Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

Centre name:	Mount Carmel Supported Care Home
Centre ID:	0546
Centre address:	Prologue Callan Co Kilkenny
Telephone number:	056-7725301
Email address:	mountcarmelcallan@gmail.com
Type of centre:	☐ **Private** ☒ **Voluntary** ☐ **Public**
Registered provider:	Mount Carmel Community Trust Ltd
Person authorised to act on behalf of the provider:	Breda Sommers
Person in charge:	Anne Walpole
Date of inspection:	4 October 2011 and 5 October 2011
Time inspection took place:	**Day-1 Start:** 10:00hrs **Completion:** 20:15hrs **Day-2 Start:** 09:30hrs **Completion:** 15:00hrs
Lead inspector:	Noelene Dowling
Support inspector(s):	Noel Sheehan
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 centres 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

Mount Carmel Supported Care Home is run by Mount Carmel Community Trust, a voluntary agency that provides a residential service to residents assessed with low dependency needs. Priority is given to residents over 65 years but, the centre will accept persons under this age range if their circumstances and assessment deem that they are suitable for this service. It provides long-term and respite care for residents who are mainly capable of living independently and who require minimal assistance with the activities of daily living. The total capacity is for 20 residents; on the day of inspection there were 19 residents.

The centre is single-story and comprises an entrance porch, large kitchen, dining room, sitting room, and oratory for prayer and reflection. There are 20 single bedrooms. Two of the single bedrooms have en suites with bath, toilet, and wash-hand basin facilities. All other bedrooms have wash-hand basins provided. There are three bathrooms, two with assisted showers. Each room has adequate storage space with a lockable wardrobe.

There is ample car parking space and garden to the rear of the premises.

In September 2005 an extension was opened in the centre and staffed by the Health Service Executive (HSE) primary care team. Following a referral from the general practitioner (GP), residents can avail of the services provided in this extension, such as physiotherapy, occupational therapy, speech and language, dietician, chiropody, and hairdressing. This primary care team is due to relocate to other purpose-built premises in the local village which will mean that the centre can utilise these rooms. One of the rooms will be used for the day care service which currently operates once weekly in the centre. The staff in the centre provides daily meals on wheels to the wider community. There are eight independent supported houses on site which are also managed by the Mount Carmel Community Trust and meals are provided. The residents living in the houses have the choice to dine in the centre or in their own houses. The independent or supported houses were not the subject of this inspection.

The centre is funded by a small grant under section 39 of the Health Act 2004, residents' fees, voluntary contributions and fundraising.

Date centre was first established:			1985	
Number of residents on the date of inspection:			19	
Number of vacancies on the date of inspection:			1	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents	0	0	2	7
Gender of residents			**Male (✓)**	**Female (✓)**
			9	10

Note: 10 residents were assessed as independent.

Management structure

Anne Walpole is the Person in Charge and reports to the nominated Provider, Breda Somers and a Board of Management which consists of 10 voluntary members, some of whom hold specific areas of responsibility such as finance. The senior care assistant and all attendant staff working in the centre report to the Person in Charge.

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 for registration under Section 48 of the Health Act 2007.

Inspectors met with residents, relatives, staff on duty and members of the board of directors over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge. The Fit-Person self assessment had been completed by the provider and the previous person in charge prior to the new person in charge taking up post and this document was reviewed by inspectors prior to the inspection, along with all of the information provided in the registration application form and supporting documentation.

The findings of this inspection demonstrate that there is a commitment on the part of the provider to improve services offered while also maintaining the social model of care offered by the trust. Since the regulatory monitoring inspection in 2011 significant work has been done in an attempt to improve standards and comply with the regulations. Improvements had been made in relation to the actions identified in that report. The provider acknowledged that a significant amount of work was needed at that time including the appointment of a full time nurse as person in charge. This action had been resolved in May of 2011 with the appointment of the current person in charge.

This inspection found improvements in the accuracy of the statement of purpose, the complaint procedures, training available for staff, the addition of another night staff member, the addition of suitable showers and bathroom facilities, furnishing and fittings.

The provider had commenced changes to all areas of practice, procedures and policies with the exception of the 24 hour nursing cover at all times in order to comply with the regulations. Good practice was found in residents' quality of life, decision making and choice and an effort to create a home-from-home environment and the residents' independence was promoted as much as possible.

Many of these changes however, were still in the early stages of development and not yet fully completed or established. Therefore improvements were still necessary in order to fully comply with 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*.

These improvements included:

- the availability of 24 hour nursing cover
- the numbers of staff available at weekends and overnight
- training for staff in the protection of residents and moving and transporting residents
- complaint management systems and recoding practices
- medication management procedures
- recruitment practices
- risk management procedures
- fire safety management procedures
- procedures to review the quality and safety of care
- residents' medical and other records
- documentation of treatment plans in relation to specific healthcare issues identified
- pre-admission decision making
- completion and implementation of all policies.

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

The statement of purpose has been amended to accurately reflect the services provided in the centre. Minor changes are required which include the addition of the name and contact details of the provider and the actual numbers of staff on duty at any one time. All admissions, with the exception of one recent admission were found to be congruent with the statement of purpose and criteria for admissions.

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

Although, there are no formal procedures used to monitor the quality and safety of care such as audits of incidents and accidents a number of initiatives have been implemented which support this. These include a residents' forum which met on three occasions in 2011 and was attended by 13 residents in September 2011. Records and interviews demonstrated that the provider is open to listening to the views of the residents and acting on them. For example, residents' wishes were respected in regard to the timing of breakfast and they were consulted regarding the dates for the holding of the annual open day..

However, there is no formal system for review or audits of quality and safety of care such as incident management or systematic evaluation and assessment.

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

There were no records or details of complaints made prior to May 2011. Inspectors found that the provider and person in charge understood that the complaints process, ease of access, transparency and response had not been adequate in the past and this fact was confirmed by residents. To this end they have developed a formal complaint policy, a complaint form and a suggestion box which is available to residents and or relatives.

The policy identifies the person in charge as the complaint manager and outlines a procedure for managing informal and formal complaints within a reasonable timeframe. A local health manager was identified in the policy as the conduit for appeals in the event of a resident being dissatisfied with the outcome of a complaint made. However, this post holder had not been consulted regarding this and depending on the type of complaint this may not be a suitable option for appeal. Residents may initially prefer to appeal to a member of the management committee in the first instance. An advocate had been appointed from the board of management but this function has not been clearly defined or introduced to residents as yet.

There are a small number of residents who do not have immediate next of kin and these residents would benefit from the support of external advocacy services in recognition of the fact that they may find it more difficult to raise issues or make complaints.

Inspectors examined records and found that a small number of complaints made in 2011 demonstrated that the person in charge had acknowledged and dealt with them in an appropriate manner and reassured residents that their issues would be heard. The recording practices however, are poor in that there are no discreet records of complaints' made outside of the resident's daily nursing records.

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

The provider had developed a policy on recognising, responding to and reporting of abuse which was centre-specific and adequate. Inspectors reviewed a record in relation to a concern regarding the behaviour of a person external to the centre. This record demonstrated that the person in charge had taken the appropriate actions and involved the appropriate authorities to protect the resident and resolve the concern. However, the recording of the incident and subsequent actions was poor. Details were recorded on the residents' nursing notes only with several pieces of information accumulated together in one record without any indication that they had occurred on different occasions. This made it difficult to ascertain a complete record of the timeframes for the actions taken.

The new person in charge had undertaken basic training with 13 staff on elder abuse in 2011. However, she herself had not undertaken any training in this matter or in imparting this learning to staff. Staff were able to articulate knowledge of the basic principals of abusive situations and did understand the internal reporting procedure.

The provider had a reasonable knowledge of her responsibilities and the services to access in such an event. The provider and person in charge agreed that the policy has not yet been fully integrated into practice.

The provider was acting as agent for one resident. Inspectors examined the details of the transactions and records in relation to this and other residents' fee payments. Documentation maintained and receipting practices were transparent and comprehensive, accompanied by the resident's signature. However, there was no copy of the agreement for the provider to act as agent held with the documentation.

Additional factors which support the protection of residents include the residents' forum, and the regular presence of the person in charge. While there is a system for various board members to visit the centre, the function of these visits and the reporting arrangements regarding this have not yet been adequately formulated to enable this to be an effective additional safeguarding mechanism.

Although governance systems are in place, there is no formal procedure outlining precisely the issues which the board of management must be informed of by the person in charge to ensure that there is adequate overview.

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

Good practice in general safeguarding was noted including the availability and usage of protective equipment, clinical waste and segregation of linens and waste. There were appropriate measures to prevent falls and accidents to residents including non slip flooring, handrails and assisted bathrooms.

A health and safety statement had been developed, however, the provider concurred with the inspector that this was not yet implemented although some areas of risk to staff and residents had been identified and controls put in place. These included the timely mopping up of spills and additional care when cleaning the premises. Inspectors observed that staff undertaking these tasks worked in safe manner so as not to cause a risk to residents.

A risk management policy had also been developed which governs accident and incidents to residents and staff. Inspectors' found that the risks identified for residents as opposed to staff had not been clearly differentiated in this policy and it did not fully comply with the requirements of the regulations. In addition, staff working alone has not been factored in to the risk assessment. For example, staff work alone at night and the ability to safely and speedily access a telephone to seek help has not been considered.

Other policies used to support this risk management were in place including a policy on missing residents, and emergency procedures. Both require amendment however, for example, the policy on missing residents, takes account of the nature of the service and the residents' rights to leave the centre freely, requires more specific details of actions to be taken and time frames for these actions to adequately guide staff in the event of a resident being missing and at risk. Although the emergency plan does contain plans for flood, serious incidents, and fire, currently there is no generator in place and the outline plan for evacuation and temporary accommodation of residents has not been completed.

The independent houses did not form part of this inspection. However, the call-bell system is connected to the houses so that these residents can seek help in an

emergency should they require assistance. Inspectors were informed that this has occurred very rarely and is not documented. However, the removal of the staff from the designated centre has not been considered as a risk to be managed.

There is currently no system for auditing risks identified and strategies implemented to address them. However, examination of the accident and incident records demonstrated that the person in charge reviewed the incidents to residents and took appropriate actions such as medication and health care review, or change of foot wear. For example, a review of medication had resulted in less falls for one resident. Staff had training in manual handling but, not in safe movement of residents which is a requirement for this service.

Notification forwarded to the authority which corresponded with the accident and incident records demonstrated that the number of falls or minor incidents were not of a significant level and the actions taken were appropriate. These were reactive measures however and a review of the premises and the incidents would support the identification of risks and other strategies to prevent incidents.

Inspectors found that significant improvements were necessary in the consistent application of fire safety and fire management systems. Inspectors examined the fire register and found that the fire fighting equipment was serviced annually with the last service taking place on February 2011, and the fire doors were examined on 21 September 2011. Fire training for 11 staff took place on 8 February 2011. However, the fire alarm had been serviced yearly as opposed to quarterly, with the last service having taken place on 12 February 2011 and there was no evidence that it was tested in between services. Fire drills were not undertaken on a quarterly basis and records demonstrated a gap of 14 months between the last drill which took place on March 2011 and the previous drill undertaken. There was no evidence that fire exits and alarm panel was checked on daily basis.

The local area fire service had undertaken an assessment of the premises in 2006 and some improvements were identified as necessary. The provider was unable to confirm if these issues had been addressed and the centre did not have written documentation from a suitably qualified person that all the requirements of the statutorily fire authority had been complied with.

Staffs were however, able to outline the procedure for the safe removal of residents within the fire compartments and to identify which residents would require most assistance. Fire plans are posted at regular and appropriate places throughout the premises.

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

The provider had a policy on the ordering, prescribing, storing and administration of medicines and inspectors found that this was in line with legislation and guidelines. Medications are administered by non nursing staff and administration is recorded on the administration sheet populated by the pharmacist which also details the reason for the medication.

Nine residents were self administering medication and there was good practice found in relation to this. The medications were stored in locked presses in residents' own bedrooms. Inspectors saw evidence of assessment of capacity to undertake this self administration and signed agreements by the residents to do so. Medications were delivered in packs clearly divided into timeframes for administration. Residents were knowledgeable regarding their medications and the reason for there use. The person in charge informed inspectors that she monitors this and undertakes a check on the medication to ascertain if residents are taking their mediations. However, there was no record of this reconciliation of medications being undertaken which is stipulated in the centre policy on self medication.

Practice in relation to prescribing and transcribing did not satisfactorily ensure safe practice in medication management. No prescriptions are held in residents' records but go directly to and remain with the pharmacist. Changes or alterations are sometimes entered by the GP on the residents' medical records. Transcribing is undertaken regularly by the person in charge but there is no GP confirmation of the content of the transcribed document.

Inspectors found that medication and controlled drugs were stored securely. However, the register of controlled drugs did not accurately reflect the count undertaken by the inspector on the day. The most recent delivery had not been included in the register.

There was evidence on medical records available that medications were reviewed by the resident's GP and residents' own views on the benefit or not of taking medication was also recorded and respected.

One medication error was recorded and inspectors found that the cause of this error was identified by the person in charge and the appropriate actions taken, namely that only one staff would administer medication to avoid risk of confusion and error.

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

The recording procedures and care planning system is based on the social and non nursing model of care utilised in the centre and the emphasis is placed on residents' choice and privacy and in how they want to live their lives in the centre.

The person in charge undertakes a pre-admission assessment of residents' health and social care needs and recognised assessment tools were utilised for identifying dependency levels, residents at risk of malnutrition, pressure areas or falls. There was documentary evidence of these being reviewed within the required timescales. Inspectors noted improvement in residents' weight and other healthcare issues identified prior to admission.

Most admissions are for social reasons, and may be initiated for reasons of isolation, deterioration in the ability to manage entirely unsupported and who would benefit from the security of having access to staff during the day and night time should they feel the need. In the majority of cases the need for admission was initially identified by the resident's GP or the public health nurse (PHN). Residents informed inspectors that they felt safer and had an improved quality of life as a result of the admission despite their initial reluctance to leave their homes. Residents' care plans on social and personal information contained very detailed biographical information, compiled in conjunction with and signed by residents and these documents were held by the

residents' themselves. Residents showed these to inspectors and were aware of the contents and what they contained.

Inspectors examined five residents' records. In accordance with the centres ethos of non nursing care and independence many residents attend their own GP or the local GP surgery independently of the centre. If necessary, centre staff will accompany them or provide transport for them to the surgery and then to the local pharmacy to collect any medications prescribed. Therefore, records do not consistently provide documentary evidence of medical care or review by GP within 72 hours of admission. In one case, there was no evidence of review for two weeks following admission.

However, interviews with residents, relatives, staff and some of the records available did demonstrate that residents' healthcare needs are attended to and that any changes are noted and addressed promptly as there is verbal communication between the staff and GP.

Nursing records are not completed daily or in any consistent manner. However, inspectors noted that significant events or changes are outlined in nursing notes as they occur by the person in charge. These records were consistent with corresponding medical records or overnight logs maintained by night staff. These overnight logs detail any occurrences that take place.

The nursing notes are also utilised to outline plans and progress in relation to issues identified by the assessment undertaken. For example, weight monitoring, identified in the nutritional assessment for one resident was detailed in the nursing record and a treatment plan for a leg ulcer was also detailed in the nursing records. Not withstanding the low dependency and non nursing model of care, this system of documentation does not provide a clear record of progress or change where specific areas of healthcare needs such as these are identified.

Residents confirmed that they had access to allied health services such as occupational therapy, physiotherapy and dieticians. In some but not all cases this was evidenced in the nursing records available. However, the person in charge informed inspectors that it is not practice for these practitioners to record in the resident's records but they do so in their own clinical notes. The presence of the primary care team including physiotherapy in the premises ensures that such access is prompt. Referrals to and ongoing support by mental health specialists was also evidenced where this was indicated by the resident's healthcare needs.

The statement of purpose, on which all subsequent decisions regarding staffing levels, skill mix, polices, procedures and recording systems depend, clearly stipulates that the centre can and will only cater for low dependency residents. There were two residents whose dependency levels were assessed as medium living in the centre. In one case the residents' healthcare needs had altered over time and the person in charge recognised that the placement was not at this time best equipped to meet the resident's needs and was seeking other options, although primarily it was the resident's mobility which was the risk factor. The person in charge stated that additional staff for supervision as opposed to nursing staff would be a more suitable option for this resident.

Another resident was deemed medium dependency prior to admission. The resident had been assessed and deemed suitable for funding for nursing home care, indicating that he was not suitable for this centre. Inspectors have to acknowledge that the resident's general physical care had improved significantly and this was confirmed by the PHN who had attended the resident in the community. However, given the staffing levels overall and the presence of only one nurse for limited periods of time, such admission decisions may place residents at risk. In addition, such decisions contribute to unnecessary disruption for residents who may find it more difficult to adjust to another environment.

There was evidence of a commitment to residents' social care needs, support of independence and the provision of a quality service consistent with the social model of care by which the centre operates. The residents living in the centre at the time of the inspection ranged in age between 64 years and 100 years old. Some residents were utilising walking aids to promote their continued independence.

Residents have significant choice in how they spend their time, in their daily routines, and freedom to exercise choice in all aspects of their lives. They may leave and visit the local village, visit their relatives or homes as and when they wish. This was observed by inspectors and confirmed by the residents. Their individual preferences and personal wishes are respected. Activities provided are meaningful and include art, bingo, helping in the house, regular contact with the local community via regular and open visiting times, access to local and national newspapers, and other media to ensure they keep in touch with news and events.

The senior care assistant is responsible for daily activities and she was observed reading newspapers, discussing current affairs or sport, and doing word games with residents. Residents continued to self care, with minimal support from staff and undertake the kind of pastimes they may have undertaken prior to admission. Residents knitted and did small chores in the house. There was an obviously well used selection of games, books, a piano, and karaoke machine available.

Residents confirmed that they can rest in their rooms when they wish and the rooms contain televisions so that they can watch in privacy of they wish. There are two hand held telephones, easily accessible on the corridors which residents can use in their rooms to make telephone call in private. Residents were mainly very positive regarding the care they received and the kindness of staff to them. Photos of residents were displayed. No methods of restraint such as bedrails or lap belts were utilised.

Of note to the inspectors was the ease of communication and concern observed between residents, the respectful communication between staff and residents and the general freedom of movement and independence of the residents, despite in some cases advanced age.

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

The policy on end-of-life care has been developed in consideration of the centres statement of purpose and taking account of the dependency levels of the residents and the right to have choice and consultation. It acknowledges that if residents become acutely ill they may not be able to continue living in the centre which the person in charge understood as a source of concern for some residents. In the event that a resident required end-of-life care, which would be in an emergency, the policy states that additional staff will be provided, GP and palliative care support sourced, family presence encouraged and the wishes of residents would be taken into account.

It had previously been the practice that residents who had lived in the centre could have funeral services held in the oratory however, the person in charge stated she found residents were not comfortable with this and has ceased the practice.

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 found that residents received a nutritious and varied diet that offered choice each day with the menu displayed. The meals were social and enjoyable occasions, residents could eat in their room if they wished or come to the dining room at a time of their choosing.

There was good interaction observed between staff and residents during the mealtime. Residents had access to regular nutritious and appetising snacks, including soup and home baking. Residents confirmed that what was observed by inspectors during the inspection is the normal procedure and inspectors also observed snacks, tea and toast available to residents in the late evening.

Specialised diets were catered for and the chef was knowledgeable as to which residents required this. Resident records examined by inspectors demonstrated that weights were checked monthly and there was noted improvement in the weight of

one resident who had been recently admitted. The Malnutrition Universal Screening Tool (MUST) was completed for each resident. Where deemed necessary by the GP fortified drinks were prescribed and given to residents.

The provider had purchased new dining room furniture and the dining room was pleasantly decorated, tables were nicely set, the general atmosphere was pleasant and the meals unhurried.

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

The contract of care for residents has been reviewed. While not all residents have yet received the revised contract most have. Residents hold this contract themselves in their room in keeping with the ethos of supporting independence and autonomy. Inspectors found that the revised contract was clear, user-friendly and outlined all of the services and responsibilities of the provider to the resident and the fees to be paid.

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 independence.

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

Inspectors found that improvements have been made which demonstrate a commitment to promoting the independence, choice and personal dignity of the residents. All bedrooms have lockable wardrobes, which residents were observed using, for personal belongings and possessions. All residents have a single room which further promotes privacy as the provider has ceased using the twin room available. Bedrooms were seen to contain significant amounts of mementoes and personal possessions.

Colourful do not disturb signs have been made for each resident's bedroom, staff were observed knocking and waiting for a reply before entering bedrooms, and residents confirmed that they have choice as to their daily routines such as getting up and going to bed. Residents are free to leave the centre as they wish, walk in the grounds, or go to the village and are only required to let staff know if they are leaving. Residents may also visit their GP in the local clinic as opposed to the centre and if needed staff will drive them and then help them collect any prescriptions.

Visitors are welcomed with no restrictions and inspectors observed visitors coming and going. The single rooms allow privacy for visits. Religious preferences are honoured and mass takes place at least weekly in the oratory. Residents can also attend services in the local community. Residents confirmed that they could make individual choices and these were respected.

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

Inspectors found that there was a commitment to maintaining residents' autonomy in numerous ways. The provider has developed policy on the management of resident property and possessions and an itemised list is maintained. The bedrooms hold adequate space for belongings.
Residents' clothing is laundered on the premises and the laundry is suitably equipped with ample space for separation of clothing. Each resident's care plan held comprehensive details of their personal possessions and residents confirmed that their clothing is well cared for and returned to them.

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

The person in charge, who was appointed to the post in May 2011, is a suitably qualified nurse with extensive experience in older person's services. She works full time in the post and demonstrated an extensive knowledge of the residents and their clinical and social needs. Residents' confirmed her presence in the centre and their ease of access to her. She is also responsible for a considerable amount of administration tasks which is a significant burden of work.

The provider has appointed a staff member to assist the person in charge, share on-call duties and to deputise in her absence. This person is the senior care assistant and has experience in working with older persons, and completed Further Educational and Training Awards Council (FETAC) to level five, and is also qualified to carry out clinical observations of residents as required. This person is the only dedicated care assistant employed and has a significant role in developing communal and individual recreational activities for residents.

The on-call arrangement is a support for staff and primarily to advise if the out-of hours GP service is required. The night staff spoken to and the records available demonstrated that the person on-call is quick to respond to calls from the night staff. However, this arrangement does not comply with the current regulations as the person in the role of key senior manager is not a qualified nurse.

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 current staffing arrangements do not satisfy the criteria as laid down in the regulations. There is no qualified nurse on duty full time in the centre. The person in charge works Monday to Friday and there is only one dedicated care assistant also employed Monday to Friday. With the exception of the catering staff who work over a seven day period, 13 multi-task staff are employed, some through FAS employment schemes. The multitask staff primarily undertake cleaning, housekeeping and laundry duties with some support or supervising of residents involved.

Examination of actual and planned rosters and observations indicated that the staffing levels vary throughout the day, with one staff available from 08:00hrs and four staff available until 15:00hrs midweek. From 15:00hrs until 21:00hrs there are two staff available. Again duties are primarily housekeeping although inspectors observed that staff were very attentive to residents' needs during these periods.

Since the regulatory monitoring inspection the provider has ensured that there is one waking night staff available. However, weekend cover is very limited with only 2 staff on duty all day and their duties include preparation of meals for the residents and for the meals on wheels service.

Since the regulatory monitoring inspection the provider had sourced and was supporting FETAC Level five training for nine of the staff which commenced in September 2011. It is expected that staff will complete all modules over a period of time and that this will alter the skill mix of staff and the duties undertaken by the staff, although this is a long term plan.

Inspectors examined the training schedules and found that some improvements were required. Mandatory training in food safety had taken place for 13 staff in 2011, fire safety training for all staff in February 2011, health and safety training had taken place for 11 staff in 2011. However, infection control training had not taken place since 2009; while manual handling training had taken place for 11 staff in March 2011 this training did not include the safe moving or transporting of residents. Although most residents are independently mobile on occasion they require the assistance of one staff member with showering or following a fall.

Inspectors examined four personnel files and found that although practices had improved and the provider was verifying information sourced by other agencies such as FAS all documentation required by the regulations had not been sourced. Missing items included Garda Śíochána vetting, three references and evidence of medical and physical fitness.
There was no supervision system implemented and no formal induction although staff did inform inspectors of a detailed and monitored induction period.

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

Inspectors found that the premises are fit for purpose, having been purpose-built. The provider has made significant improvements since the regulatory monitoring inspection with the refurbishment of two well equipped assisted bathrooms, and an appropriately equipped sluice room. The premises are single-storey and the corridors provide ample room for residents to walk safely. Grab-rails and non-slip flooring is provided.

The environment was homely, well decorated and in a style which was comfortable. There are adequate communal areas which are bright and spacious and easily accommodate the number of residents.

Décor is bright, residents' bedrooms were comfortable and very personalised and There are 20 single bedrooms in total, although one bedroom is currently utilised to accommodate clinical staff from the community services. The premises contain the required number of toilets and bathrooms for the number of residents. Three bedrooms have an en suite with assisted shower, toilet and wash-hand basin. There are the two fully assisted bathrooms containing shower, toilet and wash-hand basin and one bathroom containing a bath, wash-hand basin and sink the provider intends to refurbish this bathroom also. There are two additional toilets in proximity to the dining room and day room.

There is a small enclosed patio area in the centre of the premises and residents' have access to the garden at the rear of the premises. The patio area and the front porch, which is ventilated by natural means are used for residents who smoke.

There are no hoists used but walking aids and wheelchairs are used following assessment by the physiotherapist to support residents' independence.
The kitchen is fit for purpose and although the provider informed inspectors that the most recent environmental health officer's report was not available it had indicated the facilities were in substantial compliance.

The premises are well maintained and clean. The provider outlined further plans for improvement. Currently the day care service takes place one day a week and this does impact on the residents' living in the centre as the day room is used to accommodate the day care service. However, when the community care services vacate the rooms currently used by them in the centre the day care service will revert to this section of the premises. This will also increase the office space available.

Clinical waste was appropriately managed and staff articulated a detailed knowledge and practice in relation to the management of Methicillin-resistant *Staphylococcus-Aureus (MRSA*).Inspectors observed staff using protective clothing, and managing residents' linen and clothing in a safe manner. However some chemicals were not stored securely. Staff facilities require upgrading, and there are no separate visiting facilities and no separate washing facilities for kitchen staff and the call-bell system has not been installed in the renovated bathrooms. The provider was aware of these deficits and planned to address them.

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* ☒

Residents' records did not provide sufficient detail and were not recorded in manner to ensure completeness. **General records (Schedule 4)**

Substantial compliance ☐ Improvements required* ☒

Some improvements were required in the recording systems and the separation of complaints from nursing records and separation of reports in relation to concerns.

Operating policies and procedures (Schedule 5)

Substantial compliance ☐ Improvements required* ☒

All polices were present, however, policies on health and safety, risk management missing residents and emergency planning require amendment.

Directory of residents

Substantial compliance ☒ Improvements required* ☐

Staffing records

Substantial compliance ☐ Improvements required* ☒

All personnel files did not have three required three references, evidence of Garda Síochána vetting and evidence of mental and physical fitness.

Medical records

Substantial compliance ☐ Improvements required* ☒

Some medical records were absent and nursing notes were not completed on a daily basis.

Insurance cover

Substantial compliance ☐ Improvements required* ☒

The policy did not stipulate the arrangements in place for insurance of residents belongings.

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

Examination of the accident and incident logs demonstrated that notifications of incidents as required by the regulations had been issued to the Authority.

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

The provider was aware of her responsibilities in relation to this regulation and the situation had not occurred as the person in charge has not taken leave of a duration requiring such notification.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider the person in charge, the senior care assistant, the chef and a member of the board of directors 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:

Noelene Dowling

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

11 October 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Mount Carmel Supported Care Home
Centre ID:	0546
Date of inspection:	4 October 2011 and 5 October 2011
Date of response:	8 November 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 1: Statement of purpose and quality management

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

The statement of purpose did not clearly stipulate and indentify the person appointed to act on behalf of the registered providers and the precise number of staff available to residents.

Action required:

Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required:

Ensure that residents are admitted in accordance with the criteria outlined in the statement of purpose so that their healthcare needs can be adequately addressed within this setting.

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

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: Residents will only be admitted once they fit the criteria and we can meet their healthcare needs. Statement of purpose will identify the person appointed to act on behalf of the registered provider.	20 December 2011

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

2. The provider is failing to comply with a regulatory requirement in the following respect: There was no formal system implemented for reviewing the quality and safety of residents care.	
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: We will establish and maintain a formal system to review quality of care and safety of residents via care planning and assessment of residents needs.	2 December2011

Outcome 3: Complaints procedures

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

The complaint procedure:

- both local and formal procedures have not been clearly outlined to residents, to ensure that the environment is conducive to being able to make a complaint
- an adequate appeals process is not included
- right of referral to state agencies is not included
- a register of complaints and outcomes is not maintained.

Action required:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Action required:

Make each resident aware of the complaints procedure as soon as is practicable after admission and ensure that resident are regularly encouraged to speak to staff or the person in charge or the visiting board members regarding any concerns they may have.

Action required:

Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.

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(7) maintains the records specified under Regulation 39(7).

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 have commenced a log of complaints and their outcomes. Complaints procedures will be adjusted to include adequate appeals process and referral to state agencies. An independent person will be appointed to ensure all complaints are appropriately responded to and records maintained. All residents will be informed of complaints procedure on admission.	2 January 2012

Outcome 4: Safeguarding and safety

4. The provider is failing to comply with a regulatory requirement in the following respect: Practices in safe guarding residents were not robust :
Action required: Ensure that staff have adequate training in the prevention of harm or risk of harm to residents.
Action required: Make a discreet and detailed record of all incidents where a resident is harmed or suffers abuse or is identified as being at risk of abuse.
Action required: Put in place all reasonable measures to protect each resident from all forms of abuse taking account of the low staffing levels and formalise the role of the board of management visiting member to include monitoring of residents safety and a reporting mechanism for staff .
Action required: Ensure that there is evidence of consent and agreement for the provider to directly access resident's finances or act as agent on behalf of a resident.
Reference: Health Act 2007 Regulation 6: General Welfare and Protection Standard 8: Protection Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Records will be kept of all residents where a resident is harmed or suffers abuse. Staff will receive appropriate training in this area. Such incidents will be monitored by Board members. Evidence will be kept on file where provider has agreed with resident to access their finances.	2 January 2012

Outcome 5: Health and safety and risk management

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

Health and safety and risk management policies require review with an emphasis on resident care and staffing levels.

Action required:

Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

Action required:

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

Action required:

Complete the emergency plan.

Action required:

Ensure that staff who work alone at night carry, or have immediate access to, an alerting system or telephone.

Action required:

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

Action required:

Make adequate arrangements for detecting, containing and extinguishing fires; giving warnings of fires; the evacuation of all people in the designated centre and safe placement of residents; the maintenance of all fire equipment; reviewing fire precautions, and testing fire equipment, at suitable intervals.

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 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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Emergency plan to be completed. Staff will receive training in patient and manual handling, fire drills and fire practices and first aid training. Building will be inspected by chief fire officer on 22 November 2011.Staff have been instructed to carry phone with them. We will supply written evidence that all requirements of the statutory fire authority will be complied with.	 2 April 2012 2 March 2012 2 December 2011

Outcome 6: Medication management

6. The provider is failing to comply with a regulatory requirement in the following respect: Practice in relation to the ordering, prescribing administration of medicines were not accordance with legislation and best practice.
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference: Health Act 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Medication management training will take place for all staff. Evidence of prescribed medication will be kept on file.	2 December 2012

Outcome 7: Health and social care needs

7. The person in charge is failing to comply with a regulatory requirement in the following respect: The care planning system, documentation and records did not adequately outline assessment, treatment and review of specific healthcare needs identified for some residents.
Action required: Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident in relation to any specific condition to be assessed and treated.
Action required: Maintain records of all health care referrals and follow-up appointments.
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: Individual care plans will be implemented after consultation with the resident and assessment of their needs and will be reviewed every three months or more often if required.	2 January 2012

Outcome 13: Suitable person in charge

8. The provider is failing to comply with a regulatory requirement in the following respect: The person appointed to act in the absence of the person in charge does not have the required qualifications or experience.
Action required: Ensure that the person appointed to act in the absence of the person in charge is a registered nurse.
Reference: Health Act 2007 Regulation 15: Person in Charge Standard 27: Operational Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Senior care worker covers for person in charge at present. She has extensive experience working with older people. She has covered for person in charge to date and has done so in a very professional and competent manner. We will be reviewing staff requirements in the future.	2 November 2012

Outcome 14: Suitable staffing

9. The person in charge is failing to comply with a regulatory requirement in the following respect: There was not a qualified nurse on duty and in charge of the centre at all times.
Action required: Ensure that an appropriately qualified registered nurse is on duty and in charge of the designated centre at all times, and maintain a record to this effect.

Action required: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents at all times.
Action required: Supervise all staff members on an appropriate basis pertinent to their role.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.
Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they have the skills and experience necessary for such work.
Action required: Make staff members aware, commensurate with their role, of the provisions of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), the statement of purpose and any policies and procedures dealing with the general welfare and protection of residents.
Reference: Health Act 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications Regulation 18: Recruitment Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff are at present working on FETAC carers course. Recruitment procedures will include staff being employed who have the skills and experience necessary to care for residents' needs. We are currently working to have supported care homes assessed separately from nursing homes and will wait till this has been finalised before a decision is made to employ nurses to work here at all times.	2 December 2012

Outcome 15: Safe and suitable premises

10. The provider is failing to comply with a regulatory requirement in the following respect: Some alterations to the premises and systems are required.
Action required: Install a call-bell system in each bathroom
Action required: Ensure that chemicals are securely stored.
Action required: Proved adequate and separate washing facilities for kitchen staff.
Action required: Make the current bathroom which is not entirely suitable for residents fit for purpose.
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: Call bell system will be working properly. Chemicals will be locked away in a press. Separate washing facilities will be provided for kitchen staff. Current bathroom will be converted to an en suite bathroom.	 31 November 2011 2 March 2012

Outcome 16: Records and documentation to be kept at a designated centre

11. The provider is failing to comply with a regulatory requirement in the following respect: All required records were not maintained and some were not maintained in a manner so as to ensure completeness, ease of retrieval of information.
Action required: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

Action required:

Maintain, in a safe and accessible place, a medical record in respect of each resident with details of investigations made, diagnoses and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner.

Action required:

Maintain, in a safe and accessible place, a record of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a GP and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.

Action required:

Maintain a discreet record and details of any plans relating to a resident in respect of medical care, specialist healthcare or nutrition.

Action required:

Maintain discreet records of any incident of pressure wound and treatment provided.

Action required:

Maintain all documentation of inspections relating to food safety, health and safety and fire inspections in the designated centre.

Action required:

Provide documentary evidence that insurance purchased includes the required arrangements for event of loss of damage to residents property.

Reference:

Health Act 2007
Regulation 22: Maintenance of Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 9: Health Care
Standard 32: Register and Residents' Records
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response:	
Medical records will be maintained and a record of all drugs and medicines prescribed kept on file.	3 January 2011
Records will be kept of any incident of wounds or pressure wounds and treatment provided.	31 November 2011
Documents will be maintained relating to food safety. Fire inspections..	3 November 2011
We will provide evidence of insurance relating to residents property.	31 November 2011

Any comments the provider may wish to make:

Provider's response:

None received.

Provider's name: Breda Somers

Date: 8 November 2011