Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Aras Deirbhle Community Nursing Unit
Centre ID:	644
Centre Address:	Belmullet
	Co. Mayo
	097 8130
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Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive (HSE)
Person in charge:	Maureen Mc Ginty
Date of inspection:	10 and 11 May 2011
Time inspection took place:	**Day 1: Start:** 09:00 hrs **Completion:** 18:30 hrs **Day 2: Start:** 08:30 hrs **Completion:** 15:00 hrs
Lead inspector:	P.J Wynne
Support inspector(s):	Mary Mc Cann
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

Aras Deribhle is a community nursing unit under the management of the Health Service Executive (HSE). Older people who need long term care, people who have dementia care needs and people under the age of 65 requiring residential care who prefer to remain in the local area are admitted. The centre also provides a day care service five days a week for a maximum of seven different older people each day from the community.

The centre was built in 1975 and had under gone a program of refurbishment over the years, with the most recent addition of a day sitting and dining room in 2006.There is a nurse station located close to the main entrance.

There are 15 single and five twin bedrooms. There are four treble bedrooms with shared access to two en suites, which include a toilet and wash hand basin. There are wash hand basins in all bedrooms. There are three showers, one bath and nine toilets located around the building for use by residents.

There is a large day sitting room and dining room located to the front of the building and a second dining room located off the kitchen. Other facilitates include a smoking room, oratory, hair salon and physiotherapy treatment room.

There is a safe enclosed garden provided with seating. All entrance and exit doors were ramped ensuring ease of access for residents.

There is ample parking to the side of the building.

Location

Aras Deirbhle is located half a kilometre from the town of Belmullet. There are shops and business facilities close by.

Date centre was first established:	1975
Number of residents on the date of inspection	35 plus 1 in hospital
Number of vacancies on the date of inspection	1

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	18	7	8	2

Management structure

Aras Deirbhle is managed by the Health Service Executive (HSE). The Person in Charge is Maureen Mc Ginty, who reports to the nominated provider Michael Fahey, who in turn reports to Martin Greaney, General Manger (HSE).

The Person in Charge has a team of nursing, care, catering and housekeeping staff who report to her.

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	4	3	3	4	1	0

Summary of findings from this inspection

This was the second inspection of the centre undertaken by the Health Information and Quality Authority (the Authority). This was an announced registration inspection which took place over two days. An unannounced monitoring inspection had previously been carried out by the Authority on the 4 August 2010. An action plan detailing areas which required attention was forwarded to the provider post this inspection. As part of the registration inspection these actions were also reviewed by the inspectors. Improvements had been made since the last inspection. The last inspection report contained 10 actions and two recommendations. Seven actions were satisfactorily completed. Of those outstanding one was partially complete and two not been actioned. Those partially completed or not actioned are repeated with further actions at the end of this report. Both recommendations outlined were completed.

As part of the registration process the provider has to satisfy the Chief Inspector 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). As part of the application for registration the provider was requested to submit relevant documentation to the Authority including completion of the Fit Person self assessment. This documentation was reviewed by inspectors to inform the inspection process. Other documents reviewed during and post-inspection included residents' care plans, accident and incident records, the Residents' Guide, the record of complaints, staff duty rotas, policies, procedures and staff training records. Inspectors spoke with residents, relatives and staff during the inspection and observed care practices and the quality of the environment.

In order to assess the fitness of the provider and the person in charge separate 'Fit Person' interviews were held. The provider and person in charge demonstrated good knowledge of the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Since completing the fit person entry programme they had undertaken a number of initiatives including reviewing complaints management and the menu cycle. The systems for communicating had improved with increased residents and staff meetings occurring. Residents had an active forum to raise issues.

Fit person interviews were carried out with the provider, the person in charge and the senior nurse who deputises for the person in charge in her absence. Staff interviewed for the purposes of fitness were knowledgeable of and committed to meeting the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Overall, inspectors found evidence of good practice and a commitment by the centre's management team to continually work to improve the quality of the service that residents received. The provider and person in charge displayed a good attitude towards service improvement and indicated a willingness to work to meet the Authority's standards

Daily routines and care practices provided residents with capacity to exercise autonomy and make choices. Residents could practice their religious beliefs freely. There was a good choice and a high quality of food available to residents. The dining experience was pleasant, and residents were treated with respect and dignity by staff.

The building was well maintained and had a sense of homeliness and warmth. Bedrooms were well furnished and equipped to assure the comfort and privacy needs of residents. Residents had access to a range of assistive equipment and specialist beds appropriate to their needs. All equipment was serviced on a contract basis.

Inspectors found some aspects of the service that needed improvement. There was a need for additional training of staff in the areas of safe moving and handling of residents, care of older people with dementia and behaviours that challenge to meet the need of the current resident profile. Deficits' relating to access to specialist services to include dietician, physiotherapy and speech and language therapy were identified. Other areas identified for improvements included the need to implement a system to mange risk situations. The activities program required expansion to ensure meaningful engagement for residents of all dependencies

The Action Plan at the end of this report identifies improvements that must be made 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

The inspectors received 7 completed questionnaires from relatives and 5 questionnaires completed by residents. Inspectors also met and spoke with residents and relatives during the inspection.

Residents told inspectors that they felt “well cared for and that staff did their work in a friendly”. They felt the place was well managed and organised with the needs and comfort of residents the priority for all staff. Residents described feeling safe to the inspectors.

With regard to their health care needs, residents told inspectors that they felt well looked after and encouraged to be as independent as possible. All residents expressed satisfaction with the meals that they received. They said that food was varied, plentiful and that there was a good choice. A resident told inspectors “The food is very good”. A resident described how she remained independent and that she could get up and go to bed whenever she liked, was given the daily newspapers and enjoyed reading them.

Residents were aware that if they had a concern or complaint they could approach the person in charge or a staff member. Many of the residents were able to name the staff member whom they would confide in or make their complaint to.

Relatives highlighted how they were kept well informed about residents’ conditions and progress. They stated that the person in charge was ‘available and helpful’ and that they ‘are always informed of any changes in their relative’s condition and could ask questions any time, day or night’. All relatives spoken with were pleased with the attitude of staff and the dignity and respect with which residents were treated.

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

The centre was well organised. A clear management structure was in place. The provider and person in charge were appropriately qualified and experienced. The provider advised that he visited the centre on a monthly basis and was kept up to date through regular reports and by direct contact with the person in charge. The provider was involved in a financial, administrative and resource context. The person in charge identified her responsibilities in the provision of clinical care and the general welfare and protection of resident, in her fit person interview and during the inspection. She had knowledge of the legal requirements and was clear about her key responsibilities. Staff could explain their roles and the reporting structure. Staff members were familiar with the standards and regulations, and were able to discuss them with inspectors and described examples of person-centred care.

There was evidence that the provider and person in charge were working to ensure that the requirements of regulations and the *National Quality Standards for Residential Care Settings for Older People in Ireland* were being met. The majority of the actions requested from the previous inspection had been completed. There was a commitment to improving practice as demonstrated by the completion of the fit person self-assessment. They gave some examples of the improvements in the quality of care for residents since the completion of the fit person entry program. These included reviewing the management of complaints and the menu cycle, implementing a system to record resident's personal belongings. The systems for communicating had improved with increased residents and staff meetings occurring. The provider and person in charge were aware of their responsibility in relation to notifications and had submitted the quarterly notifications, details of accidents and/or serious incidents as required by the regulations.

The provider and person in charge were clear of the necessity of a transparent easily accessible complaints procedure. Residents spoken with displayed an awareness of their right to voice any complaint that they wished. They told inspectors that they would talk to the person in charge or the nurses if they had a complaint. The complaints procedure was outlined in a user friendly format and displayed prominently. The majority of residents and relatives told inspectors that they had

never needed to make a complaint, as issues were resolved quickly and to their satisfaction. The person in charge maintained the complaints log which was viewed by the inspector. Complaints were noted to be satisfactorily resolved.

Inspectors reviewed the procedures for managing residents' finances and spoke to the administrator with responsibility for maintaining residents' finances. Comprehensive records were maintained to provide an audit trail of each resident's finances. A policy and procedure was in place which was reflected in practice by staff. The inspector viewed a copy of the most recent external audit by a registered auditor. This indicated residents' finances were transparently and accountable managed. Two signatures were recorded in all instances. The ongoing balance was transparently managed and explained to the resident or their representative and a statement was available on request.

The inspector examined the directory of residents which was up to date and contained all information concerning residents as required by the regulations. The inspector viewed the documenting of information for the most recent death and transfer to hospital. All required information concerning both events was recorded in the directory of residents. Residents' records; care plans, medical files and staff records were stored securely.

An emergency plan was in place to guide staff in responding to untoward events. A designated senior person was nominated to be the contact point in the event of an emergency. The plan outlined clear procedures to follow in the event of fire, loss of electric power, suspect package and contamination of drinking water. The emergency plan contained specific action instructions for each grade of staff. The instructions were communicated to staff in the form of an action card, which clearly outlined each staff member's responsibilities to follow in an emergency situation. Contingency arrangement were provided for should it be deemed necessary to evacuate the building. The plan indicated how the evacuation would be undertaken and included contact details for wheelchair accessible transport. The numbers for the emergency services were displayed in the nurse's offices.

Some improvements required

The Authority was provided with written evidence confirming the building meets the statutory requirements of the fire authority in relation to the use of the building as a residential centre for older people. However, the certification did not clearly indicate the qualifications and experience of the person citing compliance and when the inspection took place to assess compliance with fire legislative requirements.

A copy of the providers insurance was reviewed by the inspectors. This did not clearly detail what cover was provided for residents' property.

Significant improvements required

Each resident had not been provided with a contract of care. The person in charge told the inspector new contracts had been developed and she was in the process of agreeing a contract of care with each resident.

The provider demonstrated a commitment to provide a quality service. However, an overall system for the review of the quality of care and the safety and quality of life of residents was not in place. There was no auditing or analysis of information to guide quality improvements. Areas such as medication errors, restraint practices, complaints and vulnerability to falls had not been audited to identify trends and enhance outcomes for residents.

There was a system in place for the management of risk situations. There was a safety statement and a safety management structure in place. A staff member was nominated as the health safety representative. There was a missing person policy in place which included clear procedures to guide staff should a resident be reported as missing. Photographic identification was available for each resident. There were profile description sheet available for staff to provide to emergency services. However, not all risks were not adequately managed and controlled. A risk assessment of the care environment, external areas and the kitchen had been undertaken. However, the hazard identification had not been carried out by a person trained and competent in risk assessments. Not all hazards were identified and controls outlined for identified hazards were insufficient to reduce the likelihood of the risk occurring. For example there was a slope in the corridor outside the nurse's station which had not been identified as hazard to residents. There was no evidence of routine safety audits to proactively manage risk. There was not a visitors log in place to monitor the movement of persons in and out of the building to ensure the safety and security of residents.

There were arrangements in place for recording and investigating untoward incidents and accidents. A description of each accident was maintained. There was clear evidence that residents who had an accident were seen by their general practitioner (GP), by the on-call service or taken to the local hospital. However, inspectors found that the person in charge had taken a limited approach to the pro active management and prevention of falls. There was no evidence for example, to indicate that they had been reviewed by the person in charge. Some of the accident report forms reviewed by the inspector were not completed in full. In some instances control measures were not outlined to reduce the likelihood of reoccurrence of falling and other preventative had not explored. For example one resident expressed he did not wish to wear hip protectors. While his wishes were respected, alternative protective measures had not been identified. Where a resident sustained a fall un-witnessed or when observed to hit their head on falling, vital signs were checked. However, neurological observations were not recorded to determine if a head injury had been sustained and/or the level of consciousness affected.

Minor issues to be addressed

The provider displayed a positive attitude towards complaints. However, the complainant's satisfaction with the resolution or outcome while documented was not clearly verified. The complainant had not signed the log to indicate they were/were not satisfied with the outcome reached.

There was no documented evidence that a missing persons drill had been carried out to ensure staff were familiar with the procedures to be followed to locate a resident who was reported as missing.

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

On a daily basis, residents were able to exercise choice over their lives within the centre. Staff told inspectors that residents can choose to participate in activities, get up when it suits them and generally please themselves. Residents were observed by inspectors getting up throughout the morning at different times. Residents could express a choice to have their meals in their own room or the communal dining room. Many residents told inspectors they like to have breakfast in bed and their lunch in the dining room. A hairdresser visited the centre frequently and residents told an inspector they looked forward to her visits.

Residents told inspectors that staff respected their privacy and knocked on bedroom doors and waited for a response prior to opening the door. Inspectors observed this in practice. Residents' privacy and dignity was respected. Mail was observed to be hand delivered unopened by senior staff to residents. Cleaning staff were observed seeking permission to enter bedrooms. The main door to the bedroom was closed by staff when assisting residents with their personal care. Notices were placed on residents' bedrooms doors when care was in progress.

Inspectors visited residents' bedrooms and noted that residents' had sufficient space to meet their needs. Bedrooms were personalised to each resident's own liking and included photographs, ornaments and pictures hanging on the wall. Residents' had suitable space for storing their clothes. Each resident had an individual wardrobe. The clothing was labelled and no concerns were raised regarding clothes going missing. Residents told inspectors that their daily personal care needs were met to a high standard. Residents were dressed well and according to their individual choice. Staff were attentive to residents' personal appearances. An inspector spoke with laundry staff and they explained how clothes and linen were segregated and laundered. Residents and relatives said they were satisfied with the laundry service, commenting that clothes were well looked after. A property book was provided in each resident's bedroom which listed their personal belongings. The laundry was clean, well organised and had industrial sized washing machines and a dryer.

Residents' civil and religious rights were respected. Arrangements were in place for residents to vote if they so wished. Residents could practice their religious beliefs. A

religious service took place each week. Residents told an inspector they were able to practise their faith and worship according to their wishes. An oratory was provided. Some residents said they liked to spend quiet time there. The inspector observed residents moving to and from the oratory during the inspection.

Residents maintained social relationships. Social interaction with families was encouraged and relatives 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 in, and through many staff who were from the area.

The kitchen was spacious, clean and suitable in size to cater for needs of residents. It was well equipped and was stocked with fresh fruit, vegetable, milk and meats. There was a plentiful supply of juice to include orange and cranberry juice. There were sugar free jams, marmalade and jelly for those on special diets. Staff were familiar with residents' food likes and dislikes. The kitchen staff were informed which residents required their meals to be liquidised, where residents had difficulty swallowing. The inspector viewed liquidised portions to be individually plated at the lunch time meal. Residents who required assistance with nutritional intake were respectfully assisted. Staff were observed to be assisting residents while allowing them time to eat at their own pace and used this opportunity to chat and check with the resident whether their needs were met and if there was anything specific they required. The meal was well presented and residents confirmed that they enjoyed the food. The chef showed the inspector the planned menu cycle which was rotated every three weeks. The menu indicated residents had a choice at each meal time. Residents told the inspector alternatives were provided if they did not like the options on the menu.

Residents had access to fresh drinking water. There was a water dispenser in the day sitting room and dining room. The chef told the inspector staff had access to the kitchen at night time to prepare snacks or beverage for residents. Residents and staff confirmed that nutritious snacks were available throughout the day and during the night. One resident told the inspector "you can get a cup of tea any time day or night".

Some improvements required

Restraint measures were in place to include the use of bedrails by 24 residents. There were no lap belts used. A risk assessment in relation to the use of restraint and a consent form were in place. However, care plans in relation to restraint were not reflective of best practice, for example, risk assessments did not provide consensus judgements that the intervention was in the best interests of the resident, was the least restrictive solution and was being put in place as previous less restrictive interventions had failed in all care plans reviewed. Where a resident was cognitively impaired no narrative was available in any of the case files reviewed that an assessment of the capacity of the residents' ability to consent to the restraint measure had taken place. Furthermore, there was limited evidence that the use of restraint was reviewed periodically as a continued need, in the best interest of the resident.

Significant improvements required

While residents' birthdays are celebrated with the agreement of the resident and there are regular live music sessions and occasional outings, there was no regular schedule of activities in place. There were no individually facilitated activities for residents on a routine basis. There was no structured program of daily activities supported by staff members to lead and engage the residents in activities appropriate to their interests and capacities. Consequently residents had limited opportunity for social engagement and had little to stimulate or occupy them throughout the day. The social assessments completed were informative but were not linked to activity provision.

Minor issues to be addressed

While there was an oratory provided for use by residents further consideration could be given to the provision of some more appropriate seating to meet the comfort needs of residents who spend time in this area.

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

Inspectors examined several aspects of life and care practices to establish how residents' healthcare needs were met. They talked to residents and staff, observed staff activity, observed how residents were spending their time and examined care and medication records.

The staff team were caring for a resident group that had a wide range of care needs, some with complex medical conditions. The majority of the resident group were in advanced old age. There were 10 residents who were aged 90 years or over and six over 85 years of age. There were a further 13 over 80 years of age.

The care files were well organised and information was easily accessible. There were a range of evidence-based risk assessments in use to determine dependency levels, vulnerability to falls, continence management and mental health needs. Residents' records showed that vital observations such as blood pressure, temperature and pulse were routinely monitored. There was evidence in medical files of residents having their eye sight and hearing checked routinely.

The person in charge informed inspectors that a pre-admission assessment would be carried out to determine the suitability of a resident for the service and to ensure that all necessary resources were in place when a resident was admitted. Where possible, admission is preceded by an arranged visit for the family and/or resident.

Residents had access to general practitioner services from several local GPs and many were able to retain the services of their own GP. Residents told the inspector they were able to see their same GP now, as they had prior to coming to live in St Augustine. There was evidence in care plans residents were seen routinely by their GP.

An inspector accompanied a staff member on the medication round. A policy on medication management, to manage all aspect of medication from ordering, prescribing, storing and administering was available. The policy included procedures for the disposal of unused or out of date medication.All medication was delivered to and returned from the centre by the pharmacist. Medication was securely stored in a

locked clinical room. Controlled drugs were secured in a locked cabinet. An inspector viewed the controlled drugs register. Controlled drugs were checked by two nurses from opposing shifts, at the change of each shift to ensure all drugs were accounted for. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication.

There was a range of equipment to enable nursing staff to respond to a medical emergency including an automated external defibrillator (AED) machine, oxygen supplies and a suction machine.

Some improvements required

There was a policy on end-of-life care. While no residents were receiving specific end of life care on the days of inspection, it was noted by inspectors that end of life care wishes were not consistently recorded in residents case files to ensure that any specific wishes the resident had were taken into consideration.

There was not clear evidence in the care plans of all residents or their representative being consulted on their plan of care or being involved when their care plan was reviewed or updated. Where care plans had been reviewed there was no narrative in the case files detailing the review. The only evidence available was a staff signature to say they were reviewed. Where residents had dementia or were cognitively impaired, there was no narrative informing the assessment of the resident to consent to the care plan.

While each resident medication was reviewed at three monthly intervals or more frequently where there was a change in a resident's condition. However, in some cases all medication was not consistently reviewed, namely aperients and psychotropic medication. The GP's signature and date was in place for all medications that had been discontinued. However, not all discontinued medication was signed individually. A signature in a block format was observed in some medication charts.

Significant improvements required

A review of care plans indicated residents' weights were monitored on a monthly basis and nutritional risk assessments were completed. There was specialist equipment available to record the weights of those residents unable to stand on a weighing scale. However, those identified at risk of losing weight, did not have their weight reviewed on a more frequent basis.

Assessment and documentation of pain management and of residents' response to the administration of medication for pain was not in line with contemporary evidence based nursing practice. While residents were prescribed analgesia and it was recorded in the case file 'to observe adequacy of analgesia' there was no pain assessment chart available.

There was evidence residents did not have access to physiotherapy, dietetic services and speech and language therapy to meet their needs. There were two residents

unable to get up each day and there was no rehabilitative plan to support their care in their case files. There were a number of residents on special diets and while the residents had been seen by their GP and supplements were prescribed, these residents did not have specialist input into their care. On review of residents' records, inspectors noted that not all information was available on file. For example, when residents were referred for physiotherapy or to other allied health professionals a copy of the referral was not retained in all cases in the residents' file.

There were two residents with a wound care problems. The residents were provided with appropriate pressure relieving equipment. Wound assessment charts were completed to monitor the wound. However, there was no evidence of an individualised repositioning plan. Input from a dietician had not been obtained to ensure these residents were obtaining optimum nutrition to promote healing. A wound care policy was available and nurses had been trained in wound care management however, staff were not were not utilising the policy to guide their action and interventions.

Minor issues to be addressed

Medications requiring refrigeration were stored in a fridge. However, the temperature was not monitored daily to ensure safe drug storage.

4. Premises and equipment: appropriateness and adequacy

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

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

Evidence of good practice

The building was designed to meet the needs of dependent people. The centre had undergone a process of refurbishment. A new day room was built in 2006 and the structure of the building now has a continuous circular corridor giving freedom of movement to residents particularly whose with confusion or dementia who like to actively walk around. An enclosed sensory garden was designed and developed in 2003. The garden contained tables and seating, a water fountain feature and bird feeder. The garden was pleasantly planted and offered residents a tranquil place to rest and enjoy fresh air. There was a nurse's station located close to the main entrance providing a point of contact for residents and visitors. There was a welcoming atmosphere and a sense of comfort in the communal areas. The décor was domestic, with warm colours and paintings of local scenes on walls.

Windows are at a level where residents can sit and look out onto the enclosed garden or surrounding views. Doorways throughout the building were of sufficient width to accommodate wheelchair users. All entrance and exit doors were ramped ensuring ease of access for residents with mobility impairment.

Bedrooms were furnished and equipped to assure the comfort and privacy needs of the residents. There were 15 single bedrooms and five twin bedrooms. Four bedrooms were occupied by three residents each. Privacy locks were fitted to all bathrooms doors and curtains were provided around beds in shared rooms. Wash hand basins were provided in all bedrooms. There was a call bell system in place at each resident's bed with which residents were familiar and found easy to use. Staff were observed responding to call bells in a timely manner. There was lighting provided in each bedroom to meet the needs of the residents to include a dim light facility.

There was a sufficient number of toilets, showers and baths provided to meet the needs of the residents. Grab support rails were fitted alongside all toilets and showers. An emergency call system was located in all bathrooms. Showers were level with the floor finish providing ease of access. The bathrooms were tiled, maintained in a clean condition and were ventilated mechanically. Hand testing indicated the temperature of radiators did not pose a burn risk to residents.

There were two sluice rooms; both were well equipped with stainless steel sinks, wash hand basins and storage areas for urinals. A bed pan washer was provided.

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

Separate staff toilets, shower and changing facilitates were provided for catering and care staff in accordance with best practice for infection prevention. Locker facilitates were provided for the storage of staff personal belongings.

The inspector viewed records of flushing the water system to prevent risk of contamination from Legionella. The result of a test on the water system indicated the water was safe and free from Legionella bacteria contamination. There was a contract for the collection of clinical waste. General clinical waste was stored in a locked bin located externally.

Smoke detectors were located in all bedrooms and general purpose areas. Emergency lighting and exit signage was provided throughout the building. The inspector viewed contracts of the servicing of the fire alarms, smoke and heat detectors, fire hose and reel. These were serviced by a professional four times a year. Fire extinguishers were serviced annually. The fire alarm was tested routinely. Routine inspection of the automatic fire door closer were undertaken to ensure they were operational. The procedure to be followed in the event of a fire was displayed alongside the fire panel. There was a safe mechanism in place to evacuate immobile residents in the event of a fire. Each resident had been risk assessed to indicate the equipment required to safely evacuate the residents in the event of fire or other emergency situation. Fire hydrant points were clearly marked and accessible to fire services.

Some improvements required

There was a good system in place for the prevention and control of infection. The premises were very clean. Disinfecting hand gel was widely available for use in all areas and staff were observed using hand gels throughout the day. Cleaners were provided with suitable equipment. Cleaning staff were observed working in an unobtrusive manner. The inspector spoke with a cleaner and she was able to tell the inspector about the arrangements to manage the risk of infection. The cleaner demonstrated to the inspector how she cleans bedrooms and bathrooms. Safe procedures were observed. Separate colour-coded equipment was used to minimise the risk of spread of infection. Appropriate cleaning chemicals were used which included a sanitizer.

However, there was no separate cleaning room provided with a sink and wash hand basin for staff to wash and store cleaning equipment. Housekeeping staff used washing facilitates in the sluice room which posed an infection hazard.

Significant improvements required

Thermostatic control valves or anti scalding measures were not in place to ensure hot water at the point of contact by residents did not pose a scald risk. The temperature of the hot water exceeded the maximum recommendation of 43°C as required by the Authority's standards. The inspector tested the hot water at a number of locations around the centre and noted the temperature reached 54°C.

There was an alarm system in place to alert staff if a resident with dementia or confusion was leaving the centre unaccompanied. At the time of inspection two residents had an alarm bracelet. Exit doors were alarmed to alert staff if a resident was leaving the centre unaccompanied or unknown to the person in charge. However, windows were not secure. Restrictors were not fitted to all windows. Restrictors on some windows were loose and could be easily opened.

Minor issues to be addressed

All staff were trained in fire safety and evacuation. Theoretical training was reinforced by fire drill practice. However, the fire drill practice was not undertaken twice a year as required by the Authority's standards. The fire drill practice did not include a simulated evacuation to reinforce the theoretical training on evacuation techniques and ensure staff were fully confident of the procedure to be followed in the case of a fire.

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 observed constant interaction and communication taking place between residents and staff. Residents told inspectors that staff have time to talk to them and families confirmed this. Staff reverted back to residents promptly when they had queries or needed information. A staff member was observed assisting residents to the day room. The staff member ensured the residents were comfortable and safe before she continued on with other duties. Staff wore name badges. Each staff grade wore a different coloured uniform. Residents were aware of each staff member's role.

Staff communicated with each other in a professional manner. There was a handover of information between staff at the end of shifts, which the inspector attended. This time was protected as it was factored into the duty roster. The health and wellbeing of the residents, allocation of workloads and other information relevant to residents' care was discussed.

There were aids available to support communication with residents who had confusion or difficulty expressing their needs verbally. There were three residents who were unable to communicate verbally. A non verbal communication tool was in use to assist these residents articulate their needs and wishes.

National newspapers were delivered daily and the local regional newspaper was delivered each week. Many residents were observed sitting in comfortable armchairs in the lobby reading various papers and magazines which reflected their cultural interests.

Many residents had their own phone and could make and receive calls directly. Those 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.

The daily menu was displayed on entrance to the dining room. There were notices boards located around the building containing information on the complaints

procedure. There were leaflets provided containing information on how to prevent falls and on financial support available towards meeting the cost of care while staying in a residential centre.

Regular staff meetings were held. The inspector saw minutes of these meetings, which were well attended and actions taken as a result of matters discussed. The meetings provided a forum for staff to raise issues and discuss procedures. The minutes indicated a range of topics were discussed including the process for handling complaints, responding to queries from visitors and the regulation and standards.

Residents were facilitated to contribute their ideas to the running of the centre. Inspectors reviewed the minutes of the most recent residents' meeting. The meeting provided a forum for residents to put forward their views on the activities and services provided.

Some improvements required

There was residents' guide available which contained valuable information to assist prospective residents to make a decision regarding choosing a placement. However, it did not contain all the information required by the regulations to include a copy of the contract of care and the most recent inspection report. Each resident had not been provided with an individual copy of the residents'' guide.

There was a comprehensive set of operating policies available including all the policies required by Schedule 5 of the regulations. However, some policies required review for example the risk management policy did not include procedures to guide staff in the event of violence and aggression, self harm or assault. The wound management policy required review. While the best practice guidelines on wound care were available they were not referenced in the wound care policy.

Minor issues to be addressed

There was no independent advocate/advocacy service to assist residents when making decisions relating to consent to treatment or care. This was confirmed to inspectors by the person in charge who had identified the issue and was working to obtain an advocacy service.

Inspectors observed that some residents had communication difficulties due to dementia or cognitive impairment. Inspectors found the building lacked orientation cues for residents with dementia. For example, bathrooms were not easily identifiable from the corridor. All doors were painted the same colour and there were no pictures and or appropriate signage on doors to assist resident's orientation to their environment.

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

The provider employs 47 staff in total which includes a whole-time equivalent of 15 registered nurses and 21 support staff. In addition, there is administration staff employed. The inspector viewed the staff duty rota for a three week period. The rota showed the staff complement on duty over each 24-hour period. The inspector noted that the planned staff rota matched the staffing levels on duty. The rota indicated there was a minimum of two registered nurses on duty at all times ensuring, the person in charge had sufficient time for management and governance tasks and to support and supervise staff.

While staff were not directly recruited by the person in charge, a clear and transparent recruitment policy was available outlining the recruitment practices to employ staff. Job descriptions outlining the reporting relationships, the purpose of the post and the principal duties and responsibilities were available for each staff grade. All staff were provided with an employee handbook on commencement of employment. The book contained information on the code of conduct expected, the observance of dignity and respect and the health and safety obligations.

Most of the staff had been working in the centre for a number of years. Inspectors found that there was a good team spirit among staff who were knowledgeable about residents and had established good relationships with them. Inspectors found that interactions between residents and staff were warm and affectionate. Staff were praised by many residents and relatives. Inspectors saw staff responding to residents in an informed way.

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

The person in charge maintained a record of An Bord Altranais PINs (professional identification numbers) for all registered nurses. This was reviewed by inspectors and seen to be up to date. Eight of the 21 care assistants had completed Further Education and Training Awards Council (FETAC) level five training or equivalent.

Some improvements required

Staff had completed mandatory training required by the regulations in adult protection, fire safety and evacuation. Staff members interviewed were clearly able to explain and demonstrate the procedure to be followed in the event of fire, including how a residents would be evacuated or moved to an area of safety. Staff were able to tell the inspector what they would do if they suspected abuse and the importance of taking measures to prevent the risk of abuse. However, the inspector viewed records which indicated not all of the staff employed had up to date training in the safe moving and handling of residents. Refresher training ensuring all staff were kept updated had not been completed. Certificates of training in this area had expired for many staff. The person in charge had identified these staff members and training was being organised.

Significant improvements required

All of the documentation required by the regulation to be held in respect of persons employed was not available in staff files reviewed. For example, evidence that Garda vetting was being processed was not available in all files. The person in charge told the inspector vetting had been applied for all staff and she was awaiting the return from the Garda Siochana. Three written references and evidence that each employee was physically and mentally fit for the purpose of the work they perform was not available in the sample of files reviewed. The staff files required reorganisation so the information required by the regulations is readily accessible.

Training in infection control, food safety and cardio pulmonary resuscitation techniques (CPR) had been completed by staff. However, there was not an adequate level of modular training undertaken by a sufficient number of staff to meet the needs of the current resident profile. Specialist training in the areas of care of the elderly with dementia, the management of behaviour that challenges, end of life care and restraint had not been completed to guide staff interactions and interventions to ensure the best outcome for residents.

Minor issues to be addressed

There was evidence in staff files appraisals were completed with staff within their first twelve months of employment. However, when staff were confirmed in post permanently a personal development plan to discuss each staff members' training needs was not developed and implemented to ensure their continuous professional development.

Closing the visit

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

P.J Wynne
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

7 June 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
4 August 2011	☐ Registration ☒ Scheduled ☐ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Arus Deirbhle
Centre ID:	0644
Date of inspection:	10 and 11 May 2011
Date of response:	05 July 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:
Residents did not have good access to physiotherapy, dietetic services and speech and language therapy to meet their needs.

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

Those identified at risk of losing weight, did not have their weight reviewed on a more frequent basis.

Copies of referrals were not retained in residents' care files.

Action required:
Ensure each resident is supported on an individual basis to achieve optimum levels of health and access is facilitated to dietetic services, speech and language therapy and physiotherapy.

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

Action required: Implement procedures to assess and document pain management in line with contemporary evidence-based nursing practice.	
Action required: Ensure each resident is supported on an individual basis to achieve optimum levels of health and those at risk of weight loss or gain have a suitable plan of care implemented.	
Action required: Maintain records of all health care referrals and follow-up appointments.	
Reference: Health Act, 2007 Regulation 9: Health Care Regulation 6: General Welfare and Protection Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We assess each resident at admission regarding the need for services. Referrals to physiotherapy, dietetic service and speech & language to be made upon admission if required or on deterioration of a patient's condition. We have a dedicated physiotherapist attached to the unit with an allocated period of time. A number of residents have been seen by the dietician since our recent inspection. To assess and document pain management including use of charts to show location of pain severity of pain when PRN analgesia is given record effectiveness. MUST assessment is carried out upon admission and reviewed 3 monthly when care plan reviewed. Residents weighed monthly, if there is an undesired loss or gain resident is to be weighed weekly. Dietician referral to be sent if required as per MUST score. A number of residents have been seen by the dietician since our recent inspection. We have reviewed our process of maintaining records and have introduced the following system: ▪ posting original request ▪ keeping a copy of request on residents file ▪ recording information on referral sheet ▪ record in care plan	 Completed July 2011 June 2011 Completed

▪ record in referral book kept in the unit	

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

The quality of healthcare promotion for pressure sore prevention and treatment was inadequate. Measures to support residents to achieve and enjoy the best possible health were insufficient.

Action required:

Put procedures in place to ensure pressure area care is managed to a high standard based on evidence based risk assessment tools, multidisciplinary input and informed by contemporary wound care guidelines

Reference:

Health Act, 2007
Regulation 9:Healthcare
Standard 12: Health Promotion
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: To ensure pressure area care is managed to a high standard include use of: Risk assessments tools. Positioning charts are used on high risk & fully dependent residents. Multidisciplinary team input & regular inspections of pressure areas during care. Multidisciplinary team includes medical officer, nursing staff, carers, physiotherapist and dieticians. Two staff nurses from the unit are trained in tissue viability The local Public Health Nurses have expertise in leg ulcer care and run a regular clinic in the area and are available to provide recommendations. We have reference to HSE national best practice and evidence based guidelines for wound management 2009.	August 2011

3. The provider has failed to comply with a regulatory requirement in the following respect:
Where a resident sustained a fall un-witnessed or when observed to hit their head on falling, neurological observations were not recorded to determine if a head injury had been sustained and/or the level of consciousness affected.

In some instances control measures were not outlined to reduce the likelihood of reoccurrence of falling and other preventative measures had not been explored.

Action required:
Ensure a high standard of evidenced-based nursing practice is met with regard to residents who have sustained a fall.

Reference:
Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 31: Risk Management Procedures
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: When an incident or accident occurs: ▪ we fill an incident and near miss form and ensure this form is entirely completed ▪ the Person in Charge is to ensure risk control measures are included on the incident form. Control measures are to help prevent recurrences of incidents or accidents and reduce the risks ▪ neurological observations are to be carried out if resident hit their head or had a fall that was not witnessed ▪ falls are monitored monthly to identify trends. When a resident has an increased number of falls we devise individual safety measures to reduce the risk. A number of residents are provided with hip protectors in the unit. To source chair alarms as a fall prevention measure if resources permit.	Completed

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

Restraint was not managed to comply with best practice and national standards.

Action required:
Carry out a full assessment, including a risk assessment, on any resident before the use of any form of restraint is introduced to ensure it is necessary and the least restrictive option available to ensure the care welfare and protection of the resident.

Action required:
Obtain the consent of the resident where the resident is able to give informed consent to the application of the restraint measure.

Action required:
Review the use of restraint on a regular basis to ensure it is in the continued best interest of the resident.

Reference:
Health Act, 2007
Regulation 6: General Welfare and Protection
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: In the unit our nurses carry out a full individual assessment including risk assessment on a resident before any restraint is used to ensure least restrictive option available is used. ▪ carryout and document restraint release checks every 2 hours while a restraint is in use ▪ obtain and document consent of resident (if able to give informed consent) regarding use of a restraint measure. Develop restraint consent document. ▪ review restraint use on a regular basis for example that it is in the best interest of the resident to continue using it. ▪ document in care plan 3 monthly regarding reviewing restraints ▪ the HSE has a National Restraint Policy which we have adapted to our unit ▪ we have a Staff Nurse from the unit who attended a "train-the-trainer course" regarding restraints and training will be rolled out to all staff.	September 2011

5. The person in charge has failed to comply with a regulatory requirement in the following respect:
Residents or their representative were not consistently involved in the care planning process.

Where residents had dementia or were cognitively impaired, there was no narrative informing the assessment of the resident to consent to the care plan.

There was no rehabilitative care plan to support residents with contractures or who did not get up each day.

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

Action required:
Set out each resident's needs in an individual care plan developed and agreed with the resident.

Action required:
Outline the conclusions of the discussion and agreement of the resident or their representative in the development of the care plan or its review in narrative format.

Action required:
Implement a rehabilitative care plan for residents with contractures or who do not get up each day.

Action required:
Document the wishes of residents and their representatives as to how they wanted care delivered at end of life.

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

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response:	
We will review each residents plan of care and obtain residents' or representatives' agreement through discussion. Develop agreement of care plan document	October 2011
Document the discussion & agreement of the resident or their representative in development of care plan or its review in narrative nurses notes	October 2011

Rehabilitative care plan for residents with contracture or who do not get up every day will include: ▪ physiotherapy referral on admission or change in condition ▪ passive and active range of motion during routine care ▪ occupational therapy referral for assessment. These residents will have a rehabilitative care plan in place outlining dedicated care. We will obtain and document residents' and their representatives' wishes for end of life care through discussion. We are developing a document for recording end of life care.	

6. The provider has failed to comply with a regulatory requirement in the following respect: In some cases all medication was not consistently reviewed, namely aperients and psychotropic medication. Not all discontinued medication was signed individually. A signature in a block format was observed in some medication charts.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Reference: Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Review medication policy. Ensure staff, including doctors are aware of medication policies. Ensure doctors document review of medications to include aperients and psychotropic medications. Doctor to sign each item on prescription sheets to commence or discontinue a particular medication.	September 2011

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

Risks were not adequately managed and controlled.
Not all of the staff employed had up to date training in the safe moving and handling of residents.

Action required:
Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:
Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Action required:
Provide training for staff in the moving and handling of residents.

Reference:

Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: HSE Risk Manager has visited the centre and undertaken to identify the risks at the centre. Precautions to control risks following assessment will be documented and implemented. Risk Management Policy is under review for identifying, recording and learning from incidents and accidents. All incidents will be discussed at staff meetings to ensure learning for all staff Updating of manual handling training will be undertaken and provided. To date we have: ▪ obtained dates for training ▪ 17 staff have had updated training since inspection. ▪ Staff allocated to a specific date, 8-10 staff members to train per month.	November 2011 October 2011

8. The provider has failed to comply with a regulatory requirement in the following respect: There was no structured program of daily activities supported by staff members to lead and engage the residents in activities appropriate to their interests and capacities.	
Action required: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.	
Reference: Regulation 6: General Welfare and Protection Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are developing a more structured programme of activities. Two staff members are very involved in this but not specifically allocated to activities (but support the activities development on their days off). We have been in contact with the local Irish Wheelchair Association centre and our residents will be welcome to attend again once they move into their new premises which will be in July. We had a 6 month planner for activities on display and are changing this to a monthly planner showing days and activities planned. It will be easier to read for the residents. Legion of Mary are visiting and reciting the rosary with residents every Wednesday morning. We are developing a plan of activities as per interests expressed in the resident satisfaction survey. Since the recent inspection we had a couple of special events ▪ a day trip with 8 residents to the Blacksod area, visiting Ionad Dheirbhle in Aughleam ▪ local school children who are part of the Glencastle School Band have been in the unit to perform for the residents	Ongoing

We are developing the role of the volunteers to visit the residents and may entail: ▪ just sitting with some residents ▪ listening to residents ▪ reading to residents ▪ talking to residents ▪ helping them write a letter, card, etc ▪ playing cards, painting, listening to music with them, ▪ doing tasks like brushing their hair, painting their nails, tidying their clothes or any task a relative would do for a resident. The role of the volunteer is to ease the burden of hospitalisation on a patient, help shorten the day, add a little light-hearted fun to their day and keep them up to date with what's going on outside the unit.	

9. The person in charge has failed to comply with a regulatory requirement in the following respect: There was an insufficient number of staff trained in care of the elderly with dementia and behaviour that challenges, end of life care and restraint to guide staff interactions and interventions to ensure the best outcome for residents.	
Action required: Provide staff members with access to education and training in care of the elderly with dementia and behaviour that challenges, end of life care and restraint to enable them to provide care in accordance with contemporary evidence based practice.	
Reference: Health Act 2007 Regulation 17: Training and Staff Development Standard 24 :Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: One staff nurse from the unit has attended "Train-the-trainer" course day for restraints and will roll out training. There is a forum for end of life care in October 2011. We have one staff nurse registered to attend and she will share knowledge gained with remainder of staff. The person in charge is organising training dates for behaviour that challenges and care of the elderly with dementia.	November 2011 December 2011

10. The provider has failed to comply with a regulatory requirement in the following respect: Each resident had not been provided with a contract of care.	
Action required: Agree a contract with each resident within one month of admission to the designated centre.	
Action required: Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.	
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Contact of care. ▪ all future new residents to receive contract of care within 1 month of admission ▪ of the current residents, 29 have agreed and signed contracts of care since the inspection. The Person in Charge is working to finalise the remainder ▪ to ensure all residents have contract of care agreed to include list of all services available to the residents.	August 2011

11.The provider has failed to comply with a regulatory requirement in the following respect: There was no system for the review of the quality of care and the quality of life of residents. Areas such as medication management, restraint practices, complaints and vulnerability to falls had not been audited to identify trends and enhance outcomes for residents.
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate

intervals.	
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Person in Charge and Ward Manager to carry out regular audits to assist in review of quality & safety of care provided: Medication audit – 6 monthly Restraints audit – 3 monthly Complaints audit – 1 monthly Falls audit – 1 monthly Resident satisfaction survey - annually The outcome of audits will be reviewed for trends and actions implemented following audit to improve safety of care and quality of life.	December 2011

12. The provider has failed to comply with a regulatory requirement in the following respect: The fire certification did not clearly indicate the qualifications and experience of the person citing compliance	
Action required: Provide to the Chief Inspector, together with the application for registration written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Assessment carried out by Fire Safety Consultants.	July 5 2011

Report of above Fire Safety Assessment to be forwarded to Health Information and Quality Authority when completed.	August 2011

13. The provider has failed to comply with a regulatory requirement in the following respect: It was unclear what insurance cover was available for residents' property.	
Action required: Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).	
Reference: Health Act, 2007 Regulation 26: Insurance Cover Standard 9: The Resident's Finances	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Insurance is a national issue with the HSE and we are awaiting a national resolution to this matter To ensure loss or damage to resident's property is minimal; ▪ advise residents not to keep large sums of money ▪ safe-keeping offered for same ▪ patient private property account available for money ▪ advised not to keep items of great value	December 2011 Completed

14. The provider has failed to comply with a regulatory requirement in the following respect: Some policies required review for example the risk management policy did not include procedures to guide staff in the event of violence and aggression, self harm or assault. Best practice guidelines on wound care were available however; they were not referenced in the wound care policy.	
Action required: Ensure policies and procedures are relevant and applicable to the centre, reviewed and updated in light of changing legalisation, quality monitoring and best practice.	
Reference: Health Act, 2007 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: Risk management policy will be reviewed to include procedures to guide staff in event of violence and aggression, self harm or assault Wound care policy will be revised to ensure linkage to HSE national best practice guidelines	December 2011

15. The provider has failed to comply with a regulatory requirement in the following respect: There was no separate cleaning room provided with a sink and wash hand basin for staff to wash and store cleaning equipment. Thermostatic control valves or anti scalding measure were not in place to ensure hot water at the point of contact by residents did not pose a scald risk. Windows were not secure. Restrictors on some windows were loose and some could be opened.	
Action required: Provide a cleaning room with a sink and wash-hand basin.	
Action required: Provide thermostatic control valves or anti scalding measure to ensure hot water at the point of contact by residents did not pose a scald risk.	
Action required: Ensure all windows are secure in the interest of resident safety.	
Reference: Health Act, 2007 Regulation 19: Premises Regulation 31: Risk Management Procedures Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Request made to maintenance department to provide separate cleaning room with a sink and a wash hand basin to wash and store equipment.	August 2011

Request made to maintenance department to install control valves. Request made to maintenance department to have window restrictors fitted.	

16. The provider has failed to comply with a regulatory requirement in the following respect: All the information required by schedule 2 of the regulations was not available.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.
Reference: Health Act, 2007 Regulation 18: Recruitment Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Recruitment procedures are in place regarding employing and vetting staff. To request information from Human Resources Department in Castlebar/Galway and ensure availability locally on staff file Files will be reviewed and all information required by schedule 2 will be provided for each member of staff	 Completed October 2011

17. The provider has failed to comply with a regulatory requirement in the following respect: The staff files required reorganisation so the information required by the regulations is readily accessible. There was not a visitors log in place to monitor the movement of persons in and out of the building to ensure the safety and security of residents.
Action required: Keep the records listed under Schedule 4 (general records) up-to-date and in good order.

Reference: Health Act, 2007 Regulation 22: Maintenance of records Standard 32: Register and Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We plan to re-organise staff files, grouping HIQA requirements together, using a specific colour paper to identify the information. Visitors log has been set up at main entrance.	September 2011 Completed

18. The provider has failed to comply with a regulatory requirement in the following respect: The Residents' Guide did not contain all the information required by the regulations.	
Action required: Produce a resident's guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.	
Action required: Supply a copy of the resident's guide to each resident.	
Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Standard 1: Information	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Review residents guide & develop to include: ▪ summary statement of purpose ▪ terms & conditions of accommodation ▪ standard form of contract ▪ most recent inspection report ▪ summary of complaints procedure ▪ address & telephone number of Chief Inspector Supply each resident with a copy of the guide.	October 2011

Recommendations

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

Standard	Best practice recommendations
Standard	Further consideration could be given to the provision of some more appropriate seating to meet the comfort needs of residents who spend time in the oratory. **Providers Response;** More comfortable seating has been placed in the oratory.
Standard	The temperature of the drug storage fridge was not monitored daily to ensure safe drug storage. **Providers Response;** Temperature is recorded daily.
Standard 24: Training and Supervision	Undertake a staff appraisal with all staff to provide a mechanism for staff to receive feedback on their performance or to identify their strengths, to ensure continuous professional development **Providers Response;** Introduce annual appraisal of staff.
Standard 26: Health and Safety	Undertake fire drills with staff at least twice annually to include a simulated evacuation. **Providers Response;** ▪ 6 monthly fire training includes simulated evacuation of resident from bed. ▪ Include fire drill twice a year with simulated evacuation.

Standard 25: Physical Environment	Improve signage to provide effective and meaningful prompts, to help residents find their way to communal areas, bathrooms. **Providers Response;** To obtain signs for doors using pictures & words.
Standard 3: Consent	Provide residents with access to an independent advocate/advocacy service. **Providers Response;** ▪ Application was made for an independent advocate. ▪ Follow up result – no one is available in the area. ▪ Follow up calls made at regular intervals. ▪ Notice displayed in the unit seeking an advocate.
Standard 29: Management Systems	Undertake a missing person drill to ensure staff are familiar with the procedures to be followed to locate a resident who maybe reported as missing. **Providers Response;** ▪ To ensure staff are aware of policy. ▪ Ensure staff are familiar with policy. ▪ Undertake missing person drill twice a year.
Standard 6: Complaints	Verify the complainant is satisfied with the outcome reached by obtaining their signature in the complaints log indicating they were satisfied with the resolution reached. **Providers Response;** ▪ To have complainant, sign complaints log that they are satisfied with resolution of complaint/concern voiced

Any comments the provider may wish to make:

Provider's response:

No response received for this section.

Provider's name: Michael Fahey

Date: 05 July 2011