weekday/weekend the person in charge is now able to supervise all staff at all times. New staff appraisals have been developed and are now in place. Person in charge is implementing a long-term staff training programme, directly linked to all legislative and other requirements. Current resources utilised to promote best practise education are provided to St. Clair's by the following: ▪ On site visits from speech and language therapist ▪ Whelehan's Pharmacy Education sessions ▪ Visiting Rep's from nutrition companies who provide training on use of products to thicken food / drinks. ▪ Person in charge will attend an information session organised by the senior speech and language therapist on IASLT/INDI National Descriptors of food and fluid consistencies.	Completed Completed 04 May 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 17: Autonomy and Independence	There was a key code lock still fixed to a toilet door designated as residents' toilet. **Provider Response**: this key code is removed
Standard 24: Training and supervision	The person in charge had commenced an appraisal system with staff. There had been no assessment of staff skills and competencies or an evaluation of the needs of residents to guide training and development needs of staff. **Provider Response:** full staff appraisal includes skill assessments at the same time as the staff appraisal
	St Clair's staff training records are not maintained separately from St Francis Private Hospital. This practice makes monitoring of mandatory training difficult. **Provider Response:** This has been moved to be stored separately in St Clairs nursing home
Standard 28: Purpose and Function	Some residents' beds were in a worn state. A replacement programme was in progress and some beds had been replaced with electric beds, which residents confirmed enhanced their comfort. **Provider Response:** all beds are being replaced ,where required
Standard 32: Register and Residents Records	Confidentiality of records required improvement. The person in charge's office was not locked and there were various documents relating to staff and residents there. **Provider Response:** all records will be locked
Standard 1: Information	There was an activity schedule displayed but in small font on the notice board. **Provider Response:** New activity boards in place.

Any comments the provider may wish to make:

Provider's response:

No response was received from the provider to this section.

Provider's name:
Date: