Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

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

Centre name:	St Teresa's Nursing Home
Centre ID:	0293
Centre address:	Friar Street Cashel Co Tipperary
Telephone number:	062-61477
Fax number:	062-63166
Email address:	carmel.mccormack@gmail.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Michael McCormack
Person in charge:	Carmel Devaney
Date of inspection:	6 July 2011 and 7 July 2011
Time inspection took place:	**Start: Day-1:** 10:00hrs **Completion:** 20:00hrs **Start: Day-2:** 09:00hrs **Completion:** 18:45hrs
Lead inspector:	Mary Moore
Support inspector(s):	Patricia Tully
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*. Residents' 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

St Teresa's Nursing Home was originally established in 1999 as a fifteen-bedded centre on John Street in Cashel but relocated in 2003 to its current location in the old Presentation Convent as a thirty-bedded unit. Long-term, respite, convalescence and palliative care are provided. On the day of inspection there were 25 residents living in the centre (plus one resident on temporary discharge) and all residents were in receipt of long-term care. All residents with the exception of one were over the age of 65 years; 18 residents were greater than 80 years of age. Eleven residents had a diagnosis of dementia.

The building was originally built as a convent in the mid 1800's and is located on a large private secure site in the centre of Cashel town with direct and easy access to all the amenities normally available in a busy tourist location. It is a three-storey limestone structure that has been extensively refurbished by its present owners. Residents are accommodated on the first and second floors. There are nine bedrooms on each floor providing accommodation for 15 residents. Per floor there is one single en suite bedroom with assisted toilet, shower and wash-hand basin, two single bedrooms with shared en suite with assisted toilet, shower and wash-hand basin, two twin-bedded rooms with en suite assisted toilet, shower and wash-hand basin and four twin-bedded rooms with shared en suite of assisted toilet, shower and wash-hand basin per each set of twin-bedded rooms (i.e. one en suite per each four occupants). There is a further assisted bathroom provided on the second floor and a sluice room on each floor.

Communal accommodation for residents is provided on the ground floor. The entrance is wheelchair accessible and leads to a foyer with stairwell to the first and second floors and a corridor that leads to a large quiet sitting room and conservatory area on the left and if one continues onwards, it leads directly into the main communal and dining areas for the residents. Accessed from the main dining area are the main kitchen and ancillary stores, staff facilities, and the laundry. There are two toilets for residents' use within close proximity of the main dining/communal areas. Two lifts are available to residents, staff and visitors. The original passenger lift has been retained and is accessed from the main dining area. A new lift with capacity to carry eight persons was installed by the present owners in 2010 and is accessed to the rear of the building. Both lifts service all floors and areas of the building.

The surrounding grounds are safe, secure, attractive and well maintained. Residents have access to all of the grounds but primarily utilise the area to the rear of the building, which offers seating and safe walkways. There is ample car parking to the front of the building.

Date centre was first established:			1999; in present location since 2003	
Number of residents on the date of inspection:			25 (plus one resident in hospital)	
Number of vacancies on the date of inspection:			5	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents:	4	4	14	3
Gender of residents:			**Male (✓)**	**Female (✓)**
			8	17

Management structure

St Teresa's Nursing Home is owned and managed by Michael McCormack and Carmel Devaney. The Registered Provider is Michael McCormack and the Person in Charge is Carmel Devaney. A team of nursing staff, care assistants, catering staff and household staff provide for the care and personal needs of the residents on a daily basis. All staff 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.

This was the second inspection undertaken by the Health Information and Quality Authority in St Teresa's Nursing Home. The first inspection took place on 17 September 2010 and was a one-day scheduled unannounced monitoring inspection. On that occasion the inspector was satisfied that a good standard and quality of care was provided to residents in a safe and comfortable environment. There was evidence of good care practices observed in meeting the needs of residents on a daily basis and a commitment to ongoing review and continuous improvement. Improvements were required to comply 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.*

Improvements included:

- medication management
- completion of staff files
- policies and procedures
- procedures for the management of complaints
- timely medical reviews of residents.

Full details of these and other required improvements can be found in the Action Plan at the end of that inspection report.

On this second inspection inspectors met with residents, relatives, and staff members, over the two day inspection. Inspectors observed practices and reviewed documentation such as residents and relatives questionnaires, 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, both of whom 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.

The findings of the inspection are presented under 18 outcome statements. These statements set out what is expected in a designated centre 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) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.* Residents' and relatives' comments are included throughout the report.

Overall, inspectors were again satisfied that residents were in receipt of a good standard of medical, nursing and social care that was person-centred and delivered to meet their individualised needs with resultant positive outcomes for residents. Staff spoken with and records reviewed demonstrated clinical competency, kindness and a respect for the individuality and autonomy of residents including residents with a cognitive impairment and associated challenging behaviours. The provider and the person in charge demonstrated a high level of commitment to the residents, the staff and the service; clinical care was closely monitored and evaluated on a daily basis by the person in charge.

Staff spoken with confirmed the expectation of high standards of care and work performance on a daily basis, contributed willingly to this ethos of care, took pride in their work and told inspectors that the resident was the focus of service delivery. Inspectors found evidence of good fire safety, health and safety, and risk management practices. The physical environment had been extensively renovated and refurbished to a high standard, was suitable for its stated purpose and well maintained.

Inspectors found a good level of compliance with the care and welfare regulations and the Standards; however, improvements were required to enhance and standardise the many findings of good practice. The required improvements are described under each outcome statement and are set out in detail in the Action Plan at the end of this report. Required improvements included:

- review and amendment of the statement of purpose
- standardisation of the complaints procedure
- review and standardisation of the care-planning process
- contracts of care.

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

A statement of purpose and function was in place and was an accurate reflection of the service; inspection findings confirmed the implementation in practice of its stated aims and objectives. For example, residents and relatives confirmed that choice and individual preference in the daily routine were facilitated and staff demonstrated in their knowledge, actions and communications, a commitment to a quality person-centred culture of care and respect for the privacy and individuality of each resident. However, review and amendment of the document is required as it did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The required information was discussed and outlined in detail with the provider and person in charge by inspectors during verbal feedback.

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

Documentation reviewed by inspectors confirmed that the quality and safety of care delivered to residents on an individualised basis was reviewed on an ongoing basis, required improvements and learning were identified and communicated to staff by the person in charge. Examples included near misses, falls and the management of challenging behaviours; these are discussed later in the report. Inspectors saw

individual “Personal Risk Management Plans” for residents where behaviours deemed to be a risk to self or others were exhibited, or there was a history of falls.

Inspectors also found evidence of the recent implementation of a more formalised and generalised system for reviewing the quality and safety of care and operational practices. The provider and person in charge had attended an education day on Risk Management and Audit within the nursing home in March 2011 and the person in charge had completed audits of medication management, respecting residents' privacy and dignity, and health and safety policy and procedure. The person in charge acknowledged that this was a recent initiative and the inspection findings confirmed that further areas requiring prioritisation for review included the process of care planning and the use of bedrails.

There was an established system in place for reviewing and monitoring the implementation of the Hazard Analysis and Critical Control Points (HACCP) food safety management system with evidence of the identification and implementation of remedial actions.

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

The complaints policy was comprehensive and the person in charge acted as the complaints officer. A synopsis of the policy was available both in the statement of purpose and the Resident's Guide. The complaints procedure was displayed on the wall in the entrance hallway. Staff demonstrated their knowledge of, and had signed an acknowledgement of having read the policy and procedure.

Residents and relatives outlined to inspectors that they would have no hesitation in bringing any complaints to the person in charge, registered provider and/or nurse on duty to discuss any issues they had but, predominately, they had little or no reason to complain. Relatives spoken with attested to the availability and accessibility of both the provider and the person in charge, open communication with them and their receptiveness to “requests” rather than the necessity to complain.

There were three complaints recorded in the complaints book between 2009 and 2011 and no new complaints were logged since the last inspection. The complaints logged pre-dated the updated policy of 5 January 2011.

Any new complaints should be documented in line with the revised policy and procedure in terms of logging all actions in regard to the complaint and the outcome

of the complaint in one comprehensive record as this was not clear from the existing records.

The name of the independent appeals person and the name of the nominated person who maintains a record of all complaints should be standardised across all documents.

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

Policies and procedures on the prevention, detection and response to elder abuse were in place; staff had signed acknowledgements of having read the policies and procedures. The person in charge and staff spoken with demonstrated their knowledge of the different forms of elder abuse and were clear on reporting procedures. At the time of inspection there were no recorded incidents or allegations of abuse.

Residents told inspectors that they felt safe in the centre and attributed their sense of safety and security to the presence of staff and the security of the physical environment. They spoke of the openness and friendliness of staff and the ethos of care in the centre where the care and welfare of the resident was paramount. Relatives spoken with confirmed that they were satisfied and reassured as to their family member's safety and used their family member's level of happiness and contentment as a benchmark. The registered provider, person in charge and staff spoke of management's 'open door' policy for residents and relatives to speak to them about any aspect of their care or if they have concerns.

While the policy and procedure on responding to allegations of abuse was comprehensive it was staff focussed. Greater emphasis should be given to supporting the resident, their family, what they can expect during an investigation of an allegation of abuse, supportive mechanisms in place for them and how they will be safeguarded.

The policy and procedure for the management of residents' money was reviewed and found to be comprehensive. Residents were encouraged to manage their own finances for as long as possible. Secure facilities were available to each resident in their bedrooms. Financial records were maintained for both the expenditure of individual residents' petty cash and the payment of accounts for their care in line

with their contract of care. Residents and relatives had shown their trust in the management by asking them to undertake management of personal finances in a number of situations. Ward of court applications are sought when this was deemed necessary.

However, in the interest of openness and transparency and the protection of all parties, documentary improvements were required particularly in relation to clearly recording all transactions. Records signed by two members of staff and the resident or their representative where practicable should be kept so that records confirm that residents' finances were indeed being managed in line with best practice.

The current centralised facility for safekeeping money held by the centre on behalf of residents or by the person in charge as an agent for the resident requires review so that it offers the best security for all concerned.

While inventories were maintained in care plans of residents personal property and possessions a sample reviewed was not signed or dated.

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 found evidence of awareness of the ongoing and dynamic nature of risk management and the implementation of required remedial actions in response to near misses and risk assessments. Tobacco consumption by residents was governed by policy and supervised by staff; however, the person in charge had also recently secured a stainless steel ash bin and a fire-retardant "apron" for residents so as to minimise the risk of fire and accidental burning.

Procedures in relation to the supervision and management of activity materials had been reviewed and enhanced following a recent near miss where a resident with a cognitive impairment was observed to have ingested a foreign object due to their inability to differentiate between edible and non-edible items. As a further risk reduction measure dispensing mechanisms for disposable gloves and aprons had also been modified by the provider so as to prevent the removal and possible ingestion of items by confused or cognitively impaired residents while not restricting the availability of equipment to staff. Staff spoken with were informed and aware of their responsibilities.

There was a centre-specific safety statement in place and the person in charge had completed a broad range of risk assessments for each area of work, clinical risks, risks associated with work systems and the risks as specified in Article 31 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

The centre was visibly clean, a colour-coded system of cleaning to minimise the risk of cross contamination was in place and cleaning staff spoken with were knowledgeable as to its implementation. Laundry staff were knowledgeable in relation to the segregation and care of infected/contaminated linen and had available to them the appropriate equipment. Hand sanitizing facilities were strategically located throughout the centre as was personal protective equipment for staff. External storage for clinical risk waste in line with national guidelines had been provided following the last inspection and consignment notes verifying its collection by a recognised contractor were available for inspection.

There was evidence of a proactive approach to fire prevention and safety. The premises had been inspected by personnel from the relevant fire safety authority; their report and a formal response confirming the implementation of required remedial actions from a fire safety consultant on behalf of the provider were available for inspection. Records reviewed demonstrated that 23 staff had attended fire prevention and management training in May 2011 and a simulated fire evacuation exercise was completed in May 2011 and June 2011 and attended by 25 staff. Staff spoken with confirmed their attendance and were knowledgeable as to the actions required in the event of fire.

Fire fighting equipment was strategically placed and seen by inspectors to have been inspected to the required standard in May 2011. Certification was also available confirming quarterly inspection and testing of the fire detection system most recently in June 2011 and annual inspection and testing of the emergency lighting in June 2010. The provider conducted checks of fire detection and fire management systems including escape routes, records were maintained including evidence of remedial actions. There was a dedicated fire escape from each end of the building and ski-pads (two per floor) had recently been secured for use in the evacuation of dependent residents and staff confirmed they had received practical simulated instruction in their use. Fire evacuation sheets were also seen by inspectors on the beds of dependent residents. Fire action notices were prominently displayed in bedrooms and throughout the building.

While personal emergency evacuation plans were in place for dependent and cognitively impaired residents they were not explicit as to the assistance required and the manner of evacuation to be applied. Once agreed this information requires communication to all staff and review in line with the changing needs of residents, and further admissions etc.

There was an emergency plan in place but it did not include the contingencies in place for loss of essential services such as power and water.

Lifting devices for use by staff when moving dependent residents had not been serviced since September 2010.

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

There was evidence of good medication management practices but minor improvements were required to enhance the findings of good practice. Medical records reviewed demonstrated quarterly review of medications by the relevant general practitioner (GP) or more frequently if required. Medications such as benzodiazepines, sedatives and psychotropic medication were prescribed in conjunction with review and advice from personnel from old age psychiatry; there was evidence of the monitoring of residents for adverse side effects, further review and appropriate reduction and discontinuation of medication. There were no controlled drugs in use at the time of inspection.

Nursing staff spoken with had attended medication management education and demonstrated knowledge and competence. Practice was governed by evidence-based policy and procedure and staff had access to other supporting regulatory documents. Records were maintained of the return to the pharmacy of unused or out-of-date medications; no excess stocks were seen by inspectors. Two residents were in receipt of medications in a crushed format and this was clearly documented in their medical notes and prescription sheet by the relevant prescriber.

Medications were supplied in blister packs with the exception of night sedation which was supplied in its original packaging and collectively stored in a locked cupboard in a container separate to all other medications. The rationale for this was discussed with the person in charge as was the potential risk if staff were not to utilise the medicine trolley when administering night sedation. The person in charge agreed to risk assess, review and discuss this practice with staff and the pharmacist.

Medication prescription records were transcribed by nursing staff and though signed by the transcribing nurse and co-signed by the relevant prescriber; records were not counter signed by a second witnessing nurse as outlined in local policy and regulatory body guidelines.

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

Based on their observations, documents reviewed, comments from residents, relatives and staff, inspectors were satisfied that the healthcare provided to residents was of a good standard. Staff spoken with demonstrated knowledge and competency and both relatives and residents reported an improvement in overall health and well-being following admission. Healthcare needs were monitored and coordinated on a daily basis by the person in charge and nursing staff in consultation with the appropriate general practitioner (GP). At the time of inspection there were five GPs attending to the healthcare needs of the residents. A review of medical records by the inspector confirmed that timely medical review in line with the residents assessed needs was facilitated. There was evidence of a responsive out-of-hours medical service and appropriate referral to the acute hospital service for investigation, diagnosis and treatment. During inspection inspectors noted that one resident was facilitated to attend for ophthalmic review, one resident was admitted to hospital on a day-patient basis and another resident was medically reviewed by their GP further to nursing concerns for their wellbeing. There was evidence of collaborative working and input from psychiatry of old age services particularly in relation to the management of challenging behaviours.

A pre admission assessment was in place. Staff spoken with clearly described for inspectors the appropriate information to be forwarded to receiving facilities on the temporary transfer or discharge of a resident and inspectors saw that staff had

access to individualised, comprehensive biographical and clinical resident profiles. Practice would be enhanced, however, by retaining a copy of the forwarded documentation in the relevant residents file and this was discussed with the person in charge.

Residents' vital signs and weights were monitored on a monthly basis. Staff had received education and training on the implementation of the Malnutrition Universal Screening Tool (MUST), they were in the process of implementing it in practice, and had recently been supplied with seated weighing scales. There was documentary evidence of referral and access to speech and language therapy and formal swallow care plans and communication plans in line with the assessed needs of individual residents were in place. These and further information on residents specific dietary requirements were formally communicated to catering staff who were also included in the daily verbal handover.

Catering staff spoken with were knowledgeable and told inspectors that their inclusion in the daily verbal handover enabled them to alter and meet the dietary requirements of residents on a daily basis. Where weight loss was noted there was evidence of appropriate nursing intervention and altered care planning including dietetic input. Diabetic residents had their blood glucose levels monitored by nursing staff and records reviewed confirmed that levels were well controlled within acceptable levels.

Inspectors found evidence of the proactive management of falls and challenging behaviours. The incidence of falls was low and preventative measures such as falls risk assessment, appropriate supervision and movement alarms mats were in place. Each reported fall was seen to have been reviewed and followed up by the person in charge with staff so as to identify possible contributing factors and implement controls so as to reduce the risk of reoccurrence. Similarly records pertaining to challenging behaviours confirmed review, discussion, the identification of possible triggers and the formulation of management strategies.

Integrated nursing and medical records were in place. Overall the standard of care planning and nursing documentation was good but would have benefited from a process of audit as inconsistencies were noted by inspectors and improvements were required to enhance the findings of good practice. Plans of care were individualised and person-centred, appropriately updated in line with changing needs, information was easily retrieved and clearly depicted the resident, their clinical needs, and planned and delivered care. Areas requiring review however included the following:

- though signed as re-evaluated not all care plans reviewed contained a progress evaluation record detailing the findings of the review and required changes to the plan of care
- where the progress evaluation record was in place it was not clear as to which care plan the required changes applied
- one resident assessed as at high risk of pressure sore development did not have a corresponding holistic wound prevention care plan
- one resident with recurring chest infections while in receipt of suitable and sufficient nursing and medical care did not have a specific plan of care in place for this problem

- care plans did not demonstrate consultation with the resident and/or their representative or that such consultation was impracticable.

Based on records reviewed, inspectors could not confirm that residents were referred and had access to chiropody and physiotherapy services in line with the nature and extent of their dependency and needs so as to achieve and enjoy the best possible health and clinical outcomes.

Inspectors saw that there was a commitment to the provision of meaningful occupation and social engagement regardless of any challenges posed by age, dependency and ability. A policy on the provision of activity programmes was in place and residents had opportunity to participate in meaningful activities on a daily basis. The activities coordinator organised a varied programme and activities and participation were determined by resident choice. Residents spoken with told inspectors of their particular favourite activities and of being facilitated to choose what they liked doing and included art and crafts, board games, quizzes and baking. One 93 year old resident had expressed a desire to take up playing the fiddle again and the person in charge was in consultation with his relatives so as to facilitate this for him.

A number of residents gained particular benefit from participating in gardening activities within the secure grounds and accompanying the registered provider as he attended to the general maintenance of the property. Other activities residents spoke of were music and the newspaper being read to them. A number of residents choose to spend time in their own rooms and confirmed that they could opt in and out of activities when they so wished. External music and dramas groups also offered entertainment in the centre.

Given the security of the environment inspectors observed and staff spoken with reported no individualised physical restraint. Medication was used as an adjunct to non-pharmacological interventions in the management of challenging behaviours and was closely monitored. However bedrails were in use and practice in relation to their use was not in line with local policy, national guidelines and regulatory requirements. Assessments and care plans for the use of bedrails were available to staff but a sample reviewed had not been completed.

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

At the time of inspection no resident was in receipt of end-of-life care. Staff spoken with however, described a philosophy of care and care practices that demonstrated

their ability to provide appropriate care and comfort to the resident, their family and fellow residents at end-of-life. While no specific facilities were available to families, staff spoken with confirmed that overnight accommodation was provided if required. Staff also described appropriate management interventions where resident accommodation was shared. Two staff spoken with had recently attended palliative care education and further staff were scheduled to attend.

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 were satisfied that residents were in receipt of a varied and nutritious diet that was prepared, provided and monitored by staff that were informed and knowledgeable as to the needs, requirements and preferences of residents. Primary food stocks were delivered on a daily basis and this was confirmed by delivery dockets reviewed. A good variety of fresh, frozen and dried foodstuffs were stocked and home baking was available. Catering staff maintained comprehensive person-centred records of each resident's dietary likes and dislikes and ascertained residents meal choices on a daily basis; the menu was displayed in the main dining area.

Residents and relatives expressed satisfaction with the variety and quality of the meals provided. Meals were served individually plated and the presentation, quality and aroma of meals and the overall dining experience was of a high standard. Adequate and appropriate supervision was in place and while independence was encouraged, assistance where required was appropriately and discreetly provided. One resident took her meals in her own bedroom but, staff, the resident and family members confirmed that this was her own choice. Inspectors saw that residents were offered fluids and snacks at regular intervals and this was confirmed by both residents and relatives. Drinking water dispensers were available in the dining area and on both floors. Records were maintained of all fluids and diet provided to residents while on bed rest.

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

A contract of care was in place for each resident. Contracts, however, did not set out the fees to be charged or how such fees were agreed, for additional services provided outside of the terms of the contract.

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 and Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings

Inspectors observed care practices, interactions between staff, staff and residents and relatives and were satisfied that residents were cared for with dignity and respect. Staff spoke with and of residents in a manner that was respectful of their individuality, their biography and their plan of care. Signs were placed on doors to 'please knock' before entering and staff were observed adhering to this practice. Curtains in shared rooms were appropriate and adequate to ensure each resident's privacy. Questionnaires completed and residents spoken with confirmed that their privacy and dignity were consistently respected in all aspects of their care as observed by inspectors during the inspection.

Personal choice and autonomy was encouraged and facilitated. While routine was inevitable it was described by relatives as “relaxed”; the atmosphere was described as “homely, human and personal”. Relatives of more dependent or cognitively impaired residents told inspectors that staff had requested from them details of previous routines and lifestyle choices and familiar objects such as family photographs and small personal belongings. Residents spoken with told inspectors that they had choice in their daily routine in relation to getting up and going to bed, meals and mealtimes and their participation in structured activities. While residents confirmed that they could remain in their own rooms if they so wished the majority were seen to be up and about, facilitated by staff to remain independent and engaged in the daily routines.

Inspectors saw and residents and relatives confirmed that visiting arrangements were flexible and relatives known to the centre and to staff were given access to the security code of the main entrance. While there was no specifically designated visitors area, residents and relatives had a choice of a variety of small quiet, private areas in which to visit and were seen to freely utilise them if they wished. Inspectors saw that residents were also encouraged to retain family and social links and regular arrangements were in place for two residents to return home and spend time with their family in their family home.

Residents, relatives and staff told inspectors that the person in charge and other relevant staff were always available and open to suggestions and feedback. Inspectors observed good interaction between staff and residents and staff and relatives. Relatives were satisfied with information provided by staff about residents’ healthcare and general wellbeing prior to admission and since they had been admitted.

A residents’ committee was in place and convened monthly. There was documentary evidence that residents were facilitated to vote and a special voters’ poll was made available for the recent general election. Residents were satisfied that their religious and spiritual needs were adequately addressed and more independent residents also had access to the main parish church that was situated directly adjacent to the centre. Residents were seen to have good access to radios, television and newspapers and the newspaper was read by staff to more dependent residents on a daily basis in a respectful and interactive manner

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 personal grooming was of a high standard and many residents spoken with expressed continuing pride in their appearance. Bedrooms accommodated a maximum of two residents and adequate segregated storage space for both residents was provided.

A laundry service was provided on a daily basis and utilised by the majority of residents. Residents and relatives spoken with reported satisfaction with the service and where issues had arisen relatives confirmed that these were satisfactorily addressed by staff and the person in charge. Laundry staff spoken with articulated a clear sense of responsibility and accountability for the management of residents clothing, a sample of clothing reviewed by the inspector was clearly marked. Once freshly laundered and pressed, clothing was seen to be returned to residents bedrooms and stored in an organised and respectful manner.

Residents' bedrooms were discreetly personalised with items such as photographs and religious items. Relatives of dependent residents confirmed that staff had requested personal items of them such as family photographs to ease the resident's transition to long term care.

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 general nurse with responsibility for the clinical and operational management of the service since its establishment in 1999. She was a partner in the overall ownership and management of the service and therefore had enhanced autonomy and accountability for the management and provision of the service. Both the registered provider and the person in charge confirmed supportive and collaborative working arrangements, shared decision making and had a clear understanding of their different but complementary roles. Prior to her appointment the person in charge had spent some time working in services for persons with intellectual disabilities and her knowledge and experience were evident in her philosophy of care for the current residents, particularly those with a cognitive impairment and/or challenging behaviour.

The person in charge demonstrated a commitment to ongoing professional development and had undertaken further education and training pertinent to her role and the statement of purpose and function, such as elder abuse "train the trainer",

mental health in later life, medication management, quality assurance, infection prevention and control, palliative care, person-centred dementia care and the use of physical restraint. Likewise there was evidence that she was proactive in relation to the ongoing education and training of staff. In conjunction with the provider she had completed the fit person entry programme, it was centre-specific and person-centred, reflected her experience and knowledge of the service, and a belief that change and improvement was a dynamic and continuous process.

She worked full time in the centre and this was confirmed by staff, residents and relatives. Staff attested to her availability when not on duty and this was confirmed by records reviewed by inspectors. She was described by staff as a great manager and a strong clinical role model; residents and relatives described her as approachable, reassuring and competent.

During her Fit Person interview, her interactions with inspectors and their observations during the two days of inspection she demonstrated competency and empathy, a commitment to the provision of quality person-centred services and a sound knowledge of her responsibilities as prescribed in 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*. She demonstrated willingness and commitment to meeting regulatory requirements and implementing any further required improvements.

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

Based on their observations, inspection findings, and a review of staff rosters inspectors were satisfied that the numbers and skill-mix of staff was sufficient and adequate to meet the needs of the residents to a good standard. Adequate staffing resources were deployed to maintain catering, laundry and environmental hygiene standards. Relatives reported that based on their experiences they were satisfied that adequate staff were employed and they rationalised this as they never had to wait and were never told by staff that they were “too busy” to attend to their

requests. There was a low turnover of staff and staff told inspectors that they enjoyed working in the centre and reported good working relationships with both the provider and the person in charge. Relatives described staff as knowledgeable and understanding of residents physical and psychological needs and staff were referred to by relatives and residents in first- name terms.

Inspectors observed and relatives confirmed that the communal areas were at all times supervised by staff, and residents on bed rest were monitored and attended to at least every 30 minutes and these visits and care provided were formally documented. Nursing staff described formal systems of delegation and monitoring of tasks and duties. All staff attended verbal handover and were therefore in receipt of the required information to allow them to deliver appropriate and individualised care. Nursing staff were visible and available to care staff, residents and visitors. All staff spoken with were clear as to their roles, responsibilities and reporting relationships. A copy of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* were seen to be available and staff spoken with had good knowledge of the legislation commensurate with their roles.

The provider and person in charge acknowledged the importance of robust recruitment processes in the delivery of safe quality care and a review of staff files demonstrated that this knowledge was implemented in practice. A sample of staff files reviewed contained all of the information required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) in relation to staff. However, where references of a testimonial type were in place there was no documentary evidence of their verification.

Staff spoken with confirmed the provision of induction on commencement of employment and a staff appraisal system was in place. Appraisals reviewed were comprehensive and constructive.

Evidence of current registration with their regulatory body An Bord Altranais was in place for all staff nurses employed.

Staff spoken with and staff training records reviewed demonstrated a commitment on behalf of management to ongoing staff education and training. The training provided reflected legal responsibilities, the stated purpose of the centre and the needs of the current resident profile and included elder abuse, fire prevention and management, manual handling, medication management, palliative care, wound management, dementia care and managing challenging behaviours. Some staff had completed the Further Education and Training Awards Council (FETAC) Level 5 while others had undertaken individual modules. Staff were knowledgeable when spoken with and residents' records demonstrated the practical implementation of learning.

Training records were maintained in individual appraisal folders. An overall staff training matrix would enhance the findings of good practice and ensure that follow up training and refresher courses were organised and delivered in line with mandatory requirements, service need and individual competencies.

Records reviewed and staff spoken with confirmed that the person in charge convened regular staff meetings on a routine basis or in response to accidents/ incidents/near misses.

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

Following its purchase the premises was extensively refurbished and modernised to provide a safe, comfortable and appropriate residential care environment for older adults. The location of the centre offered both security and social integration as the site was spacious with a secure perimeter and gated entrance but, also offered ready access to, and was in close proximity to facilities such as the church, shops and restaurants. The premise was appropriately heated, lighted and ventilated, well maintained and in good decorative order throughout; the provider attended to routine maintenance on a daily basis. The original windows were retained and were large and bright and offered reassuring views to residents of the Rock of Cashel.

All areas internally and externally were inspected. There were good systems in place that facilitated environmental hygiene and infection prevention. The centre was visibly clean and cleaning staff clearly explained to the inspector the colour-coded system of cleaning that was in place. A sluice room was provided on each floor and one bedpan washer was provided. Chemicals were securely stored in locked cupboards. Residents and relatives comments confirmed that consistently high standards of environmental hygiene were maintained. The kitchen was clean, adequately equipped and organised. There was evidence of the implementation of the HACCP food hygiene management system, records reviewed confirmed that catering staff had recently attended HACCP education and re-training and the premise was inspected on a regular basis by the relevant Environmental Health Officer. Equipment and general furnishing was of a high standard and residents were seen to be provided with therapeutic equipment such as pressure relieving mattresses and cushions appropriate to their needs. Equipment service records were available for inspection.

Though storage was limited this was not seen to present any difficulties on the day of inspection. Corridors were unobstructed as were designated escape routes. Circulation areas and en suite bathrooms were appropriately equipped with hand rails and grab-rails. Facilities were delivered over three floors and two passenger lifts

were available to residents, staff and visitors though one relative commented that signage in the main entrance lobby indicating this would be of benefit.

Adequate dining space was available and conveniently located to the main kitchen. Residents had access to two main communal areas. Dining and communal areas again were comfortable and discreetly domestic in nature with many of the original architectural features intact. All residents' bedrooms were en suite with a maximum of two residents per room and a maximum of four residents per en suite. Two further toilets were provided on the ground floor in close proximity to the main dining and communal areas.

The level of safety and security offered to residents was high without unnecessary restriction. All external doors were on key- pad release and access to stairwells were restricted with the exit doors from each floor alarmed and connected to the nurse call system. The overall site was secure and offered landscaped gardens for residents to the front and rear of the building. Residents and relatives confirmed that they primarily used the gardens to the rear of the building where seating and safe walkways were provided. Residents had access to, were seen and heard to utilise the call-bell system and told inspectors that they never wanted for anything "because I have my bell".

Staff facilities were provided including separate sanitary facilities for catering staff.

However, inspectors noted that two en suites were also directly accessed from the main corridor and these doors could not be locked by the occupant thereby compromising their privacy and dignity.

Not all en suite showers were equipped with appropriate seating to facilitate and maximise resident safety and comfort, and support safe and appropriate manual handling of residents.

There was no wash-hand basin in the assisted bathroom on the top floor.

Barriers to restrict the movement of water were in place on some en suite floors and presented a possible trip and manual handling hazard. These require review and risk assessment and the communication of required controls to staff.

7. Records and documentation to be 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 * ☒

Improvements were required to ensure the consistency of the standard of care planning and these are discussed in detail in Outcome 7.

General Records (Schedule 4)

Substantial compliance ☐ Improvements required* ☒

Improvements were required in the records maintained pertaining to residents' finances.

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☒ Improvements required* ☐

Directory of Residents

Substantial compliance ☐ Improvements required* ☒

A directory of residents was in place and designed to capture all requirements of the legislation but there were some gaps in the information entered such as details of next of kin and GP contact details.

Staffing Records

Substantial compliance ☐ Improvements required* ☒

Improvements were required in the verification of references of a testimonial type.

Medical Records

Substantial compliance ☐ Improvements required* ☒

Improvements were required where medication prescription records were transcribed and this is discussed under Outcome 7.

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

Accident and incident records were maintained and reviewed by inspectors. Documentation had been revised based on the findings of the last inspection. The incidence and pattern of documented events were not of concern to inspectors and there was evidence of appropriate intervention, review and follow up by the person in charge so as to prevent reoccurrence and ensure that staff adhered to standard procedures and supervisory arrangements. Records reviewed confirmed that the person in charge had satisfied her legal responsibility in relation to the submission of notifications to the Chief Inspector.

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 and staff spoken with confirmed that there had been no absence of the person in charge requiring notification to the Chief Inspector. There was an appropriately qualified and competent key senior manager in place who was aware of her duties and responsibilities when delegating for the person in charge.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider and the person in charge 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 Moore
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

15 July 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report

Centre:	St Teresa's Nursing Home
Centre ID:	0293
Date of inspection:	6 July 2011 and 7 July 2011
Date of response:	29 July 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 contain all of the information as 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:

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). Make a copy of the Statement of Purpose available to the Chief Inspector.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The Statement of Purpose and Function has been reviewed and sent to the lead inspector.	Completed

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: Core areas directly relevant to the quality and safety of care such as the process of care planning and restraint, were not subject to formal review.
Action required: Maintain and expand the scope of the current 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.
Action required: Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.
Reference: Health Act 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The process of care planning and the use of restraint is currently being reviewed and audited. We will maintain and expand the scope of current systems by putting in place a review of bedrail usage and implement an observation chart for residents with bedrails in place and ensure staff are aware of their responsibilities for observation and documentation. We will consult with residents or their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.	20 September 2011

Outcome 3: Complaints Procedures

3. The provider is failing to comply with a regulatory requirement in the following respect: Complaints records were fragmented. Complaint management policy and procedure required review and standardisation.
Action required: Maintain a comprehensive record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.
Action required: Review and standardise all documentation where the complaints management procedure is referenced. Make a person available as nominated in Regulation 39(10), independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).
Reference: Health Act 2007 Regulation 39: Complaints Procedures Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will review and audit our complaints procedures. We have nominated an independent person as required by Regulation 39(10) who will ensure that complaints are appropriately responded to as required under Regulation 39(6).	20 August 2011

Outcome 4: Safeguarding and safety

4. The provider is failing to comply with a regulatory requirement in the following respect: Policy and procedure on the prevention, detection and response to elder abuse lacked detail on supporting the resident, their family, what they can expect during an investigation of an allegation of abuse, supportive mechanisms in place for them and how they will be safeguarded. Practice in relation to the documenting and safekeeping of residents' monies and personal possessions require review.

Action required: Review and amend policy and procedure on elder abuse. Provide greater emphasis on supporting the resident, their family, what they can expect during an investigation of an allegation of abuse, supportive mechanisms in place for them and how they will be safeguarded.	
Action required: Review the current location utilised for the safekeeping of residents' monies.	
Action required: Maintain and keep up to date a record of each resident's personal property signed by staff and the resident or their representative where appropriate.	
Action required: Maintain a record of all monies and valuables held on behalf of or received on the resident's behalf and monies returned or given to third parties on the resident's behalf. Records shall contain all of the documentary requirements as listed in Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Best practice recommends that in the interest of transparency, accountability and the safeguarding of all parties, transactions should be witnessed and co-signed by two staff members and where possible the 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: We will review and amend our policy on elder abuse to give greater emphasis on supporting the resident, their family, and what they can expect during an investigation of an allegation of abuse and put supporting mechanisms in place for them and how they will be safeguarded We have reviewed the current location utilised for the location of resident's monies. We will maintain and keep up to date a record of each resident's personal property signed by staff and the resident or their representative where appropriate	31 August 2011

Outcome 5: Health and safety and risk management

5. The provider is failing to comply with a regulatory requirement in the following respect: Personal emergency evacuation plans (PEEPs) for residents were in place for dependent and cognitively impaired residents but, they were not explicit as to the assistance required and the manner of evacuation to be applied. Hoists had not been serviced in line with legislative requirements. The emergency plan required review.
Action required: Complete the PEEPs and once complete communicate the information to all staff.
Action required: Ensure that all mechanical lifting devices are serviced in line with legislative requirements.
Action required: Put in place an emergency plan for responding to likely emergencies such as the loss of essential services.
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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The PEEP's have been reviewed and are in place. The hoists have been serviced and we await the servicing certificates. Emergency plans for loss of heat, power and water and essential services are now in place.	Completed

Outcome 6: Medication management

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

Transcribing practices were not in line with local policy and regulatory body guidelines. The management of night sedation required review.
Action required: Put in place appropriate and suitable practices relating to the prescribing, storing and administration of medicines to residents, specifically in relation to transcribing practices and night sedation.
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: All medication charts have been reviewed in relation to transcribing practices and the administration of night sedation has been reviewed.	Completed

Outcome 7: Health and social care needs

7. The person in charge is failing to comply with a regulatory requirement in the following respect: Inconsistencies were noted in the standard of the care planning process
Action required: Ensure that nursing staff consistently set out and re-evaluate in line with their evolving needs, each residents needs and plan of care in their care plan.
Action required: Revise each resident's care plan, after consultation with him/her. Where such consultation is impracticable this is clearly documented.
Action required: Put in place evidence based policy and procedures governing the use of restraint and ensure that staff are familiar with and implement such policy. Policy, procedure and practice are in line with best practice, national guidelines and regulatory requirements.

Reference:

Health Act 2007
Regulation 8: Assessment and Care Plan
Regulation 6: General Welfare and Protection
Regulation 25: Medical Records
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will ensure that nursing staff consistently set out and re-evaluate in line with residents evolving needs their care plans by the introduction of a system of audit and review. We will revise each care plan in consultation with the resident and his/her representative and we will also document circumstances where this process is impracticable. We will review and audit our policy on restraint and ensure that staff are familiar with and implement this policy in line with best practice, national guidelines and regulatory requirements.	31 October 2011

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

Records reviewed did not confirm adequate and appropriate referral and access to chiropody and physiotherapy services.

Action required:

Facilitate each resident's access to physiotherapy, chiropody, occupational therapy, or any other services as required. Maintain records of all healthcare referrals and follow-up appointments.

Reference:

Health Act 2007
Regulation 9: Health Care
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The chiropodist visits every two to three months or as necessary and visited the centre on 25 of July. We will continue to provide this service as the residents require it. Physiotherapy is provided by the Health Service Executive on an emergency basis only, therefore we have contacted an independent company who provide physiotherapy for nursing home residents. We have an assessment date for Thursday 28 August 2011. We will also maintain records of all referrals and required follow-up.	31 August 2011

Outcome 10: Contract for the Provision of Services

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

The contract of care did not set out the fees to be paid for additional services.

Action required:

Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged including any additional health, social and personal care services to be paid for over and above those included in the fee.

Reference:

Health Act 2007
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The contracts of care have been reviewed and audited to include details of the services to be provided for the resident and the fees to be charged including any additional health, social and personal care services to be paid for over and above those included in the fee.	Completed

Outcome 14: Suitable staffing

14. The provider is failing to comply with a regulatory requirement in the following respect: There was no evidence of the verification of references of a testimonial nature.
Action required: Put in place recruitment procedures to ensure the authenticity of the staff references referred to in Schedule 2.
Reference: Health Act 2007 Regulation 18: Recruitment Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: References have been verified and authenticated.	Completed

Outcome 15: Safe and suitable premises

15. The provider is failing to comply with a regulatory requirement in the following respect: ▪ there was no wash-hand basin in one assisted bathroom ▪ appropriate and adequate assistive equipment was not available in shower rooms ▪ two en suites were not conducive to maintaining privacy and dignity ▪ further risk assessments were required.
Action required: Suitable adaptations are made and such support, equipment and facilities as required to meet the assessed needs and dependency levels of residents are provided. Equipment provided is in line with contemporary standards and suitable for the function for which it is purchased.
Action required: Ensure that existing sanitary facilities provide privacy to the extent that the resident is able to undertake personal activities in private. Where locks are installed, facilities are accessible to staff in defined circumstances and meet fire safety regulations.

Action required: Conduct risk assessments on the existing floor level water barriers. Identify and implement required controls. Ensure that staff and residents where practicable are aware of the risks and required controls.
Action required: Ensure that wash-hand basins are provided at appropriate places in the premises.
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: A wash-hand basin has been fitted in the assisted bathroom. Shower chairs present at the time of inspection have been reviewed and have been removed. Doors on both corridors to en suites have been locked to provide privacy to the extent that the resident is able to undertake personal activities in private.	Completed

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

16. The person in charge is failing to comply with a regulatory requirement in the following respect: The directory of residents was not consistently maintained.
Action required: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.
Reference: Health Act 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The directory of residents has been audited and a check list is in operation for staff to audit information entered specific to Schedule 3, paragraph 3 of the Health Act 2007.	Completed

Any comments the provider may wish to make:

Provider's response:

We wish to thank the inspectors for the courtesy and professionalism of the manner in which they carried out the inspection over the two days.

We also wish to thank our staff, our residents and their relatives who participated in the interviews and the completion of questionnaires.

The nursing home sector has come under rigorous scrutiny in recent years thus making our job very challenging but we will continue to provide the best care that we can, once given the support needed from the Department of Health and related governing bodies.

Provider's name: Michael Mc Cormack

Date: 29 July 2011