Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report Designated Centres under Health Act 2007

Centre name:	Sancta Maria
Centre ID:	0449
Centre address:	Gallows Hill Cratloe, Co. Clare
Telephone number:	061 357143
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Email address:	oliviaenglish@gmail.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Olivia English
Person authorised to act on behalf of the provider:	Olivia English
Person in charge:	Olivia English
Date of inspection:	17 and 18 October 2011
Time inspection took place:	**Day-1 Start:** 09:40 hrs **Completion:** 17:15 hrs **Day-2 Start:** 08:30 hrs **Completion:** 16:00 hrs
Lead inspector:	Mary Costelloe
Support inspector:	Linda Moore
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

Sancta Maria opened as a residential centre for older people in 1974. It is a split-evel building converted from a dwelling house. A number of extensions and alterations have been made in recent years. The centre has 34 places for residential and short-term convalescence care. There were 29 residents living there at the time of inspection, two residents were in hospital and some residents have dementia.

The main entrance is on the upper floor at the rear of the building. The nurses' office is off the main entrance corridor. The upper floor has a main day room, a dining room, and conservatory/smoking room. There are thirteen single bedrooms, two twin bedrooms, and one three-bedded room on this floor. Four of the single rooms share two en suite shower and toilet facilities. The three-bedded room and a single room share an en suite shower and toilet which is accessible from both rooms. There are three additional assisted shower rooms and one separate toilet located beside the day rooms for residents' use.

The lower level consists of one single bedroom with toilet and shower en suite, five twin bedrooms, none of which have en suite facilities, and a three-bedded room with assisted shower and toilet en suite. There is one additional assisted shower room on this level. The visitors' room, administration office, staff facilities, laundry and sluice room are all located on this level. There is a stairs and lift between upper and lower levels.

There is an enclosed paved patio area at the rear of the building which can be accessed from the conservatory and a well maintained garden to the front of the building.

The entrance is wheelchair accessible and there is ample car parking available around the building for staff and visitors.

Date centre was first established:			1974	
Number of residents on the date of inspection:			29 + 2 in hospital	
Number of vacancies on the date of inspection:			3	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents	8	2	8	11
Gender of residents			**Male (✓)**	**Female (✓)**
			15	14

Management structure

The Provider and Person in Charge is Olivia English and she is referred to as the Person in Charge throughout the report. Mary English is the Deputy Person in Charge. The Person in Charge and the Deputy Person in Charge are supported by a team of staff nurses, care assistants, catering and domestic staff all of whom report to the Person in Charge. Sharon Hickey is the Administrator and reports 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 set 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, and staff members 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. A fit person interview was carried out with the provider/the person in charge, who had completed the fit person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

Inspectors found that the person in charge provided strong leadership and delivered a good quality service to residents. She was knowledgeable about her defined responsibilities under the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Inspectors noted that many structural improvements had been completed in order to comply with requirements of the Regulations and the Standards since the previous inspection. Some smaller bedrooms had been increased in size and a four-bedded room had been replaced with two twin bedrooms. Bathroom and toilet facilities had been upgraded and a visitor's room, clean linen and equipment store had been provided. Staff changing area, staff toilet and kitchenette facilities were also provided. Structural works were completed to comply with fire safety requirements and written confirmation that all the requirements of the statutory fire authority had been complied with was submitted with the application to register.

There was evidence of good practice in all areas. The person in charge and staff demonstrated a comprehensive knowledge of residents' needs, their likes, dislikes and preferences. Staff and residents knew each other well, referring to each other by first names. Residents were observed to be relaxed and comfortable when conversing with staff.

Overall inspectors were satisfied that the residents were cared for in a safe environment and that their nursing and healthcare needs were adequately met. Inspectors observed an adequate ratio of staff to residents during the inspection and concerns raised regarding staffing levels in the evening time were addressed immediately by the person in charge.

Inspectors found that improvements were required to meet the Regulations and the Standards in terms of risk assessments, fire safety training, access to appropriate medical and allied healthcare services and development of care plans.

These areas for improvement are contained in the Action Plan at the end of this report.

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

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

1. Statement of purpose and quality management

Outcome 1

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

References:

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

Inspection findings

The statement of purpose had been reviewed by the person in charge and resubmitted prior to the inspection. The statement of purpose dated 5 October 2011 complied with the requirements of the Regulations and accurately described the service that was to be provided in the centre.

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

Inspectors were satisfied that the quality of care and experience of the residents was being monitored and developed on an ongoing basis.

The person in charge had put a system in place to gather and audit information relating to falls, accidents and incidents and complaints on a quarterly basis. Staff confirmed that audit findings were discussed with them to ensure learning and improvements to practice.

The person in charge also gathered and reviewed information on all residents on a monthly basis, such as the number of residents with pressure ulcers, catheters, weight loss, restraint, night sedation and use of psychotropic drugs. She told inspectors that she did not formally audit this information but used it to get an overview of all residents.

Residents and staff spoken to told inspectors that they could raise any issue with the person in charge and that issues raised were always acted upon in a timely manner. Residents confirmed that all issues and suggestions made at their residents meetings were all acted upon by the person in charge.

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
Inspectors found evidence of good complaints management but an improvement was identified. The management team had a positive attitude to receiving complaints and considered them a means of learning and improving the service.

There was a comprehensive complaints policy in place which clearly outlined the duties and responsibilities of staff. The complaints procedure was clearly displayed and outlined the name of the complaints officer and the appeals process.

Inspectors reviewed the complaints log and noted there were two complaints documented for 2011. Details of complaints, action taken and outcomes were recorded and all complaints to date had been resolved however the complaint log did not indicate if the complainants were informed and if satisfied or not with the outcome.

2. Safeguarding and safety

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

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

Inspection findings

Inspectors found that improvements were required in order to protect residents from being harmed or abused.

Inspectors reviewed the policy on the detection and prevention of elder abuse. The policy was not comprehensive. There was no guidance provided on who to contact in the event of an allegation of abuse being made such as the general practitioner (GP), relatives or the Chief Inspector. There was no guidance provided as to the procedures to be followed in the event of an allegation of abuse against a staff member.

The person in charge had trained as 'Train the Trainer' in elder abuse and had trained all staff. All staff spoken to confirmed that they had received ongoing training on identifying and responding to elder abuse. Training records reviewed showed that all staff had received training. The person in charge and staff spoken with displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Residents spoken to and those who completed questionnaires confirmed to inspectors that they felt safe in the centre. They primarily attributed this to the staff being available to them at all times, the presence of CCTV cameras in communal areas and outside the building and the availability of call bells.

Inspectors were satisfied that residents finances were managed in a clear and transparent manner. The person in charge told inspectors that small amounts of money were kept for safekeeping on behalf of some residents all of which were securely stored in the nurses' office. The finances of four residents were managed by the person in charge. A record of all transactions was clearly maintained and receipts were available for all purchases. All transactions were signed by the residents and a staff member or by two staff members in the event of the resident not being able to sign. Residents were issued with a monthly statement.

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
Inspectors noted that risk management procedures required improvements.

There was a centre-specific health and safety statement dated 2009. Inspectors reviewed the risk management policy which had been updated in October 2011. Risk assessments had been completed and identified some risks such as needle stick injury, violence and assault, chemical use, resident absconsion, falls and accidents, manual handling, use of equipment and toxic waste. Inspectors noted that all environmental risks had not been identified such as smoking, self harm and risks associated with the kitchen and laundry.

Inspectors reviewed the emergency plan dated January 2011. The plan contained comprehensive and clear guidance for staff on their roles in the event of various emergencies such as discontinuation of water supply, loss of telephone, power outage, heat outage, flooding and evacuation of the building. Arrangements were in place for alternative accommodation in the event of the building having to be evacuated.

Inspectors reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in May 2011 and the fire alarm was serviced on a quarterly basis, the last service took place in August 2011. Inspectors reviewed the fire register which included records of daily checks on means of escape, fire panel and fire exits. Fire orders were displayed prominently throughout the building. Staff spoken with confirmed that they had received fire safety training in the use of fire fighting equipment and evacuation and were knowledgeable on what to do in the event of fire. Records confirmed that the majority of staff had completed fire safety training. However, there were three part-time staff including one nurse who was sometimes rostered at night time who had not received training. As this nurse would be the only nurse on night duty and in charge of the centre, inspectors advised the person in charge that this nurse should not be rostered on duty at night time until such time as fire safety training was completed. The person in charge confirmed that fire safety training was scheduled for 24 October 2011.

The person in charge had trained as a manual handling instructor. All staff except three part-time employees had received up-to-date training in relation to moving and handling, training records reviewed confirmed this. Inspectors observed best practice in relation to moving and handling of residents during the inspection.

Inspectors observed cleaning procedures and spoke with the cleaner on duty. There was no comprehensive documented cleaning programme in place. Staff informed inspectors that there was no cleaner on duty on Sundays. Staff also stated they had not received formal training in infection control. Inspectors observed that some areas particularly wall floor junctions, behind bedroom doors and lockers required more thorough cleaning. A specialised floor cleaning machine was being used for all areas including corridors, bathrooms and bedrooms. Inspectors had concerns that as the same brush heads were being used throughout the building this could lead to the spread of infection from one area to another. The person in charge undertook to contact the suppliers and obtain written confirmation that this machine was suitable for use in all areas and would not pose an infection control risk when moving from one area to another. Following the inspection the person in charge confirmed that

she had allocated additional hours to cleaning staff to ensure seven day cover and to allow more time for deep cleaning. She also confirmed that training on cleaning and related procedures was completed by all domestic staff on 26 October 2011.

The design and layout of the building promoted a safe environment for residents. Handrails were provided to all circulation areas and grab rails were provided in all toilets and bathrooms. Call bell facilities were provided in all bedrooms. Safe floor covering was provided throughout the building and a lift was provided between floors.

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 inspectors found that while medication practices were generally well managed some improvements were required.

One inspector accompanied the nurse on a medication round. The nurse demonstrated her competence and knowledge when outlining procedures and practices on medication administration. Inspectors reviewed a sample of resident's medication charts and found that all medications were being reviewed on a three-monthly basis and all had been signed by the GP.

The inspectors reviewed the medication policy which was found to be comprehensive and gave clear guidance to nursing staff on areas such as medication administration, 'as required' medication (PRN), transcribing of medications, refusal and withholding of medications, medications requiring strict controls, self medication, disposal of medications and medication errors. However, the medication management policy was not being used to guide practice.

Inspectors noted that the medication policy did not guide practice in relation to medications requiring strict controls (MDA's) and self-administration of medications. The MDA's were appropriately stored and were being counted, recorded and signed by two nurses at the change of each shift. However, the nurse coming on duty was also signing that she observed the administration of the MDA's and she signed for this with the count of MDA's as a single entry. The policy stated that two nursing staff would administer these medications and sign at the time of administration, this was not the case. This was brought to the attention of the person in charge who had rectified the issue by the second day of inspection. The person in charge showed the inspectors how the MDAs were now being checked and signed by the nurse and a care assistant at the time of administration and she stated that the policy would be updated to reflect this practice.

There was one resident self-medicating at the time of inspection. There had been no assessment completed for this resident to ensure he could safely self administer and the medications were not securely stored in his bedroom which posed a risk to other residents and was not in line with the policy.

Medications requiring strict temperature control were stored in a refrigerated unit at four degrees Celsius. However, the temperature of the refrigerator was not being recorded on a daily basis. On the second day of inspection, nursing staff had commenced recording the temperature.

The person in charge and nursing staff told inspectors that they had not undertaken any educational updates on medication management. Inspectors also noted that An Bord Altrainais guidelines on the management of medication was not available to staff. Following the inspection the person in charge confirmed that training in medication management had been arranged for staff with the pharmacist on 10 November 2011.

Medication error report forms were available to record medication errors and near misses. The nurse on duty told inspectors that there had been no errors in 2011. The person in charge had completed a medication audit in September 2011, there were no areas identified for improvement. She told inspectors that the pharmacist had reviewed all residents' medications with the GP in 2010 and that she intended to recommence this arrangement in the near future.

3. Health and social care needs

Outcome 7

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

References:

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

Inspection findings

Inspectors found that there were some significant improvements required in a number of areas.

Inspectors had serious concerns about the management of a resident at risk of malnutrition. There was a policy on the management of nutrition but it was not being used to guide practice. Inspectors reviewed the file of a resident who had significant weight loss since January 2011. This resident was weighed monthly. There was a nutritional assessment completed, but it was different to the assessment outlined in the policy and it did not provide specific details such as the resident's body mass index. The assessment stated there was a need for a referral to a dietician but this had not taken place. The resident had been referred to the GP in April 2011 and had been prescribed nutritional supplements which were being administered. Despite continuing to loose weight the resident's medical notes indicated that the resident had not been reviewed by the GP for the management of weight loss since April 2011.

Nutritional intake was monitored daily and there was a nutritional care plan in place. However, it was not detailed enough to guide staff. Following the inspection the person in charge was requested to take appropriate action to manage this resident's weight loss and submit an update on the management of this resident within five working days. A satisfactory response was submitted within the timeframe. A comprehensive update on the management of the resident's weight loss, including updated nutritional assessment, updated care plan, referral to the Health Service Executive (HSE) primary care team dietician, occupational therapist (OT), Speech and Language Therapist (SALT) and psychologist. The person in charge confirmed also that six staff had completed training in Malnutrition Universal Screening Tool (MUST) nutritional assessment on 25 October 2011.

There was limited access to appropriate medical and allied healthcare services. All residents had access to GP services and residents could choose to retain their own GP if they so wished. There was an out-of-hours GP service available. Inspectors noted that residents medications were reviewed three monthly by the GP, but the residents medical health was not consistently reviewed on a three-monthly basis. The person in charge told inspectors that she had written to all GP's reminding them to medically review the residents on a planned basis, however, she had not maintained copies of these letters.

Inspectors found, there were some significant improvements required in the nursing documentation and the development of care plans as they did not set out in sufficient detail the action to be taken by staff to ensure all aspects of the health, personal and social needs of the residents were met. There was no pre-admission assessment completed. The person in charge said she visited residents in the hospital or the potential resident visited the centre where she assessed their needs, but she did not maintain records therefore there was no means of using the information from this assessment to inform care planning.

Inspectors reviewed a sample of residents' files including the files of residents with wounds, weight loss, recent falls and those who were restrained. A comprehensive nursing assessment was completed on admission for all residents'. However, some

nursing assessments were not recently reviewed or up-to-date while others were not dated and so it was unclear if they were current or not. Therefore the information from the assessment could not be used to develop meaningful care plans for residents. Up-to-date individual risk assessments were completed for prevention of falls, risk of developing pressure ulcers, nutrition, and moving and handling and this information was being used to inform care planning.

On the first day of inspection, inspectors reviewed the file of a resident with a number of small leg ulcers. Wound assessments had been completed, but they were not completed in line with best practice or as per the policy in that the sizes of the wounds were not indicated on the assessment, therefore it was difficult to track progress of the wounds. There was a care plan in place for wound care, but it did not include the specific instructions for the care of each of the wounds. On the second day of inspection the person in charge had updated the wound assessment and the care plan appropriately. This resident was complaining of pain and had been seen by the GP and was commenced on pain relieving medication. However, there was no pain assessment completed and there was insufficient detail in the care plan to guide practice in the management of pain.

Residents who were at risk of falling had a falls risk assessment completed on a three-monthly basis. Inspectors reviewed the file of a resident who had fallen twice in August 2011 and noted that a post falls assessment was not routinely completed when a resident fell. In this case a reassessment was carried out routinely in September 2011 but the care plan was not updated to reflect any additional interventions required to minimise the risk of this resident falling again.

Inspectors had concerns about the practice in relation to the use of restraint. From a review of resident's records and talking to staff, it was noted that restraint management was not based on evidenced based nursing care. Bedrails were in use for sixteen residents and three residents were seated in specialised chairs in the reclining position at times during the day. In anticipation of the national policy on the use of restraint being rolled out the person in charge had completed a 'Train the Trainer' course in the use of restraint and had recently trained all staff on the use and management of restraint. Training records reviewed and staff spoken to confirmed this. However the current use and management of restraint required significant improvements. Consent for the use of restraint was signed by the nurse with often no input from the resident. Risk assessment forms for the use of bedrails and lap belts were not consistently completed and any alternatives tried prior to the commencement of these restraints were not documented. A number of the residents' records were viewed and inspectors noted there was one generic care plan in place for all of the residents requiring bedrails. The interventions outlined in the care plan were not specific enough to guide the delivery of care to all of the residents using bedrails. Inspectors noted that monitoring of the use of bedrails at night time was well documented, residents were checked half hourly and documented checks were completed two hourly. There were no care plans in place for the use of reclined chairs and there was no documented plan to monitor and release residents in recliner chairs.

Throughout the inspection, physically dependent residents were observed seated in specialised chairs and one resident did not have their feet sufficiently supported. Residents had not been assessed for the use of these chairs as the person in charge said they had difficulty accessing OT services. One resident was assessed for the use of a chair by the manufacturing company. However, there was no guidance provided to staff on the appropriate seating position for this resident.

Many residents who required specialised diets due to swallowing difficulties had not been assessed by a SALT since their admission, for one resident this had been many years. This posed a risk for residents should they receive the inappropriate consistency of diet and fluids. The person in charge told inspectors of the limited access to allied health professionals. She said that physiotherapy, OT, dietician and SALT were available through the HSE on referral from the GP. She said that the system was unsatisfactory in that there were often long waiting periods and residents could only access the services through an outpatients department. The person in charge said that physiotherapy and OT were available privately on request at an additional fee but that often residents and their families did not wish to incur the charge.

Staff strived to meet residents' needs for social engagement and occupation in a meaningful way. All staff were involved in providing activities for residents. An activities coordinator had been appointed for five hours a week to further develop and enhance the activities programme based on the assessed individual needs of residents. There was a range of varied activities taking place including bingo, weekly coffee mornings, baking, Sonas (a therapeutic programme specifically for residents with dementia) and fit for life exercise programme. Many of the residents spoken to said that they looked forward to bingo and told how they enjoyed winning small prizes. Special events such as birthdays, Christmas and Easter were celebrated. Several themed BBQ's and a race day had been held during the summer months, residents told inspectors how they had enjoyed them. Some residents spoken to told inspectors that there was always something happening and that they never found the day long. Many staff were observed spending one to one time chatting with residents and reading with residents throughout the inspection.

The person in charge told the inspectors that she had researched a training course on communication skills for engaging activity with older people and was considering sending some staff on the course.

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

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

Inspection findings
Inspectors were satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided in centre.

There was a comprehensive policy on end of life care. The policy included guidelines for involving the resident and their families in planning the end-of-life care. Inspectors reviewed the file of a recently deceased resident. The care plan was insufficiently detailed to guide the delivery of care. However, the inspectors noted evidence in the resident's daily progress notes to indicate that a satisfactory level of care was delivered to the resident at end of life.

Staff told inspectors that families were facilitated to stay overnight in the residents room if they wished and were provided with meals and refreshments. Four staff were scheduled to attend end of life training in the coming week. Staff also told inspectors that residents were facilitated to attend the funerals of other residents if they wished.

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
Some improvements were required to the presentation of meals and how they were served to residents.

Inspectors saw meals being served to residents in a bright dining room beside the kitchen. There were four kitchen style tables with chairs seating up to six residents. The table settings were attractive and had table cloths, place mats, fresh flower centrepieces, condiment sets and serviettes. The weekly menu was displayed in booklet form on each table.

Inspectors reviewed the dining arrangements. Residents were offered a varied and nutritious diet. Choices were available at lunch time and for evening meals. Residents spoken to confirmed that they could have whatever they wanted to eat. The catering staff were aware of residents' preferences and were able to show inspectors the daily menu sheets that had been completed for all residents. Special diets and modified consistency diets were provided for residents who required them. Residents complimented the quality of the food and inspectors sampled the food, confirming that the food was of good quality. Inspectors noted that the modified consistency meals were not presented in an appealing or appetising manner. The chef blended the potato, vegetables and meats together which resulted in the meals lacking texture and colour and were less appetising to some residents.

Inspectors saw staff sitting beside residents and assisting them to eat while encouraging other residents to eat independently. Staff and residents confirmed that snacks and drinks were available throughout the day and night. A fresh water dispenser unit was available for residents, staff and visitors. Staff were observed to offer and encourage residents to take drinks throughout the day.

Inspectors observed some residents dining in the main day room and found that the dining experience for this group was not as good as for residents in the dining room. These residents had their meals served on individual trays which were placed on bed tables or small occasional tables. Some of the tables were too low and the inspectors noted that residents had to bend forward to access their meal and one resident appeared to have difficulty eating from the low table. The person in charge told inspectors that some of the residents preferred and choose to dine in the day room but she did acknowledge the issue of the tables being too low for residents to comfortably eat their meals.

4. Respecting and involving residents

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

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

Inspection findings
Written contracts of care were in place for all residents. The contracts were in line with requirements of the Regulations and included the fee to be charged and the services provided.

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 noted that the privacy and dignity of residents was respected. Screening curtains were fully closed when personal care was being delivered in shared rooms. Bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. Residents spoken to confirmed that their privacy and dignity was always respected by all staff.

Residents were treated with respect. Inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Residents and relatives all spoke highly of staff, stating that they could approach any member of staff if they had a concern or issue.

Residents' religious and political rights were facilitated. The person in charge informed inspectors that all residents were Roman Catholic but that arrangements would be put in place for residents of different religious beliefs if required. Mass took place weekly and one resident went out to attend her own church each Sunday.

Residents were facilitated to vote in house. During the second day of inspection, residents were facilitated to vote on the Presidential election. The polling box was brought to the centre by the local presiding officer and a member of the Garda Síochána.

A separate comfortably furnished visitor's room had also been provided to allow residents to receive visitors in private. Relatives spoken to stated that they could visit at any time and were always made feel welcome.

Residents had access to newspapers and magazines. A variety of newspapers were ordered daily and some residents ordered their own particular newspapers. The local newspapers were provided on a weekly basis and local newsletter on a monthly basis. Staff were observed at many times during the inspection reading articles from the newspapers to individual residents. Many of the residents confirmed that they enjoyed reading the papers themselves.

Residents maintained links with the local community. Local school children visited at Christmas and Easter time. One transition year student visited and chatted with residents every week. The local parish priest visited to say mass on a weekly basis and discussed local news with residents. Two advocates had been appointed from the National Advocacy Programme. They visited residents for two hours each week. Some of the staff were from the local area and residents confirmed that they kept them informed of local news issues.

Residents spoken to told inspectors how they exercised choice in how they spent their day, getting up and going to bed when they wished, having their meals at times that suited them. One resident preferred to have his main meal in the evening time and this was facilitated. Some residents told inspectors that they enjoyed going outside and said they got great tans during the summer.

A residents committee meeting was held every three months. The committee was facilitated by one of the carers who had a degree in social care. The minutes of the meetings were typed up, circulated and displayed. Seven residents attended the last

meeting and issues raised and discussed included the menu, activities and laundry. Residents suggested some changes to the menu, were satisfied with the laundry arrangements and made some suggestions for new activities including baking. Residents and staff spoken to confirmed that all issues raised were acted upon.

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
Residents spoken to told inspectors that they were satisfied with the laundry arrangements and had no issues with regard to mislaid clothing. All bedrooms had adequate personal storage space and clothes were stored in a neat and tidy manner. A lockable storage space was provided to all residents who requested or wished to have one. Some residents had a key to their bedroom and could choose to lock it if they wished.

5. Suitable staffing

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

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

Inspection findings
The person in charge was a registered nurse, worked full-time and was normally on duty Monday to Friday. She had taken over the business in 2001 and had been in the post of person in charge since. She was on call at weekends and out-of-hours.
The person in charge had completed a Diploma in Nursing studies, Nursing Home Management Further Education and Training Awards Council (FETAC) Level 6 and 'Train the Trainer' in Manual handling, elder abuse and restraint.

The person in charge had a good knowledge of the Regulations and Standards and her statutory responsibilities were sufficiently demonstrated both during the interview and by the documentation available. All documentation requested by the inspectors was readily available.

The person in charge told inspectors that a senior nurse and the deputy person in charge were always on duty at weekends to supervise the delivery of care. Staff spoken to and rosters reviewed confirmed this to be the case.

Inspectors were concerned at the high level of healthcare issues identified at this inspection and discussed this with the person in charge. She stated that she needed to review the nursing support she required in order to allow her to put in place the appropriate systems and practices to ensure a high standard of evidenced based care was delivered. She acknowledged there was a deficit in the support she currently received and stated she would be reviewing the post of key senior manager for the centre.

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

Inspectors reviewed the staffing rota and observed adequate levels of staff on duty during the day but had concerns regarding the staffing levels in the evening time from 6.30 pm to 11.30 pm. For 34 residents there were normally two nurses including the person in charge and four care assistants on duty in the mornings, two nurses and three care assistants in the early afternoon, two nurses and two care assistants in the later part of the afternoon. There was only one nurse and one care assistant on duty from 6.30 pm to 11.30 pm. There was one nurse, one care assistant and one general assistant on duty at night time. The inspectors discussed the staffing levels with the person in charge and she agreed to review them and stated that she would include an additional staff member in the evening time. Following the inspection, the person in charge submitted a revised rota and confirmed that she had increased the staffing levels and now had two care assistants on duty with nursing staff at all times.

Inspectors reviewed the staff recruitment policy and noted it did not state that three written references were required in line with the requirements of the Regulations. The inspectors reviewed a sample of staff files. All staff files did not contain the required documentation as required by Schedule 2 of the Regulations such as

photographic identity, evidence of physical and mental fitness and three written references.

Inspectors were shown comprehensive staff induction and orientation packs for nurses and care assistants. The pack included a section at the end for staff to sign and date confirming that they understood the content. Staff spoken to were satisfied with the induction training they received and completed packs were included in staff files.

The person in charge was committed to providing ongoing training to staff. Training had been facilitated in house during 2011 and many staff had received training on elder abuse and restraint. One staff nurse had received training on wound management and male catheterisation. The person in charge and the administrator had completed Nursing Home Management Development Programme FETAC level 6. All care assistants had completed FETAC Level 5 Training programme. Four staff were scheduled to attend training on end of life care in the coming week. Following the inspection the person in charge confirmed that she and a senior nurse were scheduled to attend a clinical audit study day on 7 December 2011.

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 noted that the person in charge had carried out many structural improvements to the building in order to comply with requirements of the Regulations and Standards since the previous inspection. Some smaller bedrooms had been increased in size and a four-bedded room had been replaced with two twin bedrooms. However, inspectors noted that the size, occupancy levels and layout of the two three-bedded rooms would not comply with the requirements of the Standards by 2015.

Bathroom and toilet facilities had been upgraded. However, during the renovations the bath had been removed. As a result there was now no bath provided which did not promote resident choice. The provider told inspectors that she did not as yet have a plan in place to address the remaining structural deficits but she would be putting a plan in place with a view to complying with the requirements of the Standards.

Additional upgrading had been completed to provide a visitor's room, clean linen and equipment store had been provided. Staff changing area, staff toilet and kitchenette facilities were also provided.

Structural works were completed to comply with fire safety requirements and written confirmation that all the requirements of the statutory fire authority had been complied with was submitted with the application to register.

Inspectors found the premises to be well-maintained both internally and externally. It was warm and odour free. Wall mounted dispensers containing hand sanitising gel were located at the entrance door and throughout, and inspectors saw staff using them regularly.

The main dining room and day-room were bright and comfortable with pleasant views. Many residents spoke of enjoying the sunshine which poured in to both rooms through the large glass windows. The day-room opened onto a secure balcony which residents could access in fine weather. The conservatory/smoking room was located near the main entrance at the rear of the building and opened directly onto a secure paved patio area. Garden furniture was provided for residents use.

Inspectors found that the building was secure and safe. All external doors were fitted with electronic finger printed keypads. CCTV cameras were fitted to corridors, external doors and outside areas ensuring additional security and safety for residents. The person in charge told inspectors that they had no residents who were confused and wandering at present so the main entrance door was unlocked. Residents were observed going in and out independently.

Bedroom accommodation met residents' needs for privacy, leisure and comfort. Specialised beds, call bell facilities and ample personal storage space were provided in all rooms. Wall mounted televisions were provided in most rooms. Residents spoken to told inspectors that they liked their bedrooms. Many residents had personalised their bedrooms with family photographs, pictures, flowers and religious ornaments.

Inspectors visited the kitchen which was located on the ground floor beside the dining room and found it to be spacious and well equipped. Separate staff changing and toilet facilities were provided for catering staff.

Adequate assistive equipment was provided to meet residents' needs such as hoists, a lift, specialised beds and mattresses. Inspectors viewed the service and maintenance records for the equipment and they were all up-to-date.

Inspectors viewed the sluice room which was found to be well-equipped, clean and well organised.

7. Records and documentation to kept at a designated centre

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

References:
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

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

Resident's guide

Substantial compliance ☒ Improvements required* ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required* ☐

General records (Schedule 4)

Substantial compliance ☒ Improvements required* ☐

Operating policies and procedures (Schedule 5)

Substantial compliance ☐ Improvements required* ☒

Directory of residents

Substantial compliance ☒ Improvements required* ☐

Staffing records

Substantial compliance ☐ Improvements required* ☒

All staff files did not contain the required documentation as required by Schedule 2 of the Regulations such as photographic identity, evidence of physical and mental fitness and three written references.

Medical records

Substantial compliance ☒ Improvements required* ☐

Insurance cover

Substantial compliance ☒ Improvements required* ☐

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

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

Inspection findings
Practice in relation to notifications of incidents was satisfactory.

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

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

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

Inspection findings

The person in charge was aware of her responsibilities to notify the Authority but as yet this was not required. Inspectors were informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge and the administrator 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 Costelloe

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

20 October 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Sancta Maria
Centre ID:	0449
Date of inspection:	17 and 18 October 2011
Date of response:	23 November 2011 and revised 2 December 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 3: Complaints procedures

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

The complaint log did not indicate if the complainants were informed and if satisfied or not with the outcome.

Action required:

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: We have had no complaints since the inspection but in future we will ensure that it is documented whether the complainant was satisfied with the outcome or not.	Completed

Outcome 4: Safeguarding and safety

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

The policy on the detection and prevention of elder abuse was not comprehensive. There was no guidance or mention provided regarding who to contact in the event of an allegation of abuse such as the general practitioner (GP), relatives or the Authority. There was no guidance provided as to the procedures to be followed in the event of an allegation of abuse against a staff member.

Action required:

Put in place a policy on and procedures for the prevention, detection and response to abuse.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The policy on the detection and prevention of elder abuse has been revised and amended to include dealing with an allegation of abuse against and staff member and also contacts added please find copy of amended policy attached.	Completed

Outcome 5: Health and safety and risk management

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

All risks had not been identified such as smoking, self harm and risks associated with the kitchen and laundry.

There was three part-time staff including one nurse who had not received fire safety training.

There was no comprehensive documented cleaning programme in place. Some areas particularly wall floor junctions, behind bedroom doors and lockers required more thorough cleaning.

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, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:

Provide suitable training for staff in fire prevention.

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.

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: All staff at Sancta Maria have now completed mandatory fire training including prevention, control, evacuation and procedure. Same was delivered on 24 October 2011. Please find relevant cert attached. Where residents have the ability to understand the procedure in the event of fire has been discussed and a copy given to these residents. Risk assessments have been completed for smoking, the kitchen area, and the laundry room. Risk assessments are ongoing in all areas. The "becks hopelessness scale" will be used for any	Completed

residents we feel is at risk of self-harm and the appropriate referrals will be made based on this. A comprehensive cleaning programme and manual are now in place and Cleaning staff have received training on same – completed on 26 October 2011 – please find certificates attached. We have a comprehensive health and safety statement which is aimed at residents, staff and visitors covering areas such as food safety, manual handling, poor housekeeping, sharps injury, bully and harassment, chemical usage and elopement amongst others and is under annual review and more frequently if required. All staff have received a copy of this and copies are also available in the office for residents and families.	

Outcome 6: Medication management

4. The provider is failing to comply with a regulatory requirement in the following respect: The medication policy did not guide practice in relation to medications requiring strict controls (MDA's) and self administration of medications. There had been no assessment completed for a resident who was self medicating and the medications were not securely stored in his bedroom which was not in line with the policy.	
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 Standard 15: Medication Monitoring and Review	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Medication management policy has been amended to reflect best practice and the practice at Sancta Maria. A self-medication assessment tool and risk assessment has been added to the policy – please find a copy self-medication assessment tool and risk assessment attached.	Completed

Outcome 7: Health and social care needs

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

There was limited access to appropriate medical and allied healthcare services.

Inspectors found, there were some significant improvements required in the development of care plans as they did not set out in sufficient detail the action to be taken by staff to ensure all aspects of the health, personal and social needs of the residents were met.

There was no pre admission assessment completed.

Some comprehensive nursing assessments were not up-to-date and had not been recently reviewed while others were not dated.

There was no pain assessment completed on a resident complaining of pain due to her wounds and there was insufficient detail in the care plan regarding this resident's pain management.

There was serious concerns around the management of one resident with significant weight loss. The policy on the management of nutrition was not used to guide practice. One resident who had significant weight loss since January 2011. The nutritional assessment was not the assessment that was outlined in the policy and it did not provide detail of the resident's body mass index. There was a need for a referral to a dietician but this had not taken place. The resident's medical notes indicated that the resident had not been reviewed by the GP for the management of weight loss since April 2011.

Inspectors noted that post falls assessments were not routinely completed after a resident fell.

Risk assessment for the use of bedrails and lap belts had not been consistently completed and the alternatives tried were not documented. There was one generic care plan developed for all of the residents and these were not specific enough to guide the delivery of care. There were no care plans in place for the use of reclined chairs.

Some physically dependent residents were seated in specialised chairs and one resident did not have their feet sufficiently supported which may have negative outcomes for this resident. Residents had not been assessed by the OT for the use of these chairs.

Many residents who required specialised diets due to swallowing difficulties had not been assessed by the SALT since their admission.

Action required:

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

Action required:

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

Action required:

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

Action required:

Facilitate each resident's access to physiotherapy, chiropody, occupational therapy, or any other services as required by each resident.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All residents care plans are currently under re-evaluation, reassessment and development to include sufficient detail to all staff to ensure all aspects of health personal and social needs of the residents are met. These are being done in consulting with residents, their representatives; staff nurses and a social care worker. They will be reviewed at least every three months and signed off by staff nurses and the social care worker. They will audited by the person in charge on a monthly basis. A formal documented pre-assessment is now done on all potential admissions - please find format for same attached. Pain assessments ("the abbey pain scale") are now done on all residents complaining of pain and the care plan reflects same including any actions to be taken. We have developed a new nutritional care plan which deals with the management of weight loss in our residents – please find a copy of same attached.	February 2012

We are using our policy to guide practice and five of our staff nurses have received MUST training from a dietician from an external company. All residents are now routinely assessed using the MUST tool and any resident with a score of two or more will be referred to a dietician for advice - which must be done via the GP. All these actions have been taken with the residents in question on the day of inspection and the care plan has already been submitted to the inspectorate. All residents at Sancta Maria are routinely assessed for falls risk using the "Canard Tool" and we are now reassessing them post falls also the care plan reflects same. A new care plan has been implemented using restraints and enablers – which include a risk assessment – please find same attached. We have now accessed primary care referral forms to enable us to have our residents reviewed by the appropriate ancillary services such as OT and SALT.	

Outcome 13: Suitable person in charge

6. The provider is failing to comply with a regulatory requirement in the following respect: The person in charge stated that she needed to review the nursing support she required in order to allow her to put in place the appropriate systems and practices to ensure a high standard of evidenced-based care was delivered. She acknowledged there was a deficit in the support she currently received and stated she would be reviewing the post of key senior manager for the centre.	
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.	
Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: The current Key Senior Manager intends to retire the end of January 2012, I am currently reviewing this post and will inform the inspectorate as soon as I have selected a suitable candidate	February 2012

Outcome 14: Suitable staffing

7. The provider is failing to comply with a regulatory requirement in the following respect: The staff recruitment policy did not state that three written references were required in line with the requirements of the Regulations. All staff files did not contain the required documentation as required by Schedule 2 of the Regulations such as photographic identity, evidence of physical and mental fitness and three written references.
Action required: Put in place written policies and procedures relating to the recruitment, selection and vetting of staff.
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 of the Regulations have been obtained in respect of each person.
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All staff have been advised to make available the required documentation needed for HR file, We are still awaiting a number of documents and staff have been given a deadline of 16 December 2011 for same. Our policy has been amended to reflect same	16/12/2011

Outcome 15: Safe and suitable premises

8. The provider is failing to comply with a regulatory requirement in the following respect: Inspectors noted that the size, occupancy levels and layout of the two three-bedded rooms would not comply with the requirements of the Standards by 2015. There was now no bath provided, this did not promote resident choice.
Action required: Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.
Action required: Provide sufficient numbers of toilets, and wash-basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will review the layout of these three-bedded rooms in due course, as we have already lost six beds since the implementation of the Standards, we are not in a position to loose anymore at this time. We will endeavour to comply with the Standards on same by 2015 when we will reduce the three-bedded rooms to two beds and provide a suitable bath for residents use.	July 2015

Any comments the provider may wish to make:

Provider's response:

None

Provider's name: Olivia English
Date: 23 November 2011