Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Aras Mathair Phoil Community Nursing Unit
Centre ID:	0652
Centre address:	Castlerea
	Co. Roscommon
Telephone number:	094 9620506
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Email address:	nora.beirne@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	HSE West
Person authorised to act on behalf of the provider:	Catherine Cunningham
Person in charge:	Nora Beirne
Date of inspection:	9 and 10 August 2011
Time inspection took place:	**Day 1: Start:** 09:00 hrs **Completion:**17:40 hrs **Day 2: Start:** 09:00 hrs **Completion:**15:40 hrs
Lead inspector:	Mary McCann
Support inspector:	PJ Wynne Patricia Tully (Day 2 only)
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **Unannounced**

About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority 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 process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

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

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Aras Mathair Phoil is situated in a housing development in Knockroe, Castlerea, adjacent to the train station. The services of Castlerea Town are within walking distance.

Aras Mathair Phoil Community Nursing Unit is a purpose-built single-storey facility, operational since 1982. The centre provides care for 30 dependent residents who require long term care, respite care, convalescent care or have dementia/cognitive impairment care needs. All residents were over 65 years of age on the day of inspection.

The front door is open from 09:00 hrs to 21:00 hrs. On entry there is a reception area with administration and management personnel offices. Bedrooms and the main sitting are to be found off this area. There are two sitting rooms, one located close to the main entrance and the other adjacent to the dining room which is beside the kitchen. There is a smoking room close to the dining and sitting room. A physiotherapy room is also available.

Accommodation consists of 19 single bedrooms and five triple bedrooms. All single rooms have a sink and each triple room has an en suite sink, toilet and shower. There are two communal bathrooms, six showers and nine toilets available for residents' use. There are five staff toilets and four staff showers which include facilities for kitchen staff and visitors.

The centre is rectangular in design with an enclosed courtyard-style garden. There is a car park to the front of the building.

Date centre was first established:			1982	
Number of residents on the date of inspection:			28	
Number of vacancies on the date of inspection:			2	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents	10	9	9	0
Gender of residents			**Male (✓)**	**Female (✓)**
			11	17

Management structure

The Provider is the Health Service Executive West. The person appointed on behalf of the provider is Catherine Cunningham, General Manager/ acting Local Health Manager.

The Person in Charge is the Director of Nursing, Nora Beirne who reports to Catherine Cunningham. She is supported in her role by Catriona Newman, Clinical Nurse Manager Grade 2 (CNM 2). The nursing, administration and maintenance staff, report to the Person in Charge. The catering staff report to the Head Chef, Fintan Dockery. The carers/multi task attendants report to the nursing staff.

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

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

This was the third inspection by the Authority and took place over two days. A scheduled unannounced inspection took place on 1 and 2 December 2009. An action plan was forwarded to the provider and Person in Charge (PIC) post this inspection detailing 43 actions which required attention. These actions included review of meaningful activities, revision of policies and documentation, assessment of the utilization of communal space, review of the heating system, provision of emergency care, and training for staff in responding to emergencies, review of staffing levels, risk management and provision of adequate storage facilities.

A follow up inspection to assess advances of this action plan took place on the 27 January 2010. The inspector found 41 of the required 43 actions were adequately met, one was partially completed and the other not addressed. The heating system had been repaired, regular monitoring of environmental temperatures was taking place, emergency equipment was in place and staff had accessed training in responding to medical emergencies. The provider and the person in charge had also completed a review of staffing levels, introduced a key worker system, reviewed and reorganized case files, introduced documentation in relation to restraint and ensured staff had accessed a range of training to ensure they effectively met the needs of the residents. A system of review of the quality of the care provided to residents has also been introduced.

An action plan was forwarded to the provider and Person in Charge (PIC) detailing the two actions that still required review. As part of the registration inspection these actions were reviewed. One action was complete and the other was partially complete. Daily and provincial newspapers were available to residents.

Not all staff personnel files complied with current legislation. The PIC confirmed that she would continue to progress this action. These reports are available at www.hiqa.ie.

Inspectors met with residents and staff, observed practices and reviewed documentation such as care plans, accident and incident logs, policies, procedures medical files, complaints log and staff files. A fit person interview was carried out with the provider and person in charge. The Fit Person Entry Programme: Self-Assessment (FPEP) document had been completed by the person in charge and discussed with the provider in advance of the inspection. This, together with the registration application form, pre inspection questionnaire, resident and relative questionnaires, notifications and all other submitted supporting documentation was reviewed by the inspectors. Since completing of the fit person entry programme, a number of changes had been introduced including erection of pictorial orientation signage, introduction of advocacy services, provision of a post box in the residents sitting room, refurbishment of the visitors room, development of policies and procedures and staff training.

There were systems in place to protect residents from abuse, evidence of effective management systems including risk management and review of the quality and safety of care, access to a good standard of evidenced based nursing care and allied health services.

The person in charge displayed an adequate knowledge of her responsibilities in accordance with relevant legislation. She informed inspectors that she ensured that all staff were aware of the legislation and the national standards and regulations were available to staff and discussed at staff meetings. She also displayed a good knowledge of her role in the centre and the resident profile. Staff spoken with said she was freely available in the centre and provided appropriate supervision and advice.

Overall, inspectors found evidence of positive outcomes for residents. Residents spoken with and from analysis of the residents' questionnaires of which there were fifteen expressed satisfaction with the care provided and described staff as "always available, helpful, caring and hard working". They confirmed that they were well respected by staff and their needs were met. They were complimentary of the food. From analysis of the relatives questionnaire, of which there were eight, relatives expressed satisfaction with the service provided including comments such as "staff are very caring, the food is good and the centre is very clean" and confirmed that staff communicated well with them in relation to their loved ones.

The person in charge and staff interviewed voiced a commitment to continually work to improve the quality of service that residents received. Inspectors found that the health needs of residents were met and care practice was observed to be carried out, to ensure the privacy and dignity of residents was respected. Residents were provided with opportunities to exercise choice in the way they spent their days at the centre. Inspectors found that residents' views were taken into consideration and a residents committee was in place. Residents had opportunities to practice their religious beliefs.

Mass was celebrated weekly and prayers were recited daily. There was a good variety of food provided and residents told inspectors that they 'enjoyed the food, it was always good', and they 'don't want anything changed'. They stated they felt safe in the centre and if they had any concerns they would tell 'matron'.

Inspectors found aspects of the service that required improvement. These included environmental issues with regard to having a separate cleaning and sluice room to comply with best practices in infection control, controlling the water temperature at point of contact with residents and maintenance of an up to date property list. The contract of care, complaints policy and statement of purpose required revision. Additionally, there was a need for refresher training for staff in fire safety and in the safe moving and handling of residents.

The Action Plan at the end of this report identifies actions that are mandatory 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*.

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

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

1. Statement of purpose and quality management

Outcome 1

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:

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

Inspection findings

The statement of purpose did not meet all of the requirements of Schedule 1 of the Care and Welfare of Residents in Designated Centres for Older People, Regulations 2009 (as amended). It set out the services and facilities provided in the designated centre and staff knew residents as individuals and could clearly describe to inspectors how they met their needs. However, the profile of the residents was not accurately reflected, the specialist nursing care offered at the centre for example in relation to palliative care or mental heath assessment and review was not detailed. Other omissions included the size of the rooms. The PIC gave a verbal commitment that she would review the statement of purpose without delay. This she has completed and a revised copy has been received by the Authority.

Outcome 2

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

References:

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

Inspection findings

There was evidence of a quality assurance and continuous improvement system in place. The inspector reviewed several audits completed by the person in charge and Clinical Nurse Manager. Audits of areas such as falls by residents, medication practices and care planning were reviewed and results analysed to determine patterns and areas for improvement and development. The audit of care plans resulted in improved practices.

The documentation used was reviewed and staff was advised to ensure accuracy of recording and to use the 24 hour clock to ensure greater accuracy and clarity.

There were arrangements in place for recording and investigating untoward incidents and accidents and the recording of 'near misses'. However, no audit of accidents/incidents had been completed. Consequently, there was no system to ensure learning for all staff from accidents and serious or untoward incidents.

Weekly reviews were completed on all residents monitoring pain, use of sedative and psychotropic medication, weight loss, whether a catheter was insitu, and those who spent a significant amount of time in bed. This was audited by the person in charge and data was collated on a monthly basis. This allowed trends to be monitored. The person in charge confirmed that all residents got up every day and that no residents had a pressure sore on the day of inspection.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

At interview the Person in Charge (PIC) and clinical nurse manager demonstrated a positive attitude towards complaints. They supported the view of a robust transparent complaints procedure that was easily accessible. The PIC stated that she took complaints seriously and viewed complaints as a means to review service provision. The complaints procedure was displayed in a prominent position in the centre and described in the residents' guide and the statement of purpose. The complaints log for 2011 contained records of five complaints. All relevant information about the complaint, the investigation and the outcome was detailed. The complainants' satisfaction with the outcome was recorded. However, a second person had not been nominated (one who is independent of the person receiving the complaint) to ensure complaints are appropriately responded to and records maintained. Other omissions included the contact details of the HSE complaints officer and contact details of the Chief Inspector of Social Services.

Residents informed inspectors they felt comfortable raising any concerns with the PIC or any member of staff should the need arise. From analysis of the relative questionnaires it was documented that they had knowledge that if they had a complaint they would feel able to discuss this with the person in charge or nursing staff. All residents spoken with confirmed that they had no issues that they were dissatisfied with at the current time.

Residents had access to an advocacy service. The centre also had a volunteer who was a retired psychologist who attended the centre as a be-friending service.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

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

Inspection findings

Inspectors found that measures were in place to protect residents from being harmed or suffering abuse. All staff had received training on Adult Protection to ensure that they could identify and respond appropriately to allegations of abuse. Confirmation of Garda clearance was awaited for one staff member.

Staff spoken with displayed knowledge of the different forms of abuse and all was clear on reporting procedures. Residents spoken with stated that they felt safe in the centre and there were adequate measures in place to protect them from harm. Questionnaires completed by residents and their relatives confirmed to inspectors that residents felt safe. Many residents attributed their safety to the front door being secured and having a call bell to summon assistance. There were no reports or allegations of abuse received by the Authority from the centre.

A centre-specific elder abuse policy was in place. However, this policy did not document local contact arrangements for the senior case worker for elder abuse. The policy also failed to contain a procedure on how to manage an allegation of abuse against a senior member of the management team. At the time of inspection there were no recorded incidents or allegations of abuse.

Inspectors reviewed the procedures for managing 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. The inspector viewed a copy of the most recent external audit by a registered auditor. This indicated residents' finances were transparent and managed appropriately. A three monthly statement was made available to residents.

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

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records

Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

A detailed risk assessment was in place in relation to all risks related to the centre. This had been updated in April 2011 and detailed the hazard, the risk, existing control measure and a risk rating using the 'traffic light system'. It also detailed the person responsible for monitoring and ensuring controls were in place to minimize the risk. This was well completed and detailed an assessment of the risk and the controls necessary to minimise the risk. One risk that was recently reviewed was related to a notification that had been submitted to the Authority. This was as a result of a person going missing. As a result of this assessment a new protocol was developed in relation to the locking of doors. Additional control measures have been identified to include an extra staff member on night duty, this was at discussion level. A comprehensive emergency plan was in place to guide staff in responding to untoward events. The plan outlined a clear procedure to follow in the event of fire, flooding and loss of utilities. Contingency arrangements were provided should it be necessary to evacuate residents from the building. A visitors' log was in place to monitor the movement of persons in and out of the building to ensure the safety and security of residents and to inform staff re who was in the premises should evacuation be required. A health and safety policy was in place. This had been reviewed and updated on the 16 February 2011. A safety representative is nominated at the centre. There was evidence available that he was provided with formal training in his role. Other documents that were in place included a corporate safety statement.

The environment was clean and odour free. Some measures were in place to control and prevent infection. These included a centre-specific policy on infection control, thirty one staff had been trained in infection control, arrangements for the management of waste including clinical waste and a procedure to guide and inform staff in the event of an outbreak of norovirus. However, inspectors were concerned that there was no designated cleaning room separate from the sluice room. Cleaning staff were using the sluice room to store the cleaning equipment. Household staff were also working as multi task attendants and did a variety of tasks during the day such as cleaning, laundry and care provision without changing their uniforms or changing aprons for each specific role.

A missing person policy was in place to guide and inform staff should a resident be reported as missing. Recent photographic identification was available for each resident; however, a missing person's profile was not in place for any resident. A food safety system was in place. Records indicating staff involved in food handling had been trained in food safety were available. The local environmental health officer inspected the premises; the last inspection was carried out on the 9 March 2011. This detailed "in general kitchen was in compliance with food hygiene legislation".

The PIC confirmed that all staff with the exception of one staff nurse had been trained in the safe moving and handling of residents. All records in relation to fire safety were provider to the inspectors which confirmed that of fire drills which took place on a routine basis

The mandatory requirement for registration of a designated centre, to provide a fire certificate from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for dependent persons was not available. An inspection had been carried out on the 3 August 2011 in relation to this issue.

Controls were not in place to ensure the temperature of hot water was restricted to 43°C on point of contact with residents.

Smoke detectors were located in all bedrooms and general purpose areas. Emergency lighting was provided throughout the building. An inspector viewed contracts of the servicing of fire alarms, smoke and heat detectors. These were serviced quarterly. Fire extinguishers were serviced annually. Routine inspection of the automatic fire fighting equipment was inspected frequently to ensure it was in place and intact. Plans to show the escape to the nearest fire exit were displayed. around the building. However inspectors were concerned that the doors to the rear of the building required manual deactivation by key pad in order to exit even when the fire alarm was activated. Senior staff confirmed that this had been assessed on the recent inspection by competent fire personnel and pending the outcome of this assessment they would review as advised. The mechanism in place to evacuate immobile residents was the blanket drag technique. Staff spoken with confirmed that this was discussed at the fire safety training and deemed appropriate and safe. The inspector viewed records of fire drills which took place on a routine basis and included simulated evacuation techniques. However, not all staff had been trained in fire safety and evacuation procedures within the past 12 months.

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

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

Inspection findings

Iinspectors found evidence of good medication management procedures. An inspector accompanied a nurse completing a medication administration round. Medication was administered in accordance with professional guidelines. Medication was dispensed by the local pharmacy. There were appropriate procedures for the handling and disposal for unused and out of date medicines.

A comprehensive policy on medication management, which included ordering, prescribing, storing and administration of medication, was available.
The inspectors found that the processes in place for the handling of medicines, were safe, secure and in accordance with professional guidelines and legislation.

All medication was reviewed by the prescribing doctor at three monthly intervals and more frequently should a change in residents' health occur. The doctor had documented that a medication review had occurred.

Controlled drugs were stored safely in a double locked cupboard and stock levels were recorded at the end of each shift and recorded in a register in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1982. As stated in Outcome 2 the good practice outlined above was further developed by regular medication audits.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

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

Inspection findings

Inspectors found a high standard of evidence-based care and appropriate medical and allied health care access. The arrangements to meet residents' assessed needs were set out in individual care plans. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and moving and handling assessments. The centre had

adapted a proactive approach to falls management with regular audits, reviews and staff training forming part of the prevention strategy.

There was good linkage from the assessment to implementation of the care plan. Where the assessments had been reviewed this was reflected in the care plans. An omission was noted by inspectors with regard to a resident who had epilepsy. It was noted that this resident had been admitted to hospital due to an epileptic seizure six months ago. While emergency medication was prescribed should the resident develop status epilepticus there was no emergency care plan to guide and inform staff on this issue. Staff confirmed at the feedback meeting that they would action this as a matter of priority. A narrative note was not made of the involvement of the resident and their significant other in the development and review of the care plan. A narrative was available of the assessment of the capacity of resident with cognitive impairment as to their ability to understand the care plan but staff were clear that regardless of capacity they tried to involve and engage the resident in the care planning process. There was good narrative information that the staff discussed the care plan with all residents and their significant other.

Care plans were regularly reviewed at a minimum of every three months or more frequently should a change in a resident's condition occur. A key worker system was in place**.** While there were comprehensive personalised social care histories available and care plans in relation to suitable personalised activities, there was poor documentary evidence available as to the level of participation of resident's in the day to day activities.

A sample of medical records were reviewed which confirmed that the general practitioner reviewed residents regularly as their needs dictated. An out-of-hour's service provided medical cover at weekends and bank holidays.

The PIC described and there was evidence of strong links with mental health services. The psychiatrist for later life team attended the centre as required. Medication was reviewed by these services as required.

A physiotherapist was available at the centre two mornings per week. There was good evidence in the case files that many residents accessed this service. She ran an exercise group on a weekly basis which was highly valued by residents spoken with and well attended. Occupational therapy, chiropody ophthalmic dietician and audiology and dentistry services were available to residents. A specific sheet was available in the case notes detailing attendance and review by allied health professionals

There was a range of equipment to enable nursing staff to respond to a medical emergencies including access to a defibrillator.

Residents had access to a variety of scheduled activities which included physical, mental, social, cultural, educational and spiritual activities. One of the inspectors spoke with the activity co-ordinator. She had attended training in Sonas and completed a course in activities for older persons. One-to-one hand massage, live music and card games were part of activities provided to ensure meaningful engagement for residents. Inspectors observed staff ensuring that residents who

were cognitively impaired were included in activities. Nursing, care staff, residents and the majority of relatives (from analysis of their questionnaires) confirmed that there were regular activities provided. One relative commented that there was a need to motivate residents more to engage in meaningful activities. However inspectors noted that some male residents didn't seem to actively engage in activities. They requested that staff look at how they could be actively engaged.

The activities therapist stated that weekend activities in the unit were dictated by the residents. She stated that this was generally a time when visits from family and friends are enjoyed. The weekend is seen as a time of relaxation and reflection for residents. The weekend newspapers are enjoyed by residents and if there are request for specific activity e.g. music, DVD's these requests are accommodated by staff.

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

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

Inspection findings

Inspectors reviewed a sample of end of life care plans. There was good evidence that staff had discussed end of life care wishes with residents and significant others. Personalised care plans were available on each file reviewed detailing the residents wishes and a plan as to how these would be accommodated. Burial wishes and undertaker choices were also documented. These were detailed and clear. Staff members spoken to were knowledgeable about the residents' preferred wishes which included their wishes in relation to whom they wished to spend time with. The PIC informed the inspectors that while there was not a specific accommodation for families to stay in the centre, families used the visitors' room and had access to refreshments and shower facilities. An oratory is available at the centre for private prayer and reflection. Other residents were given an opportunity to pay their respects and to attend requiem services. An annual memorial service is arranged for all deceased residents. Inspectors noted that memorial cards for deceased residents were displayed in the oratory. Thank you cards to staff were also available from relatives.

While no resident was receiving end of life care at the time of inspection, staff described person-centred care that would be provided. The PIC described good links with palliative care services who attended the centre to provide support and advice as required. Thirteen staff had recently attended a course on palliative care.

Outcome 9

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

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

Inspection findings

Inspectors spoke with staff serving the meals in the dining room and kitchen staff and found they were knowledgeable about individual resident's special requirements including special diets. Where residents were seen by speech and language therapy services, the recommendations from these assessments was displayed on the notice board in the kitchen. Residents who required assistance with nutritional intake were appropriately and discreetly assisted. There was adequate staff to assist residents with lunch. From analysis of the residents and relative questionnaires together with talking with the residents it was clear that residents were happy with the catering arrangements at the centre. The chef on duty on the days of inspection was clear that he wanted to ensure a high standard of food was always available to residents and would be guided by resident's feedback. Catering staff confirmed that they had food hazard analysis training. A complete record of all food served was not available.

Residents received a nutritious and varied diet that offered choice. The menu was on an eight day cycle which avoided repetition of the same choice on the same day. Mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff.

The kitchen was suitable in size to cater for the residents' needs. It was clean, well equipped and contained suitable facilitates for the storage, preparation and cooking of food. It was well stocked with a plentiful supply of vegetables, fresh fruit, meat and fish. There was a good supply of juice including orange, prune and cranberry juice.

Residents were offered a variety of snacks and drinks throughout the day. The chef confirmed that snacks were available outside core working hours for kitchen staff. Jugs of water and squashes were available in sitting room areas and staff were observed assisting residents with fluid intake. Residents told inspectors that they could have tea or coffee and snacks any time they wished. Food and fluid diaries formed part of the nutritional monitoring policy at the centre for vulnerable residents.

A policy was available to guide and inform staff on the procedures to ensure residents' nutritional and hydration needs were met. On review of the case files it was noted that all residents' weights were monitored monthly and more frequently if loosing weight. This was completed in an organised weight chart where it was easy to monitor residents' weight from month to month. A nutritional risk

assessment was completed and this was updated regularly. There was good linkage from the nutritional assessment to the nutritional care plan. Where the assessment identified a risk, the resident was highlighted for more intensive supervision and appropriate intervention, such as a referral to a dietician. The PIC confirmed that the centre could assess speech and language therapy assessments and dietetic advice as required.

4. Respecting and involving residents

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

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

Inspection findings

Residents had been provided with a contract of care. This did not detail what extra charges were applicable for example hairdressing. The contract also contained a clause with regard to liability for damage to laundry that was not in compliance with current legislation. The contract was not agreed with the resident within one month of admission as most residents were in the centre for many years and these had contracts which had recently been agreed. The PIC informed the inspectors that a national HSE contract is being devised for all HSE establishments which they will implement once available.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her in dependence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings

A residents' forum was in operation at the centre, minutes were available of these meetings. There was a good attendance by residents and two relative representatives attended. It was evident from the minutes of these meetings that suggestions that were made for change had occurred or were been developed. Inspectors read the minutes from the meetings and noted resident's views and suggestions had been implemented for example, to have a post box in the sitting room, to arrange a trip to knock. A survey on the provision of meaningful activities within the unit is scheduled for the end of August 2011.

A comprehensive communication policy was in place which contained information with regard to communication with residents with cognitive impairment. The policy also contained an appendix of a fact sheet from the Alzheimer's Society on communication. The PIC informed the inspectors that she is obtaining a communication pack from the Somas programme to assist residents who have difficulty in communicating. An advocacy service was available at the centre. A volunteer also attended the centre. These services provided a safeguard to ensure that residents who as a result of their dependency and /or cognitive impairment who had difficulty engaging in the running of the service had a 'voice'. One man with a cognitive impairment had a communication aid to assist him.

Inspectors observed the practice of delivery at intervals over the inspection period. From this observation together with analysis of the of resident and relative questionnaires inspectors formed the opinion that the privacy and dignity of residents was respected by staff, for example, doors to bedrooms and shower rooms were closed while staff were assisting residents. Privacy curtains were drawn around beds in shared rooms while staff were delivering care. Residents were dressed well and informed staff that they could choose what clothes they wished to wear.

Residents informed the inspectors staff were always available and they felt that communication was welcomed and encouraged. Inspectors observed good interactions between staff and residents. There was a high visibility of staff in the sitting room engaged in meaningful activities with residents. Daily and provincial newspapers were available in the day-room.

Staff were proactive in encouraging and retaining contact with family and friends. Residents could meet with their visitors in the privacy of their own rooms or in the visitor's room which had been renovated and was a pleasant meeting place. A box of toys was available to entertain children. Mass celebrated in the centre every week. Other religious denominations were visited by their ministers, as required. The inspectors observed that the rosary was said regularly throughout the days of inspection. Residents told inspectors that religion was an important aspect of their daily lives.

Links were maintained with the local community. The local secondary school children visit the centre regularly and complete the community involvement part of their 'Gaisce' award at the centre.

Residents had access to televisions, radios and telephones. There were notices boards located around the building containing information on the activities planned for the day, the menu options and the complaints procedure. Questionnaires completed by relatives confirmed they were kept well informed by the PIC and staff of the wellbeing of their loved one. They also confirmed that staff of all grades were freely available should they wish to contact them. It was noted in case files on accident and incident records that staff informed the significant other of the resident when an incident occurred which affected their loved one.

The inspectors observed that there were a few gentlemen who were not actively engaged in the activity programme on the days of inspection.

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

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

Inspection findings

The laundry when inspected was clean, well organised and was equipped with industrial sized washing machines and dryers. A new discreet and effective system for labelling clothing was being developed; however, this system had not been adapted as yet for all residents. The PIC confirmed that it was planned that all residents' clothes would be labelled in this way. No concerns were raised regarding clothes going missing.

There was a policy on the management of residents' personal property. A record of property was completed for each resident on admission. However, a system to ensure that any additional property brought in or returned home by the resident or their family was recorded was not in place.

The laundry was clean, well organised and suitable in size. The inspector spoke with a multi task attendant who was working in the laundry during the inspection. She explained the procedures she follows to ensure that clothing is laundered appropriately and returned to residents.

There was a relaxed atmosphere in the centre and residents told inspectors that they could spent their day as they wished and dip in and out of the programme as much or as little as they wished. One resident told the inspector that she enjoyed helping the staff with cleaning tasks because "I did this all my life".

Many rooms were personalized by residents and staff informed inspectors that they encouraged this. Each resident was provided with a lockable facility by their bedside to allow them secure personal possessions.

5. Suitable staffing

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

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

Inspection findings

The position of PIC is held by Nora Beirne. She works full time at the centre Monday to Friday and is on call out-of-hours. She is a registered general nurse with many years experience in the area of geriatric nursing as well as post graduate qualifications in management, infection control and gerontology. She has been in this post of director of nursing at the centre since August 2000. The person in charge was supported in her role by a clinical nurse manager who work worked on a full time basis and is also responsible for the day to day running of the centre. She in conjunction with the CNM demonstrated a sufficient knowledge of clinical audit with processes in place for auditing information to identify trends and improve the quality of service and safety of residents. When the PIC was absent the CNM is the designated person to take responsibility in her absence. The PIC informed the inspectors that she attended the handover on regular occasions. She said she supervised staff in the delivery of care and had a special interest in maintaining and promoting continence in residents. She gave examples of residents who had returned from the general hospital with catheters or incontinence problems but she had worked with these residents and staff to gain back continence.

As part of the registration process, the inspectors interviewed the person in charge. She could clearly explain to the inspectors how she engaged in the governance, operational management and administration of the centre. She had many years experience as a nurse and in leadership roles which equipped her well with appropriate experience and knowledge to provide leadership at the centre. She was eager to ensure that she 'run a good centre' and ensure compliance with legislation. She demonstrated a working knowledge of the regulations and standards throughout the inspection.

Staff spoken with was clear about their areas of their reporting arrangements and stated there was good working relationships within the staff team.

Outcome 14

There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

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

Inspection findings

The provider employs 36 staff in total which included registered nurses, multi task attendants, catering and administration staff. The inspector viewed the staff duty rota for a three week period. There was a separate rota for nursing staff, multi task attendants and catering/administration staff. The only rota available was the actual rota. This showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff rota required reviewed to ensure that is was clear and that a planned and actual rota was in place.

The rota indicated the clinical nurse manager had sufficient time for management and governance tasks and to support and supervise staff. She informed the inspectors that her time was split with half time (approximately) on governance and management issues. There was a formal nursing on call arrangement in place for outside of core hours. Both the PIC and CNM were on call. In the questionnaires returned to the inspectors the majority of relatives said they found there was generally adequate staff on duty, but on occasions they felt “staff were very busy”. On the days of inspection the inspectors formed the view that the numbers of staff on duty and skill mix were appropriate to meet the needs of residents. Call bells were answered promptly, all residents had adequate assistance at meal times and residents informed the inspectors that “staff were always available to help you”. No nursing or care staff had left the centre within the past 12 months. This ensured that there was continuity and consistency in care. Two part-time chefs had retired.

Copies of the regulations and standards were available to staff. Staff confirmed that these had also been discussed at team meetings.

An up to date record of An Bord Altranais PINs (professional identification numbers) was available for all registered nurses. There was one regular volunteer in the centre. The PIC described how she received an acceptable level of

supervision and support. No Garda vetting clearance was available for this person but the PIC stated that she always chatted to the residents in the sitting room where there was always staff available. This volunteer had worked in a professional capacity in the HSE prior to volunteering at the centre. The PIC stated she would discuss Garda Siochana vetting with this lady without delay.

A detailed policy for the recruitment, selection and vetting of staff was available which was reflected in practice. There was evidence that staff had been inducted on commencement of employment.

The provider and person in charge were committed to providing on going training to staff. A training matrix was available detailing all staff training that had occurred and when refresher training was due. Training of staff was an area where there had been significant input since the first inspection of this centre. In the last year 10 staff had attended training on falls prevention and more training was planned in this area. Five staff had attended training in behaviours that challenge, 31 in basic life support/cardiac life support, 12 in Communication strategies, 13 in palliative care and six nursing staff in medication management. One staff nurse was completing a Masters in Gerontology and another staff nurse had completed the train the trainers course in infection control. Four staff had attended the Train the Trainer course in the restraint policy and it was planned that the centre would train all staff on this policy without delay.

However, not all staff had received up to date mandatory training in fire safety and the safe moving and handling of residents as identified under outcome five. The PIC had identified these staff and ensured inspectors that she would organise training for these staff.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

The centre was purpose built. The environment was bright, clean and well maintained throughout. The sitting room was reorganised after the first inspection and inspectors observed that this provided a more homely comfortable environment. Communal areas such as the day-rooms, visitor's room and dining

room were furnished comfortably. Residents spoken with confirmed that they felt comfortable in the centre.

An enclosed garden was available. This garden was attractive and had an all weather soft impacting safe surface, however, on doors leading into the courtyard no hand rails were in place to assist residents to exit safely.

The kitchen was found to be well-organized and equipped with sufficient storage facilities. See outcome above nine above.

There was appropriate assistive equipment available such as wheelchairs, walking frames, hoists, profiling beds, pressure relieving mattresses and cushions. Internally hand rails were available to promote independence. Hoists and other equipment had been maintained and service records were up-to-date.

There was no wash hand basin in the sluice room and only one sink was available in the three bedded areas.

There were no ccontrols in place to ensure the temperature of the hot water at the point of contact did not pose a risk to residents. Hand testing of the water indicated it did pose a scald risk. Inspectors recorded temperatures of 53 degrees centigrade at some exit points.

Staff facilities were provided which included toilets and a changing room with lockers. Separate toilet facilities were provided for catering and care staff.

The physical environment did not comply fully with the *National Quality Standards for Older People in Ireland.* While the size of the single rooms were deemed to meet the needs of the current residents as they contained a wash-hand basin, call bell, lockable locker and individual wardrobe, bed and comfortable chair, they ranged from 8m sq to 8.5 m sq. Also some residents were accommodated in three bedded rooms.

7. Records and documentation to kept at a designated centre

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

References:
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents

Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

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

Resident's guide

Substantial compliance ☒ **Improvements required*** ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ **Improvements required*** ☐

General records (Schedule 4)

Substantial compliance ☒ **Improvements required*** ☐

Operating policies and procedures (Schedule 5)

Substantial compliance ☒ **Improvements required*** ☐

Directory of residents

Substantial compliance ☐ **Improvements required*** ☒

Cause of death was not recorded in all instances.

Staffing records

Substantial compliance ☐ **Improvements required*** ☒

A sample of six staff files were examined to assess the documentation available, in respect of persons employed. An individual file was available for each staff member. The one outstanding action from the previous report was in relation to staffing records. The PIC had completed a lot of work in this area. However, not all aspects of current legislation were complied with, for example most files had photographic identification but this had not bee authenticated. Additionally not all staff files had three validated references.

Medical records

Substantial compliance ☒ **Improvements required*** ☐

Insurance cover

Substantial compliance ☐ **Improvements required*** ☒

A copy of the providers insurance was made available to inspectors. This detailed that the onus of liability rested with the resident to prove negligence of the staff in relation to the loss before liability would be accepted.

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

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

Inspection findings

Practice in relation to notifications of incidents was satisfactory. Inspectors reviewed a record of all incidents/accidents that had occurred in the centre since the previous inspection and cross referenced these with the notifications received from the centre.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

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

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

Inspection findings

There were appropriate arrangements in place for the absence of the person in charge. The clinical nurse manager grade two (CNM 2) deputised for the person in charge. The provider was aware of her responsibility to notify the Authority, but as yet this was not required.

Inspectors were informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge, the clinical nurse manager, manager of older people's services, nursing, care and catering staff to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

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

Report compiled by:

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

19 August 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Aras Mathair Phoil
Centre ID:	0652
Date of inspection:	9 and 10 August 2011
Date of response:	1 September 2011

Requirements

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

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

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

There were arrangements in place for reviewing the quality and safety of care and quality of life in the centre. However, no audit of accidents/incidents had been completed. Consequently, there was no system to ensure learning for all staff from accidents and serious or untoward incidents.

Action required:

Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre to include the auditing of accident and incident records.

Reference:

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

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: We will develop a system to audit accidents and incidents to ensure learning and best practice for all staff at Aras Mhathair Phoil.	September 30 2011

Outcome 3: Complaints procedures

2. The provider is failing to comply with a regulatory requirement in the following respect: A second person had not been nominated (one who is independent of the person receiving the complaint) to ensure complaints are appropriately responded to and records maintained. Other omissions included the contact details of the HSE complaints officer and contact details of the Chief Inspector.
Action required: Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7). Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.
Reference: Health Act, 2007 Regulation 39: Complaints procedures Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will update our complaints policy to include a person independent to the person nominated in Regulation 39 (5) and also include details of an independent appeals process. It will include the contact details of the HSE complaints officer and contact details of the Chief Inspector.	September19 2011

Outcome 4: Safeguarding and safety

3. The provider is failing to comply with a regulatory requirement in the following respect: The elder abuse policy did not contain a procedure on how to manage an allegation of abuse against a senior member of the management team or outline clear procedures to investigate an allegation of suspected or confirmed abuse.	
Action required: Revise the elder abuse policy to include procedures to manage an allegation of abuse against a senior member of the management team and outline clear procedures to investigate an allegation of suspected or confirmed abuse.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will update our Elder Abuse policy to include procedures to manage an allegation of abuse against a senior member of the management team. We will also outline clear procedures to investigate an allegation of suspected or confirmed abuse.	19 September 2011

Outcome 5: Health and safety and risk management

4. The provider is failing to comply with a regulatory requirement in the following respect: Not all of the staff had up to date training in the safe moving and handling of residents.	
Action required: Provide training for staff in the moving and handling of residents.	
Reference: Health Act 2007 Health Act, 2007 Regulation 30: Health and Safety 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:	

Two members of staff have completed training in moving and handling since inspection. All staff now have up to date training in moving and handling. Arrangements will be made to update staff as required.	Completed and ongoing

5. The provider is failing to comply with a regulatory requirement in the following respect: The statutory fire safety certificate was outstanding. Not all staff had been trained in fire safety evacuation procedures within the past 12 months.	
Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.	
Action required: Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.	
Reference: Health Act, 2007 Regulation32:Fire precautions Standard 26:Health and safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Training in fire drill and fire practices for staff and residents will take place on September 29 2011. Once this has occurred all staff will have up to date training in fire safety. The registered provider is in liaison with fire safety officer in technical services re provision of completion of fire certificate. We are awaiting report of the fire inspection carried out on August 3 2011.	September 2011

Outcome 7: Assessment and Care Plan

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

One resident did not have a care plan to ensure safe management of epilepsy.

Action required:

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

Action required:

Ensure the care plan accurately reflects the findings of the assessment of need.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Since the inspection we have reviewed the care plan and have now included the management of an emergency situation e.g. prolonged seizure and status epileptics.	Completed August 2011

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

Not every resident was engaged in activities. Some male residents were observed not to be actively engaged in the activity program provided.

Action required:

Provide opportunities for each resident to participate in activities appropriate to his/her interest and capacities.

Activities :

Implement findings arising from survey on meaningful activities scheduled for August 2011.

Reference:

Health Act, 2007 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: Survey on meaningful activities in progress and we will review our activity programme based on the findings.	October 28 2011

Outcome 10: Contract for the provision of services

8. The provider is failing to comply with a regulatory requirement in the following respect: Each resident had not been provided with a valid contract of care.
Action required: Agree a contract with each resident within one month of admission to the designated centre.
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All current residents have a contract of care. We will ensure that a valid contract of care is agreed with each resident within one month of admission to Aras Mhathair Phoil.	Ongoing

Outcome 12: Residents' clothing and personal property and possessions

9. The provider is failing to comply with a regulatory requirement in the following respect: An up to date record of each resident's personal property, signed by the resident was not available.

Action required: Maintain an up to date record of each resident's personal property that is signed by the resident.
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will introduce a system to ensure that any additional property brought in or returned home by the resident or their family will be recorded.	October 31 2011

Outcome 14: Suitable staffing

10. The provider is failing to comply with a regulatory requirement in the following respect: Three references and evidence of medical and physical fitness was not available in one of the staff files inspected in accordance with schedule 2 records.
Action required: Have all the required schedule 2 documents available for all staff.
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: We will make every effort to ensure that all the required schedule 2 documents are available in all staff files.	November 25 2011

11. The Person in Charge is failing to comply with a regulatory requirement in the following respect: The only rota available was the actual rota.
Action required: Maintain a planned and actual staff rota, showing staff on duty at any time during day and night.
Reference: Health Act, 2007 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 will maintain a planned and actual staff rota on a weekly basis for all staff.	12 September 2011

Outcome 15: Safe and suitable premises

12. The provider is failing to comply with a regulatory requirement in the following respect: There was no wash-hand basin in the sluice room. There was no cleaning room. There were no controls in place to ensure the temperature of the hot water at the point of contact did not pose a risk to residents. Hand testing of the water indicated it did pose a scald risk. Inspectors recorded temperatures of 53 degrees centigrade at some exit points. Doors leading to the courtyard had no handrails in place to assist residents to exit safely.
Action required: Provide a sufficient supply of piped hot and cold water, which incorporates thermostatic control valves or other suitable anti-scalding protection.
Action required: Provide a safe system to comply with best practice in relation to infection control.

Action required: Provide and maintain external grounds which are suitable for and safe for use by residents.	
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: We are currently in liaison with maintenance to provide a Wash-hand basin in the sluice room. We are currently looking at an area to convert into a cleaning room to comply with best practice in relation to infection control. We are in liaison with technical services regarding the water temperature and they are progressing the issue. We have forwarded a risk assessment to technical services and the registered provider. We are in discussion with an occupational therapist on installing handrails on the doors leading into the courtyard to assist residents to exit safely	 October 1st 2011 November 31 2011 October 31 2011 October 31 2011

0utcome16: Insurance Cover

13. The provider has failed to comply with a regulatory requirement in the following respect: The insurance cover stated does not meet the legislative requirements.	
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 31: Financial Procedures	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: The registered provider and person in charge are liaising with finance in Galway re an amended certificate to include the above.	31 October 2011

Outcome 16: 0perating Policies and Procedures – Directory of Residents

14. The provider is failing to comply with a regulatory requirement in the following respect: Cause of death was not recorded on all occasions when residents passed away in the centre.	
Action required: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) 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 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Following inspection the cause of death of residents whose death occurs at Aras Mhathair Phoil is being recorded. This is recorded in the medical file and a separate folder will be kept in relation to all causes of death.	Ongoing

Any comments the provider may wish to make:

Provider's response:

We thank you for your co-operation during your visit at Aras Mhathair Phoil and we look forward to a collaborative working relationship to ensure we maintain quality standards for the benefit of residents, their families, and staff.

Provider's name: Catherine Cunningham

Date: 1 September 2011