Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Mc Bride Community Nursing Unit
Centre ID:	0647
Centre Address:	The Crescent Westport Co. Mayo
Telephone number:	098-25592
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Email address:	rita.boyle@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Mayo PCCC - HSE West
Person in charge:	Rita Boyle
Date of inspection:	4 and 5 May 2011
Time inspection took place:	**Day 1: Start:** 09:00 hrs **Completion:** 18:00 hrs **Day 2: Start** 09:00 hrs **Completion:** 17:00 hrs
Lead inspector:	Mary McCann
Support inspector(s):	Damien Woods
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **Announced** ☐ **Unannounced**

About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

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

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

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

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

About the centre

Description of services and premises

The McBride Community Nursing Hospital is a single-storey, purpose-built facility, which opened in 1975. It accommodates up to 37 residents requiring long term care and two respite care beds. Day care is also provided Monday to Friday for up to 14 residents.

An open porch leads to the front door which opens into a foyer area. A reception office is situated on entry with a corridor to the left and right. The right corridor leads to the lounge and further on to individual bedrooms. The left corridor leads to the dining area, and kitchen. The kitchen has a serving hatch opening into the dining room. The oratory is located in close proximity to the sitting room. Directly off the foyer area is that day room/lounge area.

Accommodation includes 21 single rooms with a sink, six three bedded rooms of which two have shared en suite shower, toilet and wash-hand basin facilities. The remaining one has exclusive en suite facilities to include shower wash-hand basin and sink. There are five additional toilets, three showers and one assisted bathroom. Separate staff changing and toilet facilities are available. A smoking room with various other rooms including storage, clinical, staff offices, sluice, cleaning, laundry and staff facilities complete the structural layout.

The centre is quadrangle in shape with two enclosed garden that provide a safe accessible outdoor area for residents. There is very limited car parking to the front of the building.

Location

The centre is located in the town of Westport Co Mayo, in a turning off the main street. It lies in close proximity to St Mary's Crescent which is a residential area. A church is in close proximity to the centre.

Date centre was first established:	1975
Number of residents on the date of inspection	34 long stay plus 2 respite
Number of vacancies on the date of inspection	3

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	15	3	9	9

Management structure

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

The Person in Charge is Rita Boyle (known in the centre as Director of Nursing). She reports to Mr Fahey. He attends the centre on a four to six weekly basis and as required. He is easily accessible by phone. She is supported in her role by the Clinical Nurse Manager (Grade 2). The Clinical Nurse Manager, clerical, general operative, laundry and catering staff, report to the Person in Charge. The staff nurses report to the clinical nurse manager. The carers/multi-task attendants report to the nursing staff.

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	4	2	2 Plus contract cleaners	2	1*

*maintenance staff – general operative

Summary of findings from this inspection

This was an announced registration inspection and the second inspection by the Health Information and Quality Authority (the Authority). This inspection took place over two days. A scheduled monitoring unannounced inspection had previously been carried out by the Authority, Social Services Inspectorate on the 28 July 2010. An action plan detailing areas which required attention was forwarded to the provider post this inspection. As part of the registration inspection these actions were reviewed by the inspectors. Some improvements had been made since the last inspection. The report contained 19 actions. Six actions were completed, 11 were partially completed and two were not completed. Those partially completed or not actioned are repeated with further actions at the end of this report.

There were some improvements in the provision of meaningful activities including commencement of social care histories. A second person had been nominated in the centre to ensure complaints are appropriately responded to and recorded. There was a greater focus on quality assurance systems, restraint management and further development of policies and procedures, staff had been trained in basic life support and a defibrillator was available.

The provider had submitted an application to be registered for 39 dependent persons aged 18 years and over for long-term and respite care under the Health Act, 2007 (Registration of Designated Centres for Older People) Regulations 2009 and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations (as amended).

In order to gain registration the provider has to satisfy the Chief Inspector that he/she is a fit person and will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and show a willingness to comply with the Authority's standards. The person in charge confirmed to inspectors that she had completed the fit person self assessment document and discussed it with the provider. He agreed in interview that he supported the areas identified for review in the document. Following completion of the fit person entry programme, the person in charge had identified areas for development. Inspectors spoke with the person in charge in relation to these identified areas which she has designated as requiring review. Some of these issues identified for improvement in the fit person's self assessment had been completed, for example:

- Policy on nutrition and hydration
- Signs on bathroom doors to assist residents with independence around the centre.

Area which had been identified but had not been addressed included:

- development of policy on falls management
- involve residents and their significant other in development of their care plan and reviews of care
- installing wash hand basin in the laundry
- provision of a suggestions box
- personalise bedrooms to make the residents room easily identifiable
- development of an audit policy

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

Fit person interviews were carried out with the provider, the person in charge and the CNM2 who deputises for the person in charge in her absence. Staff interviewed for the purposes of fitness was knowledgeable of and committed to meeting the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

While the inspectors found the centre to be adequately managed and were satisfied with the standard of medical and nursing care provided, staff acknowledged that the documentation required improvement. They were able to assure the inspectors that they delivered safe care to residents; this was confirmed by the residents in person and in their completed questionnaires and by relatives in their questionnaires. All policies and procedures required by current legislation were in place. Residents and relatives were complimentary of the staff and positive in their comments regarding the care provided. The risk in relation to the numbers of staff on night duty was documented by the Authority at the last inspection. The inspectors were concerned about the implications this poses to meet the adequate care needs of residents and for staff to be confident that they will be able to safely evacuate all residents swiftly should the need arise. One staff nurse and one care assistant are rostered to work from 21:00 hrs to 07:45 hrs to meet the needs of up to 39 residents, many who were highly dependent. This was discussed with the provider and person in charge who both acknowledged that this posed a risk to residents and that they had informed senior management of this risk. They informed inspectors that they would continue to monitor this risk.

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

Comments by residents and relatives

Inspectors received eight completed questionnaires from residents and eleven from relatives/carers. These contained positive comments and were complimentary of the service provided. Inspectors also met with residents and relatives during the inspection. They were also complimentary of the service provided and felt that the centre was "great", and the care delivered "wonderful".

Many of the relative questionnaires stated that the centre “was a great local resource to have and felt that it was required by the local community and utilised well”. Many described positive aspects of the fact that it was a joint day and residential facility.

Two relatives commented on the lack of activities available at the centre for resident who were unable to participate in ‘games’.

Residents and relatives could clearly identify the person in charge. They were positive in their comments in relation to her commitment to providing a quality service. They described her as “kind” and “a caring person”. They said she was “approachable” and they could talk to her if they had a problem. One relative commented on how she resolved issues swiftly when they were brought to her attention. Relatives confirmed that she was in the centre on a daily basis, some stating “we see her here every day”. Some residents were unable to verbally express their views due to communication difficulties and confusion associated with dementia.

Relatives were of the view that there were adequate staff on-duty most of the time but two questionnaires commented that ‘staff didn’t have enough time’. Residents stated that staff chatted with them “about the local news”.

Residents spoken with stated that they felt safe in the centre. They stated that “there was always someone about day or night”. Many commented positively on the religious component to the activity programme. Mass was celebrated on the first day of inspection and residents described how much they enjoyed mass. They also confirmed that they read the daily newspaper which was provided.

Overall findings

1. Governance: how well the centre is organised

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

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

Evidence of good practice

A clear organisational structure was in place and the person in charge was actively involved in the day-to-day operation of the centre providing ongoing support and supervision to the nursing and care staff. The person in charge confirmed that the designated provider was freely available for support and advice and attended the centre on a monthly basis. Staff interviewed was knowledgeable about their roles and responsibilities. They were able to describe the staff structure and the reporting mechanisms in place, to ensure appropriate delegation, supervision and competence in the delivery of care to residents. They confirmed that the person in charge was easily accessible and onsite daily at the centre. Inspectors observed the person in charge working with the staff delivering direct care to residents. The person in charge informed the inspectors that she worked with staff 'on the floor' on a daily basis and this gave her the opportunity to supervise, support and guide staff and ensure the delivery of safe quality care.

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

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

The person in charge demonstrated a commitment to provide a safe quality service. She had commenced a system for the review of the quality of care delivered to residents. An audit of assessments completed in care files had taken place in December 2010 and the findings of this were discussed and reviewed at staff meetings. A key worker system was put in place with specific staff responsible for specific resident documentation, development and review. Plans were in place to complete quarterly audits in relation to the environment, restraint care planning and medication charts. The person in charge was clear that enacting recommendations from these would enhance outcomes for residents.

One of the 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. Resident's finances were transparently managed and two signatures were recorded at all times. The ongoing balance was explained to the resident or their representative and a statement was available as requested.

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

A computerised directory of residents who were currently accommodated in the centre was available. Information requested by the legislation was recorded, for example, personal details of residents, next of kin, and general practitioner (GP), the dates of admission, discharge or transfer outside the centre. This was reviewed by the inspector and found to be up to date, easily accessible and well maintained. The person in charge confirmed that she would download a back up hard copy every month.

Hand gels, gloves and aprons were available throughout the centre and inspectors observed staff using these. A missing person's policy was in place which included clear procedures to guide staff should a resident go missing. Photographic identification was available for each resident. A description sheet was available which would assist emergency services should a resident go missing.

All policies required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were in place.

Some improvements required

A centre-specific complaints procedure was on display in the centre which was comprehensive in nature and provided clear guidance to staff on how to deal with any type of compliant. It also contained a procedure with regard to provision of information to elected public representatives. A summary of the policy/ procedure was available in the resident's guide. Residents confirmed that if they had a complaint they would talk to the person in charge or the nurses. All residents spoken with confirmed that they were satisfied with the service provided and had no complaints at the current time. The complaints log was made available to the inspectors. While it contained details of the complaint and the investigative process was detailed, there was no evidence of whether the complainant was satisfied with the outcome. While the date the complaint was made was recorded there was no further date entry with regard to the timelines of the investigative process or when the compliant had been deemed closed.

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

While written evidence confirming that the building meets the statutory requirements of the fire authority in relation to the use of the building as a residential centre for dependent persons was submitted to the Authority, however, this certification did not detail the qualifications and experience of the person citing compliance or when the inspection took place to assess compliance with current legal requirements.

While an individual, record of each resident's personal property was recorded on admission this was not updated to reflect changes throughout the residents stay. Inspectors confirmed with residents that there were no instances of missing items. The person in charge said she had plans in place to address this.

A copy of the providers insurance was made available to inspectors. On analysis of this, it was not clear what cover was provided for residents' property therefore it dif not comply with current legislation. While a contract of care had been agreed with some residents many residents had not been issued with a contract of care detailing the terms and conditions of the service provided which included the fee payable and any extras to be paid for, such as hairdressing.

The Authority had received notifications of accidents and/or serious incidents and quarterly returns from the centre.

The inspectors reviewed the process for recording incidents and accidents. Staff spoken with relayed a positive attitude towards reporting incidents. A high percentage of incidents related to falls which were un-witnessed. While there was good evidence of risk minimisation in relation to falls which included review by the physiotherapist, further review by the doctor and /or hip protectors, use of low beds and/or crash mats, neurological observations were not always recorded where a resident hit their head or a fall was un-witnessed.

Significant improvements required

While a plan was in place to manage risks which included a centre-specific risk management policy, (this did not comply with current legislation) and a health and safety statement, an emergency plan was available which detailed procedural guidelines in relation to flooding, fire, utility failure drinking water contamination and burglary. It specified the control measures to manage these risks. Contingency arrangements were provided for should, it be deemed necessary to evacuate the building.

The most recent risk assessment had been completed on the 9 February 2011. This detailed the hazard, the risk, existing control measure and a risk rating using the 'traffic light system' and the person responsible for monitoring and ensuring controls were in place to minimize the risk. This gave a good assessment of the risk and the controls necessary to minimise the risk. Two significant risks that were identified by the inspector at the last inspection remained a risk on this assessment. These were in relation to the levels of staffing on night duty and the implications this poses to meet the adequate care needs of residents and for staff to be confident that they will be able to safely evacuate all residents swiftly should the need arise.

The inspector was concerned that the number of staff on duty from 21:00 hrs until 07:45 hrs was not appropriate to the assessed needs and dependencies of the residents and the design and layout of the centre. One staff nurse and one care assistant are rostered to work during this time period to meet the needs of up to 39 residents, many who were highly dependent. This was discussed with the provider and person in charge who both acknowledged that this posed a risk to residents and that they had informed senior management of this risk.

The other risk identified was the location of the river. The control identified was to extend the fencing inside the hedge towards the front of the unit. It also detailed to contact Westport Town Council with regard to erecting railings along the river bank to the rear of the unit. The provider confirmed that he had contacted the town council in relation to this but had not received a reply. He stated that he would follow up on this. Current controls in place include accompanying residents outside the building who are at risk and a hedge is insitu between the unit and the river. Other risks identified included communal space, lack of hand washing facilities in the laundry, congestion in the car park and staffing levels at night.

While a weekly check was completed on fire alarms, fire doors, emergency lights and a quarterly inspection of servicing and testing of the fire detection and alarm system, an individual evacuation assessment for each resident was not in place. Additionally not all staff had up to date mandatory training in fire safety and prevention.

2. Quality of the service

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

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

Evidence of good practice

There was good supervision of residents in the sitting-room area. On the days of inspection, inspectors observed that there was a staff member on all occasions in the sitting area.

A call bell system was in place. Call bells were available at each resident's bed with which was accessible from their bed and a chair by the bed. A call bell was also available in all toilets. Residents confirmed that staff responded to call bells in a timely fashion. Staff was observed by inspector to respond swiftly on the days of inspection. One of the inspectors spoke with staff in relation to this and staff was very clear as to the importance of responding swiftly to call bells.

Residents' privacy and dignity were respected by staff. Inspectors observed staff knocking on bedroom, toilet and bathroom doors and waiting for permission to enter. Residents were smartly dressed and their clothes looked well cared for. Residents spoken with described to inspectors how could choose what clothes they wished to wear. Staff were observed to interact with residents in a courteous manner and to spend time chatting with residents.

Resident's religious rights were respected. Mass was celebrated each Wednesday and was available on the on the radio each morning. Eucharistic ministers visited daily and residents from other denominations are visited by their clergy according to their wishes. The advocacy service attends the centre twice weekly and once they are qualified in July they will play a greater role in the lives of the residents. The person in charge informed the inspectors that she has plans that they will run the residents committee ensuring that this gives the residents an independent avenue to discuss openly any comments they wish to make with regard to the service. The person in charge confirmed to inspectors that no satisfaction surveys were completed to date but this was something she planned to do.

Residents confirmed there was a choice of main course at dinner time and the food was good and portions were adequate. They described that there was a good variety of food available. The chef was knowledgeable with regard to which residents had special diets, including diabetic or low fat. There was ample food stocked in clean storage conditions. Catering and care staff has been trained in food hygiene. Residents who required assistance with nutritional intake were respectfully assisted. Staff was 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.
Fresh fruit and jugs of water were available in communal areas and staff regularly offered drinks to residents. There was also a variety of drinks rounds throughout the days of inspection. Relatives spoken with informed inspectors that they were always warmly welcomed by the staff and could visit at any time. Inspectors observed that the tea was a social and interactive occasion.

All persons spoken with were positive in their views of the service provided and the staff who provided the service. National and local newspapers and magazines were provided.

Some improvements required

Prior to admission a referral form detailing biographical data and a brief needs assessment is forwarded to the centre prior to admission. When people are referred they or their significant other can visit the centre and obtain up to date information about the centre. The person in charge liaises with the general practitioner (GP) regarding medical needs and medication is always available for the resident on admission. However, the person in charge did not routinely assess the resident in person prior to admission to validate the 'paper assessment' and to ensure that the centre could meet the needs of the prospective resident and the admission would not impinge on the needs of current residents.

While a programme of activities was displayed in the day room which included art, aromatherapy, card playing, rosary, mass, music and bingo inspectors observed that many residents were not engaged in any meaningful activity other than mass on the days of inspection. While completion of life histories had commenced, these documents need to be linked to planning of meaningful activity so as to enhance the person centred approach to activities and ensure that personal interests are linked into the programme of activities.

There was a policy for end-of-life care which provided direction to staff on the care of residents who were dying, while there was good recording of individual end of life care wishes end of life care wishes in some case files reviewed this was not consistent on all files.

Significant improvements required

The inspector noted on the previous inspection that due to the design of the building, residents' privacy was impinged. The day room/sitting room was also used by staff to cut through from the front of the building to the back of the building. The response received to this action from the last inspection detailed that the provider was going to engage with the HSE estates department to review the current layout. This was discussed with the provider and person in charge who both confirmed that while the estates department had been requested to attend the centre they had failed to do so to date.

Restraints measures in use included lap straps and bed rails. While some documentation in relation to consent and review of restraint was reviewed in the case notes these did not comply with best practices. Further work was required in order to ensure best practice and protect safety and human rights of residents. Care plans in relation to restraint were not reflective of best practice, for example, risk assessments did not identify alternatives to the use of the restraint measure, and there was no supporting evidence to suggest that

the restraint measure was used as a last resort. The rationale for necessitating the use of the restraint measure was not stated on all occasions.
Where a resident was cognitively impaired no narrative was available in any of the case files reviewed that an assessment of the capacity of the residents' ability to consent to the restraint measure had taken place. There was no documentary evidence of on-going review of consent for the use of restraint measure. Documentation did not support that an explanation, which was likely to be understood by the resident and/or significant other was given to explain the potential risks and benefits of using the restraint measure, not using a restraint measure and any other suitable alternatives. The case files reviewed did not clearly outline in cases where the resident was competent that the consent of the resident was obtained. It was not consistently documented on files reviewed that where a decision is made on behalf of a resident it must always be made with their best interests in mind and involve a multi disciplinary approach.

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

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

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

Evidence of good practice

Inspectors talked with residents with regard to their healthcare. They informed inspectors that they were well cared for and they regularly seen their general practitioner. Inspectors 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 high level of dependency. Fifty percent of residents had been assessed as maximum or high dependency. A large proportion had cognitive impairment and/or difficulty with communication.

Residents had good access to their GP. Many residents retained their own GP on admission to the centre, which benefited the residents as they had knowledge of the resident's previous medical status.

A policy on responding to medical emergencies and a range of equipment to enable nursing staff to respond to a medical emergency was available at the centre.

There was good evidence of infection control measures in place. Hand sanitizers were strategically placed throughout the centre and staff had received training on infection control measures. Good evidence of hand washing was observed.

Some improvements required

In relation to input for allied health care professionals, there was varied evidence of accessibility and service provision. A physiotherapist was available to the centre one day per week. There was good evidence on case files reviewed that the physiotherapist was monitoring some of the residents. The person in charge informed the inspectors that one of the care staff worked closely with the physiotherapist and complimented their work while they were not in the centre. Chiropody services are available on a regular basis. Ophthalmic services attend the service yearly and all residents have an eye test. Eye check ups are also arranged as required. Audiology services were available via GP referral. The person in charge stated that the centre had developed good links with community mental health services and residents were regularly reviewed by the community mental health services. However, access to occupational therapy services, dietician services and speech and language services was problematic.

A medication policy was in place which staff was familiar with. It detailed procedures for prescribing, administering, recording and storing of medication. The prescription for regular and PRN (as necessary) medication was written on the same page. It was not always clear until careful consideration had taken place as to how the medication was prescribed. Some prescription charts were incomplete as they did not include weight, age and date of admission or drug sensitivity. A maximum dose for PRN (as required) medication was not recorded. One of the inspectors accompanied a nurse during the medication round and observed her practice in administration. Recent photographic identification was attached to the each medication chart. The person in charge informed the inspectors that the centre was in the process of changing prescription charts and was going to obtain a chart which has a designated section for PRN and regular medication.

While a lot of work had been undertake in relation to the organisation of care files sine the last inspection, further work was required to ensure the delivery of safe quality care to residents. Staff had reviewed the way information in relation to residents was stored. A case file containing all care documents was available for each resident. This file was well organised and information was easily accessible. Assessments were completed such as continence, dependency level and nutritional status. Social care assessments were completed for a minority of residents. However, there was poor evidence of regular review.

There was poor linkage between residents' assessments and the development of the care plans, consequently care plans did not inform person centred quality care provision or did not support good clinical decision making. There was problems detailed in the daily kardex where there was no corresponding care plan to inform care. Although residents reported to inspectors that they were happy with the care they received, there was a lack of formal resident and significant other involvement. Where residents had dementia or were cognitively impaired, there was no narrative detailing the assessment of the capacity of the resident to consent to the care plan. Care plans were not consistently evaluated as required by legislation.

The person in charge is a representative on the 'HSE West Older Person's Residential Services Nursing Documentation Project'. This group are in the process of undertaking a structured review of current documentation and plan to make recommendations with regard to the most appropriate nursing documentation for use in designated centres managed by HSE West. She informed inspectors that this group will be looking at care pans as a priority and the centre will adapt the recommendations from this group.

Pain assessment charts were not observed to be completed in files. Assessment and documentation of pain management and of residents' response to analgesia did not comply with best practices thereby ensuring effective monitored pain relief.

While there was good evidence of access to a GP and an out-of-hours service is also available, there was poor evidence in medical files reviewed that medical staff were reviewing residents medication as required and in any event at three monthly intervals.

Significant improvements required

The person in charge stated that the centre did not have access to wound care specialist services. One man had a pressure sore at the time of inspection. A dietician had not reviewed him nor had specialist advice from wound care specialist services been obtained. The risk register detailed that there was a risk of sub optimal care to residents due to lack of timely access to dietetic and speech and language services. Inspectors discussed with the provider the need to arrange for access to dietetics and wound specialist input. He stated that he would discuss this with senior personnel.

A nutritional policy was available and the centre was assessing the nutritional needs of residents on admission. While some files supported that weights were recorded regularly, there were many instances where weights were not recorded regularly or frequency of weighing reviewed in response to residents changing needs.

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 purpose built in 1975 and designed to meet the needs of dependent persons. The centre was clean and well maintained. Since the last inspection locks had been provided on sluice room doors, a cleaning and maintenance programme had been put in place and the ventilation was working in the laundry.

A contract was in place for the cleaning of the premises and a cleaning schedule was available and signed on a daily basis. The grounds were well maintained. A reception area located inside the main entrance where a receptionist was available to assist with enquiries. A nurses' station and toilet was located in close proximity to the day room which provided a point of contact for residents and visitors. The grounds were well kept. The design of the building allows freedom of movement for residents to walk around as there is a corridor around the main sitting area and the enclosed gardens. Handrails were available on both sides of this corridor to assist residents with maintaining independence. The corridors were clear and unobstructed.

A smoking room is available for residents use. Some of the bedrooms were found to be personalised with photos but dormitory areas were noted not to be personalised. There are two accessible courtyard garden areas, available for residents use. These provided a safe accessible outdoor area for residents. There was suitable lighting provided in each bedroom to meet the needs of each residents. A separate laundry room was available. Clothes were discreetly labelled and no residents voiced any concern in relation to the care of their clothes.

There were 21 single bedrooms and six bedrooms were occupied by three residents each. A sufficient number of bathing and toilet facilities to meet the needs of residents were available. Showers were level with the floor finish providing ease of access. Inspectors found there was suitable and sufficient equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. Hoists and mobility aids were available in toilets and bathrooms to assist people with maintain their independence. Pressure relieving equipment, e.g. air mattresses and cushions are provided for residents who are at risk of pressure ulcers. A service contract was in place which covered breakdown and repair for all beds, air mattresses and other equipment, used by residents. Inspectors reviewed the records of servicing to electric beds and hoists. Equipment was serviced in January 2011.

The person in charge told the inspector she had access to an on call maintenance department to undertake emergency and routine repairs.

Smoke detectors were located in all bedrooms and general purpose areas. Emergency lighting was provided throughout the building. An inspector viewed contracts of the servicing of fire alarms, smoke and heat detectors. These were last serviced in April 2011. Fire extinguishers were serviced annually and these were last serviced in July 2010. The fire alarm was tested routinely. Weekly fire checks were completed on fire alarms, fire doors, emergency lighting and on the generator and records were available to support these checks. A quarterly inspection of servicing and testing of fire detection and alarm system occurs. Fire escape routes were checked frequently to ensure they were unobstructed. Notices to indicate the procedure to be followed in the event of a fire were in place throughout the building. The HSE fire officer had attended the centre on the 16 April 2011.There was a contract for the collection of clinical waste which was viewed by the inspector. All clinical waste was tagged to ensure traceability. General clinical waste was stored securely.

Good stocks of dried ingredients, fresh fruit, vegetables, milk, meats and eggs were evident. Specific foods for special diets such as sugar free jam and low fat options were available. There were separate staff changing and toilet facilities provided for nurses, catering and support staff. A staff dining area was also available and a further staff toilet.

Gloves and plastic aprons were visibly available, the staff informed the inspector that continence aids, and cleaning materials were readily available.

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

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

Some improvements required

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

No suitable private area which is separate from the resident's bedroom was available to meet with visitors. This is particularly important as some residents have shared bedroom accommodation.

There was no wash-hand basin in the sluice room or in the laundry room.

There was inadequate space for drying clothes in the laundry room. This is necessary for items that cannot be placed in the tumble dryer.

Significant improvements required

The hot water at the point of contact to residents was above 43 degrees and presented a scald risk to residents.

Minor issues to be addressed

The person in charge informed the inspector that she had requested that the local fire officers attend the centre to carry out a familiarisation visit but this had not occurred to date.

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

Communication links throughout the centre were good, ensuring continuity of care. A residents' guide available which contained information to assist prospective residents to make a decision regarding with regard to the services available at the centre. This complied with legislation with the exception that it did not contain a copy of the contact of care. A suggestions box was available on entry.

A nurses' dairy detailing daily issues and resident appointments was used by staff to promote communication. A nurse's liaison book was also in place. This detailed any medication changes that occurred on each day.

Daily national and weekly local newspapers were available. A cordless phone was available to facilitate resident's privacy taking phone calls. Some residents also had personal mobile phones. A notice board detailing the day date and activities was available in the day room. Residents stated that they could talk to staff at any time.

The inspectors were told by residents that the person in charge was always available and they felt that communication was welcomed and encouraged. Relatives were satisfied with information provided by staff about residents' healthcare and general wellbeing. Relatives confirmed in person and on the completed questionnaires that staff communicated regularly with them and they were kept updated in relation to the care of their relative.

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

The daily menu was displayed in the dining room. There were notices boards located around the building containing information on the activities planned for the day and the complaints procedure. A cordless phone was available which enabled residents to take calls in privacy.

Staff meetings were held and minutes indicated a range of topics were discussed which included polices and procedures and the analysis of any audits that had recently occurred.

The person in charge directly supervised and worked with staff. Inspectors observed that the person in charge had good interpersonal and social skills when interacting with residents and staff. Daily staff handover meetings which informed the incoming staff group of the health and wellbeing of the residents took place at the change of each shift. Inspectors noted that residents and staff files were maintained confidentially. Records required by the legislation were stored securely and accessible when requested.

A communication policy was in place and there was evidence of good communication links between nursing and catering staff.

Some improvements required

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

Inspectors observed that some residents had communication difficulties due to dementia or cognitive impairment. However, the building lacked orientation cues for residents with dementia. For example, bedrooms and 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.

Minor issues to be addressed

A comprehensive written operational policy and procedure on communication was available. However there was a communication observation chart available as part of this policy. There was no evidence on any of the files that this chart was in use.

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 centre was welcoming to the inspection team and there was a relaxed atmosphere in the home during the inspection. Staff was observed to get on well together and to assist residents with their requests. Staff spoken with displayed a positive caring attitude towards caring for dependent persons. The person in charge was clear that she wished to work with the authority and wanted to improve outcomes for residents and ensure the delivery of safe quality care to residents.

A comprehensive recruitment policy was available outlining the recruitment practices to employ staff. Staff informed inspectors that they obtained job descriptions detailing the principal duties and responsibilities of their post. An induction programme was in place on commencement of employment.

Staff informed inspectors that they were happy in their work and felt supported by the person in charge. A large proportion of the staff had worked in the centre for many years and was knowledgeable of the residents and local services that the residents could access. Some staff knew relatives of the residents and the local history and talked to the residents re this. A key worker system had recently been introduced in the centre.

The provider employs 33 staff in total which includes a whole-time equivalent of one director of nursing, one clinical nurse manage, 9.5 registered nurses and 18 support staff. In addition, there are two administration staff and a chef. Catering staff interviewed confirmed that their Hazard Analysis Critical Control Point (HACCP) training was up to date. Currently all care staff of with the exception of one who is a multi task attendant have Further Education and Training Awards Council (FETAC) level five training in the care of older people. Staff wore identification badges detailing their name and position.

The inspector viewed the staff rota and found that the planned staff rota matched the staffing levels on duty. The staff roster detailed their position and full name. A registered nurse was on duty at all times. When the person in charge was on duty there was another staff nurse on duty thereby enabling her sufficient time for management and governance tasks and to support and supervise staff. There was a system in place to provide cover in the absence of the person in charge.

The clinical nurse manager deputised in her absence. A chef is on duty every day. A staff handover occurred at the commencement of the morning and night shift.

The person in charge informed the inspectors that agency staff was not employed at the centre and leave was planned in advance. Where there were unplanned absences due to unforeseen circumstances, part time staff are organised to work extra shifts. This assists with continuity of care and ensures that residents are familiar with the staff.

Staff records were available to support that training was provided and staff spoken with confirmed their attendance at training. In the last year, staff had attended training on basic life support, elder abuse reporting and protection, manual handling, food hygiene, nutritional assessment of residents' and end of life care.The record of An Bord Altranais personal identification numbers for registered nurses was inspected and found to be in up to date.

Staff spoken with was knowledgeable of their responsibility to report any allegation of abuse.The person in charge stated that all staff had up to date training in manual handling elder abuse.

Some improvements required

A sample of staff personnel files were reviewed by inspectors. While a proportion complied with current legislation, there were still files, which required further documents to comply for example Garda Síochána vetting and three references.

Significant improvements required

Not all staff had completed mandatory training on fire safety and safe evacuation procedures. The person in charge informed the inspectors that she would ensure that training in this area would be scheduled as soon as possible to ensure compliance with current legislation.

Specific training in care of the elderly with dementia, the management of behaviour that challenges, and restraint management had not been completed by sufficient staff to guide and inform staff in the delivery of specialist care and ensure care was delivered in line with evidenced based practice to in ensure the positive outcomes for residents.

Minor issues to be addressed

No formal arrangements were in place in relation to supervision of staff or appraisal for staff.

Closing the visit

At the close of the inspection visit, a feedback meeting was held with the provider person in charge, catering staff and nursing 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
24 June 2011

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

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Mc Bride Community Nursing Unit
Centre ID:	0647
Date of inspection:	4 and 5 May 2011
Date of response:	15 August 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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

The number of staff on duty from 21:00 hrs until 7:45 hrs was not appropriate to the assessed needs and dependencies of the residents and the design and layout of the centre.

Action required:

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

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

Action required: Provider to ensure that they are satisfied that procedures are in place to safely evacuate the residents at all times taking into consideration the residents specific needs and dependency levels.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 9: Health Care Regulation 16: Staffing Regulation 14: End of Life Care Regulation 31: Risk Management Procedures

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Requirement for additional staff for night duty has been referred to senior management.	Awaiting decision from HSE Senior Management

2. The provider is failing to comply with a regulatory requirement in the following respect: The provider failed to ensure that adequate fire safety management arrangements and equipment were in place to ensure residents safety in the event of fire.
Action required: Ensure staff have up to date mandatory fire training at all times.
Action required: Conduct a risk assessment on each resident to assess how each resident would be evacuated if there was an incident or fire which would enable staff to safely evacuate the residents. Document an individual plan for each detailing how resident is to be safely evacuated.
Action required: Ensure all staff is familiar with the contents of each individual plan and a copy is easily accessible at all times.

Action required: Make adequate arrangements to include appropriate equipment to ensure safe evacuation of residents and staff in the event of fire.	
Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Regulation 6:General Welfare and Protection Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Fire training is ongoing at intervals throughout the year, thirty staff has attended fire training so far this year. The next training date is arranged for September 2011. Once this training session is completed all staff will have up to date fire training. A risk assessment for safe evacuation in case of fire has been conducted on each resident and a master copy is accessible to all staff. Available equipment is in line with risk assessment	September 2011 and ongoing. Completed

3. The provider has failed to comply with a regulatory requirement in the following respect: While a risk assessment of the external grounds and of the river had been completed and the provider had contacted the local council in relation to recommendations to date, the recommended controls had not been implemented.
Action required: Ensure the external grounds are maintained in a safe manner and are suitable for use by the residents. Implement any recommended controls to minimise risks to residents.
Reference: Health Act, 2007 Regulation 19: Premises Standard 26: Health and Safety Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: Arrangements are being made to erect an appropriate fence at the boundary.	 September 2011

4.The provider is failing to comply with a regulatory requirement in the following respect: The provider has failed to adapt comprehensive contemporary evidence based restraint practices which complies with current legislation. The decision to use a restraint measure was not supported by multi disciplinary decision making.
Action required: Implement the national policy on restraint. Ensure all staff are trained in the national policy prior to implementation.
Action required: Put processes in place whereby a risk assessment is completed on all residents subject to a restraint measure which ensures that the restraint measure is only applied in the best interests of the resident. Ensure that the use of a restraint measure is only ever considered as a measure of last resort and is the least restrictive option for the shortest period of time.
Action required: Where a resident lacks the capacity to give informed consent to the use of the restraint measure, a consensus view should be reached between all healthcare staff involved in the residents care and the residents' next of kin / significant other. This decision should be documented clearly in the notes in narrative format.
Action required: Any restraint measure whether physical or chemical must be kept under constant review with documentation evidencing motion times during waking hour.
Action required: Conduct a quality audit review of all residents subject to a restraint measure restraint and implement recommendations from this audit.

Reference: Health Act 2007 Regulation 31: Risk Management Procedures Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Risk assessment is completed on all residents subject to a restraint measure. There is documentary evidence of restraint release for all residents subject to a restraint measure. Audits are undertaken of all residents subject to restraint and findings discussed with staff. Two staff have been trained as trainers in the HSE restraint policy and will roll out training to staff on the unit. HSE Restraint Policy to be fully implemented on completion of training. Training to commence week commencing 24 August 2011 and includes exploring all options other than restraint, consent and capacity, and restraint review.	 Completed Ongoing Ongoing October 2011

5. The provider has failed to comply with a regulatory requirement in the following respect: There was a limited programme of activities for residents with impaired communication, cognitive impairment and/or those with dementia.	
Action required: Provide opportunities for all residents to take part in meaningful activity in accordance with their needs, preferences and capacities.	
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Regulation 6: General Welfare and Protection Standard 18 : Routines and Expectations Standard 20: Social Contacts	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response 'Key to Me' is currently being completed for residents this will be used to develop activities in line with interests/hobbies expressed by residents. Aromatherapy is available on a weekly basis for residents with cognitive impairment. Advocacy service is available.	September 2011

6. The provider has failed to comply with a regulatory requirement in the following respect: Confirmation of Garda Síochána vetting had not been obtained for staff working the centre. Not all staff had three references on file.
Action required: Maintain in a safe and accessible place, a record of all information detailed in schedule 2 for each member of 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: Two staff are awaiting Garda Siochana vetting. Three references are being sourced for all staff where deficits occur.	Awaiting returns from Garda vetting unit. September 2011

7. The person in charge has failed to comply with a regulatory requirement in the following respect: Although staff were clear residents were weighed regularly there was fragmented documentary evidence to support this.

Action required:

Residents to be weighed on a regular basis and weight documented in case files in an organised fashion so as to enable and inform clinical practice.

Action required:

Care plans to be implemented detailing measures that address nutritional care, these care plans to be reviewed according to the needs of the residents.

Reference:

Health Act, 2007
Regulation 17: Training and Staff Development
Regulation 6: General Welfare and Protection
Regulation 9 : Health Care
Standard 13: Healthcare
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Each resident has an up to date weight chart. Where nutritional risk assessment indicates, each resident has a care plan to address nutritional care. A regional steering group is currently looking at care planning in older person's services and recommendations from this group will be implemented.	 Competed December 2011

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

The statement of purpose did not contain all the criteria as outlined in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), for example the qualifications of the provider.

Action required:

Complete a statement of purpose to include all criteria as outlined in Schedule 1 in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older people) Regulations 2009(as amended).

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The statement of purpose was revised and forwarded to lead inspector.	 June 2011

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

The medication administration charts were not clear. The prescription for regular and PRN (as necessary) medication was written on the same page and it was not always clear until careful consideration had taken place as to how the medication was prescribed which could increase the likelihood of error.

The maximum dose for PRN medication was not stated.

They were not fully complete as they did not include weight, age and date of admission or drug sensitivity.

Action required:

Review the medication charts to ensure they are clear and fully complete.

Reference:

Health Act, 2007
Regulation 33: Ordering Prescribing, Storing and Administration of Medicines
Regulation 25: Medical Records
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All medication charts have weight, age, drug sensitivity and date of admission recorded. We will communicate with GP's regarding their role in light of the report.	 Ongoing November 2011

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

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

Action required:

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

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Our estates department have visited the unit and are actively evaluating options to provide this space within the existing unit.	December 2011

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

No non-verbal communication system was in place. It was not possible to facilitate and encourage communication with residents who could not express them verbally.

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

Action required:

Devise an alternative communication system that ensures that all residents are facilitated and encouraged to communicate enabling them to participate in the activities and running of the centre.

Utilise the communication observation chart available in the communication policy.

Action required:

Put in place practices that facilitate and encourage each resident to communicate.

Reference: Health Act, 2007 Regulation 11: Communication Standard 1:Information Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: Pictorial signage is in place on toilet and bathroom doors. Alternative communication system is being sourced.	 Completed November 2011

12. 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 on all occasions to determine if a head injury had been sustained and/or the level of consciousness affected.	
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: This practice has been addressed, when a resident sustains an un - witnessed fall neurological observations are carried out.	 Completed and ongoing

13. The person in charge is failing to comply with a regulatory requirement in the following respect: There was inconsistent evidence available that the resident or their significant other had been involved in completion or review of their care plan.

Care plans were not reviewed as required by the resident's changing needs and no less frequently than at three monthly intervals.

Residents had not had a comprehensive assessment of their social care needs.

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

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

End of life care wishes were not documented in all care plans.

Action required:

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

Action required:

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

Action required:

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

Action required:

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

Action required:

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

Document end of life care wishes in all residents care plans.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Standard 11: The Resident's Care Plan
Standard 3:Consent
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Staff have commenced work on assessing social care needs and developing care plans. End of life wishes are discussed as appropriate (when resident is willing/ready to discuss these) and care plans developed. Appropriate pain charts to assess pain are being examined. Nursing documentation to indicate use of and response to analgesia. A regional steering group is currently looking at care planning in older person's services to comply with the issues outlined above and recommendations from this group will be implemented.	 September 2011 November 2011

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

Aspects of the physical environment were not in accordance with the Authority's standards and failed to comply with the regulations.

Action required:

Review the use of the large day room as the only sitting room space available.

Ensure privacy and dignity of residents is respected on all occasions.

Action required:

Provide suitable adequate space for drying clothes.

Action required:

Provide adequate storage space for all equipment so that items are not routinely stored in the bathroom.

Provide a wash hand basin in the sluice and laundry room.

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

Provide a suitable storage area for equipment.

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: This issue is being evaluated by our estates department who have visited the centre.	December 2011

15. 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 and best practices in the use of restraint measures 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 and best practices in the use of restraint measures 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: Two staff have completed the Train the Trainers programme in best practice in use of restraint and will roll out training to all staff. Training in dementia and behaviour that challenges is available through Centre of nurse education and will be prioritised over the next year.	October 2011

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

There was a limited system for the review of the quality of care and the quality of life of residents. Areas such as complaints, vulnerability to falls, activity provision and satisfaction surveys 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: An audit system will be put in place to review issues identified on a quarterly basis. Satisfaction surveys will be conducted on an annual basis	 Commenced August 2011and ongoing December 2011

17. 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: This item is being referred to our Insurers and also the State Claims Agency for a response. This is primarily a national rather than local issue.	 Awaiting response

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 of Social Services.

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: The residents Guide has been amended in line with above.	 Completed

19. 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 of Social Services, 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: A risk assessment has been conducted by a firm of fire safety consultants. Awaiting report.	September/October 2011

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

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

Action required:

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

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The inspectors noted on the day of inspection that comprehensive records are maintained for the management of residents' finances. A system will be put in place for recording residents' personal property.	September2011

21. 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: All admissions since 2009 have contract of care agreed within one month of admission. Four residents admitted prior to 2009 are being updated and contacts will be agreed.	September 2011

22. The provider has failed to comply with a regulatory requirement in the following respect: The temperature of the water posed a potential scalding risk to residents.	
Action required: Ensure hot water at the point of contact is thermostatically controlled and at point of contact it is no greater than 43 degrees C	
Reference: Health Act, 2007 Regulation 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: This issue is referred to maintenance department for urgent attention.	October 2011

Any comments the provider may wish to make:

Provider's response:

We would like to thank the inspectors for the professional and courteous way in which they conducted the inspection, and for the constructive feedback received at the end of the inspection.

We welcome constructive recommendations as a means to enhance the quality of our residents care to the highest standards possible.

Provider's name: Michael Fahey
Date: 12 August 2011