Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Powdermill Nursing Home
Centre ID:	0270
Centre address:	Ballincollig Cork
Telephone number:	021-4871184
Fax number:	021-4876670
Email address:	powdermill.nursinghome@gmail.com
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered provider:	Joseph Peters
Person in charge:	Ajami P. Kuriakose
Date of inspection:	28 January 2010, 29 January 2010, and 8 February 2010
Time inspection took place:	**Day-1 Start:** 11:30hrs **Completion:** 18:00hrs **Day-2 Start:** 08:00hrs **Completion:** 18:30hrs **Day-3 Start:** 09:00hrs **Completion:** 12:00hrs
Lead inspector:	Allison Cummings
Support inspector(s):	**Day 1:** Breeda Desmond **Day 2:** Breeda Desmond (note: additional support inspectors, Noel Sheehan and Dr Michael O' Connor, supported from 16:30hrs to 18:30hrs) **Day 3:** no support inspector
Type of inspection:	☐ Announced ☒ Unannounced

Purpose of this inspection visit	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☒ Information received in relation to a complaint or concern

About the inspection

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

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

Additional inspections take place under the following circumstances:

- to follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or well-being of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Powdermill Nursing Home is a two-storey building that is about one hundred years old, with an additional single-storey extension built in the 1970's or 1980's. The centre has a narrow front garden facing onto a quiet public road. Parking for vehicles can be found on the public road or on rough ground adjacent to the public road. There are raised patio decks on the gable sides of the centre and a small deck at the back of the centre.

The centre can accommodate 42 residents. It predominantly provides care to a mix of female and male people over 65 years, including older people with dementia. It also provides care to two people under the age of 65 years with a physical disability, as well as respite care.

In total, there are 28 bedrooms compromising of 21 single bedrooms, two twin bedrooms, three triple-bedded rooms and two four-bedded rooms. Of the single bedrooms, seven have a hand basin in the bedroom as well as an en suite toilet and shower. Another 11 bedrooms have an en suite toilet, hand basin and shower. The remaining three single rooms are fitted with a hand basin only. One twin bedroom has an en suite toilet, shower and hand basin however the other twin bedroom does not.

There are two conservatories, one of which serves as a smoking room for residents. There is a combined dining and sitting room to the left of the main entrance. A library, which also serves as a second sitting room, is located to the right of the main entrance.

Location

The centre is located approximately one kilometre from the centre of the town of Ballincollig, Co Cork, facing the local Gaelic Athletic Association club grounds. Access is via a private road.

Date centre was first established:	1984
Number of residents on the date of inspection:	41

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	10	7	17	7

Management structure

The centre is owned by Joseph and Catherine Peters. The Registered Provider is Joseph Peters. The Director of Nursing, Ajami P. Kuriakose, is the Person in Charge of the nursing home.

The senior social carer reports to the Person in Charge. The Person in Charge, administrative staff, and the caterers all report to the Provider, Joseph Peters. The residents' advocate reports in the first instance to the Person in Charge, who then refers on to the Provider.

The nurses, the senior care assistant, care assistants, and the physiotherapist report to the Person in Charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	1	5.5	1	2 Cleaners	2	1

Background

An inspection took place on 25 November 2009 as a result of a concern received by the Authority. The relative of a resident contacted the Authority to state that the centre was understaffed and, in particular, that nursing staff were overworked and appeared tired. The inspectors focused on two specific areas: governance and staffing, as these two domains cover the general care issues contained in the concern received by the Authority. The provider had also recently notified the Authority that a new person in charge had been appointed.

Due to the concerns found on inspection on 25 November 2009, the Authority made the decision to inspect other aspects of the service including the quality of the service, healthcare, the premises and equipment, and communication. This further inspection took place on 28 January 2010 and 29 January 2010. It was a triggered and unannounced inspection. On 29 January 2010, the inspectors were accompanied by Dr Michael O' Connor, medical practitioner, as a qualified person to assist the inspectors.

A number of significant improvements required the provider's immediate attention. These were outlined in an emergency action plan and sent to the provider on 2 February 2010. An inspector visited the centre to collect and discuss the provider's responses on 8 February 2010. These responses have also been included in the report.

Summary of findings from this inspection

Inspectors met with the provider, the person in charge, staff, residents and relatives. They reviewed documents such as residents' care plans, staff rotas, training, policies and procedures.

Powdermill Nursing Home failed to comply with the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland* in a number of areas. Inspectors found that there continued to be a lack of adequate governance in the centre. The provider and the person in charge failed to adhere to the required regulations. Inspectors concluded that the management of incidents, risks and complaints was unsatisfactory. Nursing care and care practices were found to be inadequate and did not meet the needs of residents. Care practices were inappropriate and compromised the privacy and dignity of residents. There were inadequate precautions taken to protect residents. The staff levels and skill mix on-duty were inadequate, given the dependency levels of residents and the layout of the centre. Staff training was neither adequate nor suitable. The premises were unsafe and poorly maintained.

Inspectors identified a number of significant improvements that required the provider's immediate attention. An emergency action plan was drafted for the provider to address the lack of appropriate skills and experience shown by the person in charge. Other issues included the failure to make proper arrangements to prevent and control an outbreak of an infectious disease, and ensure appropriate numbers and skill mix of staff to meet residents' needs. There was a lack of suitable and sufficient care to maintain residents' welfare and wellbeing with regard to pain management and catheter care. The emergency action plan sent to the provider also outlined aspects of the premises that posed immediate health and safety risks to residents, as well as inadequate management of incidents. The provider's response to the emergency action plan is encompassed within this inspection report.

The Action Plan at the end of this report identifies areas where significant improvements are required to meet the requirements of the Health Act 2007 (care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Issues covered on inspection

Governance

Leadership

The person in charge did not have the appropriate skills and experience required to carry out her duties. Discussions held with the person in charge concluded that she lacked an understanding of risk management principles. This included the management of an outbreak of an infectious disease which occurred during this triggered inspection. The

person in charge said that written policies and procedures on risk management had not been developed. At the last inspection on 25 November 2009, inspectors identified that there were no risk management systems in place to protect the residents and staff. The provider had not made any progress in this respect.

There were inappropriate numbers and skill mix of staff to meet the needs of residents. Discussions with staff and a review of the roster indicated that two care assistants and one staff nurse were on-duty overnight. The two care assistants were responsible for laundering residents' clothing as well as providing care to residents. During the inspection on 28 January 2010 and 29 January 2010, inspectors observed that the laundry was untidy and disorganised. Clean washing was seen stored and air dried in the same room as dirty laundry. There was no running water or sink for hand washing or laundering soiled items of clothing. Due to these conditions, the spread of infection may have increased. In response to an emergency action plan, the provider made temporary arrangements so that an extra staff member assisted with the laundry during the day for the period of the outbreak. On an inspection on 8 February 2010, the provider confirmed that this had reverted to previous arrangements.

Furthermore, one staff member told the inspectors that she had been vomiting whilst on duty on the day of inspection. This posed a serious risk to residents and staff but the person in charge had told her that she could only go off duty if she found someone else to replace her. The staff member told the inspectors that she had tried to find a replacement but no one was available.

The person in charge did not provide staff with education and training to enable them to provide care in accordance with contemporary evidence-based practice as contained in the *National Quality Standards for Residential Care settings for Older People in Ireland*. This was evident from the undignified care practices observed by inspectors, the low attendance levels documented in mandatory training records and the lack of arrangements observed to prevent and control an outbreak of an infectious disease, which become apparent on the afternoon of the first day of inspection. These issues have been described in further detail in the report below.

The provider was asked to review the fitness (including qualifications, skills and experience) of the person in charge to work at the centre by 7 February 2010. The provider did not comply with the required action. The provider documented that he would review her appointment within two months. Documentation submitted to the Authority together with the provider's response confirmed that the person in charge does not have three years experience in the area of geriatric nursing as required by regulation 15(2) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.

Incident management

The arrangements for managing incidents were unsatisfactory. An inspector observed a dressed wound on one resident's left lower leg. The resident explained that another resident's wheelchair had knocked her in the leg. The person in charge said that she did not how this happened. The incident had been recorded in nursing notes but it had not been recorded on an 'incident report form' as per the centre's procedures. The form was

subsequently completed by a staff member and was seen on the second day of the inspection. When informed of her legal obligation, the person in charge formally notified the Authority of this incident.

Furthermore, the person in charge failed to notify the Chief Inspector of some incidents as required under the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009. At the inspection feedback meeting, the person in charge was clearly unaware of her responsibility to notify the Authority of incidents occurring within the centre. There were completed incident forms in a folder that the Authority had not been made aware of in the last quarterly return. During the inspection feedback meeting the provider described an allegation of abuse that he had investigated. The Authority had not received notification of this allegation. Additionally, at the inspector's request, the person in charge notified the event relating to the outbreak of an infectious disease on the appropriate form and submitted it to the Authority four working days after the outbreak commenced.

Complaints management

The centre did not have written policies and procedures relating to the making, handling and investigation of complaints. In the entrance area there was a framed notice advising people of their right to complain to the Health Services Executive (a body who no longer have legal authority to deal with complaints against the centre other than residents in contract beds). The need for these improvements was brought to the attention of the provider at the inspection carried out on 25 November 2009. However, no action had been taken to comply with the requirements.

Quality of service

Privacy and dignity

Inadequate arrangements had been made to maintain residents' privacy and dignity. Curtains rails in two bedrooms were broken and therefore curtains could not be drawn to maintain residents' privacy.

Some staff did not care for residents in a dignified manner. A carer assisting residents to walk to the dining room for tea did not speak with them; instead, he touched them on the shoulder and indicated with a nod of his head that the resident had to get out of his chair to go for tea. He then transferred two residents in wheelchairs to the dining area. A female resident partially obstructed his way but instead of asking her to move aside, he just stood there, not interacting with anybody, until another resident asked her politely to move aside. The carer then escorted another resident to the dining room for tea but instead of walking beside the resident, he walked in front with no interaction with the resident.

Another carer was observed feeding a resident using a large desert spoon which was not appropriate to the small size of the resident. The resident did not have the ability to open her mouth wide enough to take the food from the spoon and consequently, some of the contents from the spoon fell onto the resident's sleeve. The carer said to the resident: "you're making a mess already". This was an undignified and uncomfortable experience

for the resident as well as demonstrating a lack of adequate training and supervision of staff.

Staff did not wear name badges, making it difficult for residents to know who was caring for them.

An item of clothing that belonged to one resident was found in another resident's wardrobe. A carer was made aware of this. She commented that staff members whose native language was not English were sometimes confused with the spelling of residents' names.

Independence

Efforts were made to promote the independence of residents. A toaster was seen in the dining room enabling residents to make their own toast for breakfast.

Protection

Inspectors read documentation that highlighted two accounts of behaviour that was challenging, where a resident had been abusive towards another resident. Inspectors discussed the management of challenging behaviour with the person in charge. She said that she did not know how to manage aggressive behaviour and proceeded to ask the inspectors how she should best manage the resident. The person in charge declared on numerous occasions that she did not have a policy on managing challenging behaviour. She then went to the cupboard to locate a folder containing policies. Whilst looking through the folder she realised that she did have a policy on managing challenging behaviour.

Restraint procedures were unsatisfactory. There was no written policy. Clinical risk assessments were not carried out prior to the initiation of restraint. Residents' representatives' consent was taken even where the resident was capable of giving consent. The form asked the resident's representative to agree *"that, where medical treatment is recommended…by a medical practitioner, the nursing staff of … [the centre] …may administer the recommended treatment without obtaining my specific consent".* The completed consent forms seen by the inspectors were not dated.

Healthcare

Infection prevention and control

Suitable and sufficient care to maintain the residents' welfare and wellbeing was not provided. During the inspection of 28 and 29 January 2010, inspectors became aware of an outbreak of vomiting and diarrhoea. On the 28 January, inspectors confirmed that there three residents were affected. On the 29 January the person in charge informed the inspectors that eight residents and one member of staff were affected. During the post inspection feedback meeting on 1 February 2010 the person in charge estimated that 14 residents in total were affected. This number was confirmed in the notification submitted to the Authority on 4 February 2010.

The person in charge failed to make adequate arrangements to prevent and control the outbreak of the infectious disease:

- an infection control policy was present in the centre although the person in charge was not aware of it and therefore did not adhere to it
- the training record folder provided to the inspectors by the person in charge indicated that education on correct hand washing technique was provided to staff in September 2009. The training did not include other aspects of infection prevention and control
- there was a lack of adequate personal protective equipment, clinical waste facilities, alcohol gel dispensers and signage to prevent and control the outbreak
- the person in charge had been advised by a general practitioner (GP) to restrict visitors. However, the inspectors observed the person in charge greeting the visitors on arrival without implementing the GP's recommendations
- some residents who displayed symptoms of the outbreak were brought into communal areas, placing other residents at risk of acquiring the infection
- there were no facilities for the segregation of laundry
- during the outbreak, a staff member folded residents' clean clothing on a bed in an infected room on the upper level of the centre. When an inspector commented that the practice could result in cross-contamination, she said that she was not concerned because she knew that the duvet cover used to fold the clothes was clean. This response demonstrated a lack of awareness of infection prevention and control precautions.

On 8 February 2010, the person in charge confirmed that all residents had recovered from the infection. The person in charge said she had notified the relevant department within the Health Services Executive (HSE). She said she was provided with a copy of current infection guidelines during a visit made to the centre by the HSE on 2 February 2010. Minutes of a meeting with senior staff confirmed actions taken in response to the outbreak. In his written response, the provider stated that the person in charge would undertake a complete review of how the outbreak was handled by the centre. This had not been completed by 8 February 2010 when an inspector revisited the centre.

Pain management

Suitable and sufficient care to maintain the resident's welfare and wellbeing was not provided. On the inspection of 28 January 2010, inspectors observed a resident resting in bed and displaying signs of pain. The senior carer said that "he is in agony with his legs. All he is getting is two paracetamol and that has no effect". Inspectors reviewed the resident's records. In his medical records on the 17 September 2009, the doctor wrote that he queried a cramp in the resident's right foot and subsequently prescribed an anti-inflammatory gel. On 21 January 2010, the doctor prescribed regular analgesia twice daily. An inspector also reviewed the nursing notes for these dates but there were no entries about the resident's pain. Medication administration records between 3 August 2009 and 17 January 2010 showed that the two prescribed prn (as necessary) analgesics (anti-inflammatory gel and paracetamol) were rarely administered. No analgesics were administered to the resident in August 2009. The analgesics were administered to the resident on one occasion in September 2009. Paracetamol was administered to the

resident on one occasion in October 2009, and once in the month of November 2009. No analgesics were administered to the resident in December 2009. The last administration record reviewed (ending 17 January 2010) indicated that the resident received paracetamol on four occasions and the anti-inflammatory gel was applied once. Once the order for regular analgesia was prescribed on 21 January 2010, records showed that it was administered by nursing staff. A medical practitioner authorised to accompany inspectors assessed this resident and confirmed the existence of pain in his right lower leg and that the resident's medication and pain management was in need of review. There was no written evidence that nursing staff adequately provided ongoing assessment of the resident's pain, monitored the effect of the analgesia and took appropriate remedial actions.

The medical practitioner authorised to accompany inspectors recommended an x-ray of the resident's leg to determine if the leg was fractured. A letter received from the resident's GP dated 2 February 2010. He argued that "he [the resident] is treated with simple analgesics, etc., which more than compensates him for any pain" [and that there was] "no apparent cause for the pain".

Wound care management

Wound care documentation was inadequate. The documentation did not outline the type of dressing (including solutions) to be used. When an inspector asked the person in charge where this information could be found, the person in charge began documenting the information in front of the inspectors. Inspectors were concerned that the documents did not provide sufficient information to staff, for the care of residents. Written nursing assessments of a resident's wound indicated "suspect of an infection", but other observations of the wound indicated that the wound was healing. Inspectors were concerned that there were deficits in nurses' wound care knowledge.

Catheter care

Suitable and sufficient care to maintain the residents' welfare and wellbeing was not provided. The inspectors reviewed a folder that contained information about the care of residents' urinary catheters. On three occasions the documentation indicated the due date for changing the residents' catheters, but no change was recorded. One resident's catheter was due to be changed on 16 January 2010. Another resident's catheter was due to be changed on 14 December 2009. Two of these residents had previously experience a blocked catheter as a result of which one resident subsequently required a larger catheter. On the 8 February 2010 the person in charge provided documentation to show that two residents' catheters were changed. However, a doctor's records dated 4 February 2010 stated that one resident's catheter was difficult to remove and that another doctor would be called to remove it. The person in charge said that she had commenced a fluid balance chart for each resident with a catheter. An example shown to an inspector indicated that the resident's output was higher than her input. When asked by inspectors about these findings, the person in charge said that she did not know how she was going to respond.

Care Planning

Documents pertaining to the care of residents were not integrated and could give rise to incomplete information being readily available to staff and medical practitioners: information could be found in 11 different folders. The inspectors reviewed a sample of care plans and found that they had not been developed, nor agreed, with each resident. Care plans were often undated and did not provide sufficient information to staff for the care of residents. Inspectors also found that the form used to record personal hygiene care given to residents was often incomplete.

Medication management

Appropriate and suitable practices for the safe administration of controlled drugs, in accordance with An Bord Altranais "Guidance to Nurses on Medication Management" and the relevant legislative requirements, were not in place. The person in charge said that controlled drugs are checked as they are used, and not at the changeover of each shift, as specified in An Bord Altranais Guidelines (2007). The recording of the controlled drugs was contained in three different books.

The revised system observed on 8 February 2010 remained inadequate. This system was confusing and could lead to errors.

Nutrition

The nursing care provided to residents was assessed to be of poor quality and did not promote residents' health and well-being. Significant changes in residents' weights occurred, with no evaluation being made to determine the cause or consequence of this. As residents' records were not integrated, it was difficult to monitor fluctuations in a residents' weight. Records showed that there was a system for weighing each resident monthly but the documentation showed that this was not always done.

An inspector reviewed the documentation for one resident who appeared very frail. In January 2007 the resident weighed 49 kilograms (kg). According to the records she was not weighed again until April 2008: she weighed 36 kg. Her weight decreased by 13 kg during this period. Whilst she was weighed on a more frequent basis thereafter, the resident's records did not indicate that at any point the resident was referred to a dietician or that other steps had been implemented to maintain the resident's body weight. A medical practitioner authorised to accompany the inspector assessed this resident and confirmed that the resident was clearly undernourished. A nutritional assessment tool was not used by nursing staff on any of the residents reviewed by inspectors. The person in charge said that she would only involve a dietician in a resident's care if a doctor suggested it.

Premises and equipment

Windows and walkways

Inspectors found that the premises were not safe or well maintained. Reasonable measures were not taken to prevent accidents to any person in the centre or in the grounds of the centre.

The second level of the premises posed immediate health and safety risks to residents:

- the latches on two windows in a resident's bedroom were broken. One window opened out 52 centimetres and the other window opened out 48 centimetres. The structure and operation of the windows potentially allowed residents to fall from the second floor
- a ramp located in the upper level of the premises was not fitted with grab rails. At the bottom of the ramp there was a 'lip' approximately two centimetres in height between the ramp and the floor. There was a risk that residents could fall when walking from their bedroom to communal areas.

On 8 February 2010 an inspector observed that the two windows had been restricted to 20 cm. This was not in line with best practice. Inspectors noted that the provider had also not made arrangements for the review of other windows on the second level. An inspector observed that one window opened so far out that it could not be measured. The handles had not been repaired within the timescale outlined in the emergency action plan. The ramp had not been fitted with a grab rail and its lip had not been repaired. However, the provider responded in writing that a new grab rail would be fitted by the end of February 2010 and the lip of the ramp would be repaired by 13 February 2010.

Laundry

Inspectors considered that the laundry was not a safe or healthy environment to work in. The laundry room was found to be untidy, disorganised and in a state of disrepair. Leads and wires were exposed on one side of the wall. Limited space was available for staff to carry out their duties. Inspectors could not enter into the laundry room due to large amounts of clothing and other equipment covering the floor space. The laundry was not fitted with a sink or a hand washing basin. There were insufficient worktops and racks for sorting, drying and storing laundry.

Inspectors identified additional infection risks to residents, in that there were no arrangements for separating clean and dirty laundry.

Clinical waste

There are no facilities for disposing of clinical waste. The person in charge said that any form of clinical waste was disposed of in bins lined with black bags and that eventually it goes into the same area as food waste. This is poor practice and presents a significant risk of infection.

Equipment

There was no dedicated storage space for assistive equipment. Inspectors observed that when equipment was not being used it was stored in bathrooms. Hoists, as well as other items, such as specialised chairs, were kept in residents' bedrooms even when not used by those particular residents.

Inspectors observed that the material on many of the chairs in the sitting rooms was torn. The material on some of the pressure relieving cushions was also torn.

Communication

Policies and procedures

Since the last inspection a policy for the prevention, detection and response to abuse has been implemented. All staff, except for one, had signed that they had read the policy. The administrator said that the staff member who had not read the policy required a translator to be able to read the document. The person in charge said that training on the topic was planned for the week following the inspection. Other policies and procedures reviewed by the inspectors were authored by an external organisation and therefore were not centre-specific.

Communication systems

Communication between staff was at times ineffective. For instance, the chef was aware of residents' dietary requirements but there was no documentation kept of these requirements that enabled other part-time staff to become aware of their needs. This potentially compromised the provision of special dietary requirements for some residents.

Report compiled by

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

5 February 2010

Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Provider's response to inspection report

Centre:	Powdermill Nursing Home
Centre ID:	0270
Date of inspection:	28 January 2010, 29 January 2010, and 8 February 2010
Date of response:	19 March 2010

Requirements

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

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

The person in charge did not have the appropriate skills and experience to:

- prevent and control an outbreak of an infectious disease
- provide adequate numbers of staff and skill mix appropriate to the assessed needs of residents
- provide staff with education and training to enable them to provide care in accordance with contemporary evidence based practice
- assess, plan for, and monitor the residents' care needs
- record any incidents and take the appropriate action where a resident is harmed.

Action required:

The provider must review the fitness of the person in charge to work at the centre. The provider must determine whether she has qualifications suitable to the work that she is to perform and the skills and experience necessary for such work.

Reference: Health Act 2007 Regulation 18: Recruitment Standard 27: Operational Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The centre had prevented an outbreak of the norovirus (winter vomiting bug) for over four years, since the provider took over the centre in November 2005. On the day of the outbreak the two inspectors continued with two days of inspection, with a team of two people on day one and four people on day two. This was a distraction for nurses and staff, who were concerned about the residents and the inspection could easily have been postponed in the interests of the residents and in reducing the risk of the spread of the norovirus. The issue of staffing levels is not one that is easily reconciled. It is quite a shock to people to realise that there are over 45 staff on the payroll, taking care of some 40 residents. Staffing levels have increased steadily over the last four years. The provider who works daily at the centre was not even acknowledged in the list of people who were working on the previous inspection. What is equally important as the number of staff on duty is how they are organised. A review of the organisation of staff and how they are deployed in the centre will be undertaken by the Person In charge. I think to blame the person in charge for an allegation of inadequate numbers of staff is unfair and is not supported by empirical evidence or documentation. The residents are well looked after and ways to improve the care are always considered. The person in charge has over two years' consecutive gerontology experience. Each nurse on the team has at least the same, and two have three years' consecutive gerontology nursing experience. The role is demanding and the provider will undertake a review of her appointment. In the interim all reasonable support mechanisms will be put in place including further training, appointment of an assistant director of nursing, and providing extra nursing staff to assist the residents.	Authority timescale: by 7 February 2010 Provider comments: two months

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

Suitable and sufficient care to maintain residents' welfare and wellbeing was not provided. During the inspection of 28 and 29 January 2010, inspectors became aware of an outbreak of vomiting and diarrhoea. On the 28 January, inspectors confirmed that three residents were affected. On 29 January the person in charge informed the inspectors that eight residents and one member of staff were affected. During the post-inspection feedback meeting on 1 February 2010 the person in charge estimated that 12 - 14 residents in total were affected.

The person in charge failed to make adequate arrangements to prevent and control the outbreak of the infectious disease:

- an infection control policy was present in the centre although the person in charge was not aware of it and therefore did not adhere to it
- the training record folder provided to the inspectors by the person in charge indicated that education on the correct hand-washing technique was provided to staff in September 2009. The training did not include other aspects of infection prevention and control
- there was a lack of adequate personal protective equipment, clinical waste facilities, alcohol gel dispensers and signage to prevent and control the outbreak
- the person in charge had been advised by a GP to restrict visitors. However, the inspectors observed the person in charge greeting the visitors on arrival without enforcing the GP's recommendations
- some residents who displayed symptoms of the outbreak were brought into communal areas, placing other residents at risk of acquiring the infection
- there were no facilities for the segregation of laundry.

Action required:

The registered provider shall:

- ensure all staff are familiar with, and adhere to, the infection control policy*
- train all staff in infection prevention and control
- provide adequate personal protective equipment, clinical waste facilities, alcohol gel dispensers and signage to prevent and control the outbreak*
- provide facilities for the segregation of laundry.

Reference:

Health Act 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A complete review of how the norovirus was handled by the centre will be undertaken by the person in charge. Improvements can and	Authority timescale: * with immediate effect

should be made and staff, especially the nursing staff, would have benefitted from refresher training. The person in charge had reviewed all policies in September 2009. Actions already completed and ongoing action taken by the person in charge. A copy of the norovirus policy has been given to each nurse and to the head of hygiene. The person in charge instructed the nurses to have a daily meeting regarding the infection. During this meeting she reviewed the number of residents who were affected, the implementation of the policy and what decisions needed to be taken to prevent the spread of the infection. Instructed staff regarding the importance of hand washing, changing gloves, masks and aprons after each resident. Assisted residents to stay in their bed to prevent spread of infection. Restricted visitors. Contacted the doctor of each resident who became affected to ensure that the resident received care and treatment appropriate to their special needs. Monitored fluid intake of each resident affected to ensure that they were hydrated at all times. Instructed staff about the proper disposal of affected waste. Instructed staff about separate washing of clothes. Increased staffing levels so that a competent care assistant worked in the laundry each day. Discussed with the head of hygiene the appropriate deep clean action to be carried out once the centre was clear for forty eight hours.	Others by 7 February 2010

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

There were inappropriate numbers and skill mix of staff to meet the needs of residents. Discussions with staff and a review of the roster indicated that two care assistants and one staff nurse were on duty overnight. The two care assistants were responsible for laundering residents' clothing as well as providing care to residents.

Action required:

The person in charge shall ensure that at all times the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

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: Duties assigned to care assistants, such as laundry, are not mandatory. Night staff are only instructed to begin laundry at midnight when there is low demand for care from the residents. While a care assistant is in the laundry room the other two staff monitor the call bells. If that person's assistance is needed they can immediately leave the laundry room and assist. A person may only be in the laundry room for ten minutes at a time. An experienced nurse is on duty every night who knows each resident personally and she instructs the night staff in their duties. She is well aware that care of the residents is the primary responsibility of the night staff. If a resident for example becomes ill during the night she can ask extra staff to come in and assist. The duties assigned, such as laundry, are secondary to the primary role, which is to look after the residents. As the residents are mostly asleep in their beds there is very little care to be given apart from doing rounds and monitoring the call bells. The night nurse and staff are aware of the residents' sleep patterns and regularly check those residents who they know are prone to wake or need something. Some duties, such as laundry or sweeping the dining room floor, often break the routine of waiting for a bell to ring and keep the care assistants occupied and physically alert so that they are instantly alert when the need arises. The provider has often assigned a social care assistant to work from 18:00hrs – 21:00hrs and one is rostered two evenings per week. I would like to think this can be expanded and would like to recruit social care assistants who would work those hours, as I can see this being an additional benefit to the residents.	Authority timescale: with immediate effect Provider comments: Under review by management at present and will consider the concerns raised. Feedback will be sought from the night nurses and night care assistants so that an informed decision can be made.

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

Suitable and sufficient care to maintain the residents' welfare and wellbeing was not provided. Inspectors observed a resident resting in bed and displaying signs of pain. Following a review of the resident's medical records, this issue became apparent in September 2009. Following a GP review, analgesics were prescribed. However, medication administration records indicated that these were not administered. A medical practitioner authorised to accompany the inspector assessed this resident and confirmed the existence of pain in his right lower leg, and that his medication and pain management was in need of review. He also advised an X-ray of the resident's leg to determine if the leg was fractured or not. Nursing staff did not adequately monitor the effect of the analgesia/ pain and take appropriate remedial action.

Action required:

The registered provider shall ensure that suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency and needs as set out in their care plan.

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: I have responded to this aspect of the report by 3 February 2010. This report is false, unhelpful and misleading. The resident in question has some psychiatric problems and may have complained of pain to the inspectors. However, there is no evidence that he is in pain. He was examined thoroughly by his GP the next day. He concluded that there was no evidence of pain, and further ordered that no x-ray was necessary. He wrote a letter to this effect which was handed in to the HIQA office on 3 February 2010. It was untrue to state that he was allowed to remain untreated for pain since last September. He had several visits by his GP which I will document here. The resident saw his GP on 3 September 2009, 10 September 2009, 17 September 2009, 24 September 2009, 23 November 2009, 18 January 2010, 21 January 2010, 25 January 2010, and 30 January 2010. The gentleman in question has been visited by his wife three times	Authority timescale: by 3 February 2010

per week for the last eight years. He was with her for his dinner on Christmas day. She is mortified at the suggestion that the centre or herself would have allowed her husband to remain in pain and absolutely refutes the notion that he was in pain since last September, or was left untreated. The inspectors, on examining the medical administration records, noted that on one occasion in five months he was not given a painkiller in the evening. The centre maintains that suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency and needs as set out in their care plan, was given to this resident, and that there is no clinical evidence to the contrary.	

5. The provider is failing to comply with a regulatory requirement in the following respect: Suitable and sufficient care to maintain the residents' welfare and wellbeing was not provided. The inspectors reviewed a folder that contained information about the care of residents' urinary catheters. On three occasions the documentation indicated the due date for changing the residents' catheters, but they had not been changed. One resident's catheter was due to be changed on 16 January 2010. Another resident's catheter was due to be changed on 14 December 2009. The inspectors were concerned that two of the residents had previously experience a blocked catheter and in one instance the resident subsequently required a larger catheter.	
Action required: The registered provider shall ensure that suitable and sufficient care is taken to maintain each resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency and needs as set out in their care plan.	
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 control and changing of urinary catheters is very obviously a clinical medical decision and the provider is not qualified or authorised, legally or otherwise, to instruct a doctor in how to treat his patient. The doctor in question made the informed decision that if the catheter is working well and not infected or blocked then he will decide when to change the catheter for the resident in question.	Authority timescale: with immediate effect

The doctor has informed the staff nurse at the centre that he will consult with the residents' consultant urologist on what is best practice as regards each resident. In this case the registered provider has ensured that suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency, has been provided for the residents. The nurses reported to the doctor regularly if there was any problems with the catheters, and to discuss the issue of changing the catheter. Our records show that this was done in a timely manner. They then followed the doctor's instructions to his patient.	

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

All reasonable measures were not taken to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

The second level of the premises posed immediate health and safety risks to residents:

- The latches on the two windows in a resident's bedroom (14) were broken. One window opened out 52 centimetres and the other window opened out 48 centimetres. The structure and operation of the windows potentially allowed residents to fall from the second floor.
- A ramp located in the upper level of the premises was not fitted with grab rails. At the bottom of the ramp there was a 'lip' approximately two centimetres in height between the ramp and the floor. There was a risk that residents could fall when walking from their bedrooms to communal areas.

Action required:

The provider shall take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

The provider must have regard to the number and needs of the residents and ensure that:

- the physical design and layout of the premises to be used as the designated centre meets the needs of each resident
- suitable adaptations are made, and such support, equipment and facilities as may be required are provided, for residents.

Ensure that window restrictors are set to restrict the window opening so that risk to residents is minimised (for information please refer to the document 'Health and Safety Executive/Local Authorities Enforcement Liaison Committee (HELA), Local Authority Circular Number 79/6, Falls from Windows in Health and Social Care).

Reference:

Health Act, 2007
Regulation 19: Premises

Regulation 31: Risk Management Procedures Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The windows have now been adjusted by a competent person and the opening has been restricted since the inspection. Grab Rail. A new grab rail will be fitted where indicated. A lip of two centimetres at the start of the ramp. This will be remedied.	Authority timescale: by 7 February 2010 Provider comments: By the end of February 2010 13 February 2010

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

The person in charge did not:

- maintain a record of all incidents that occurred in the designated centre
- notify the chief inspector of incidents as outlined in Regulation 36 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.

Action required:

The person in charge must maintain a record of all incidents occurring in the designated centre.

The person in charge must notify the chief inspector of incidents as outlined in Regulation 36 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009. Any notice made in accordance with this article that is given orally must be confirmed in writing within three working days of the occurrence of the incident.

Reference:

Health Act 2007
Regulation 36: Notifications of Incidents
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All the nurses have received instruction which gives them the details	Authority timescale: with immediate effect Provider comments:

that they need to know to maintain records of all incidents. All nurses have been instructed by the person in charge to notify the chief inspector and have the requisite forms printed to simplify the reporting process.	With Immediate effect With immediate effect

8. The provider has failed to comply with a regulatory requirement in the following respect: There were no written operational policies or procedures relating to the making, handling, and investigation of complaints.	
Action required: Implement written operational policies or procedures relating to the making, handling, and investigation of complaints.	
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: A new complaints policy has been written. All staff will need to be trained in implementing the new policy.	By 15 April 2010

9. The provider has failed to comply with a regulatory requirement in the following respect: Some care practices observed by inspectors did not adhere to best practice and guidelines regarding maintenance of privacy and dignity.	
Action required: Ensure that all care practices are in line with best practice and adhere to current guidelines while observing the privacy and dignity of residents, including assisting residents with feeding, mobilisation and control over their own clothing.	
Reference: Health Act 2007 Regulation 6: General Welfare and Protection Standard 4: Privacy and dignity Standard 19: Meals and Mealtimes	

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: This will be reviewed again by the new person in harge and new guidelines issued to staff.	Immediate

10. The provider has failed to comply with a regulatory requirement in the following respect:	
The curtains rails in some bedrooms were broken which prevented curtains from closing to maintain residents' privacy.	
Action required: Keep the premises in a good state of repair externally and internally, including the bedroom curtains, to maintain residents' privacy.	
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: New fire proof curtains have been sourced and will be fitted in all shared rooms in a systematic manner.	Immediately ensure that all dividing curtains are working properly. Replace dividing curtains in all shared rooms by 15 August 2010

11. The provider has failed to comply with a regulatory requirement in the following respect:
Challenging behaviours were not managed effectively in the centre. The policy on managing challenging behaviours was not operational.
Action required: Produce and implement operational policies and procedures on behaviour management. Train and familiarise staff to implement all policies and procedures within the residential care

setting. Provide clear documentary evidence of this.

Ensure that all staff have up-to-date knowledge and skills, appropriate to their role, to enable them to manage and respond to behaviour that is challenging. There are arrangements in place to obtain advice, training and support from key professionals with the required expertise.

Reference:

Health Act 2007
Regulation 9: Health Care
Standard 21: Responding to Behaviour that is Challenging
Standard 29: Management Systems

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response:	
1. Immediate review of the action required in this section.	Immediate
2. We will undertake a multi disciplinary medical review of all residents who present with the symptoms of challenging behaviour and act on the findings.	Immediate
3. We will review existing policy and update.	Two months
4. We will send a staff nurse to attend a training course on "Working with people who have behaviours that challenge"	Four months
5. All staff involved in the care of residents to receive training and to read and understand the policy relating to challenging behaviour.	Five months
6. Develop new behaviour assessment forms as a tool in patient analysis.	Four months

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

Restraint procedures used in the centre were inadequate.

Action required:

Develop written policies and procedures on the use of physical restraint. They should be evidence-based and adhere to regulations and national guidelines. Keep a record of any occasion on which restraint is used, the nature of the restraint and its duration.

Reference:

Health Act 2007
Regulation 25: Medical Records
Standard 21: Responding to Behaviour that is Challenging

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: Policy is now in place. This policy is now in place. Training of staff will commence as part of an overall training programme which is being prepared.	 15 June 2010

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

Care plans did not inform the nursing care required. For instance, the wound care documentation did not outline the type of dressing, including solutions, to be used.

Care plans were not developed and agreed with each resident.

Action required:

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

The person in charge must:

- make the resident's care plan available to the resident
- keep the resident's care plan under formal review as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals
- revise the resident's care plan, after consultation with them, unless it is impracticable to carry out such consultation
- notify the resident of any review.

Reference:

Health Act 2007
Regulation 8: Assessment and Care Plan
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: All new care plans for new residents will be agreed with the resident and relatives where the resident lacks the mental capacity to assess the care plan. All existing care plans will be reviewed with the residents and updated.	 15 June 2010

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

Documents pertaining to the care of residents were not integrated: information could be found in 11 different folders. Key documents pertaining to residents' care were often incomplete and undated.

Action required:

Maintain residents' records in a manner that ensures completeness and accuracy. Keep records up-to-date and in good order.

Reference:

Health Act 2007
Regulation 22: Maintenance of Records
Standard 32: Register and Resident's Records

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: The new Person in Charge has said that all new admissions will be using integrated records and over the next three months all older records will be integrated.	30 June 2010

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

Appropriate and suitable practices for the safe administration of controlled drugs in accordance with An Bord Altranais "Guidance to Nurses on Medication Management" and the relevant legislative requirements were not in place.

Action required:

Put in place appropriate practices for the safe administration of controlled drugs. Enter appropriate documentation of the administration of the controlled drugs in the residents' records and in the controlled drug register.

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 following the inspection with timescales:	**Timescale:**

Provider's response: The newly appointed person in charge has informed me that this is a priority and is receiving her immediate attention.	Before 15 April 2010

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

Suitable and sufficient care was not provided to maintain the residents' welfare and wellbeing, having regard to the nature and extent of the residents' dependency and needs as set out in their care plan. Residents' weight was poorly monitored and documented. Remedial action was not taken in response to a significant reduction in one resident's weight. A nutritional assessment tool was not in use at the centre. Arrangements for accessing a dietician were inadequate.

Action required:

Make certain that:

- residents' health needs are comprehensively assessed and reviewed as indicated by the residents' changing needs or circumstances, and no less frequently than at three-monthly intervals
- the residents' general physical and mental health is promoted through the provision of appropriate health-promoting interventions, devised and reviewed by allied health professionals.

Reference:

Health Act 2007
Regulation 6: General Welfare and Protection
Standard 10: Assessment
Standard 12: Health Promotion

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This is currently being reviewed by the new person in charge and the nursing team. Any proposals will be acted on immediately to ensure that the care of the resident is never compromised.	Immediate. A comprehensive review of all residents will be completed by 25 June 2010

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

There was insufficient of storage space for assistive equipment and devices.

Action required: Make suitable provision for storage in the designated centre, having regard to the number and needs of the residents.
Reference: Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This matter will be given immediate attention so that satisfactory arrangements can be made for storage.	July 2010

18. The provider has failed to comply with a regulatory requirement in the following respect: Fabrics on furnishings, including chairs and pressure-relieving cushions, were not maintained in a satisfactory condition.
Action required: Maintain equipment provided for use by residents in good working order, including chairs and pressure-relieving mattresses.
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: Damaged fabrics will be replaced immediately. Pressure-relieving mattresses are serviced under a service contract.	By 30 April 2010

19. The provider has failed to comply with a regulatory requirement in the following respect: Facilities for disposing of clinical waste were not provided.

Action required: Make adequate arrangements for the proper disposal of swabs, soiled dressings, instruments, disposable syringes and sheets, incontinence wear and other similar substances and materials.	
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: Proposals have been received from companies who can properly dispose of clinical waste. A contract will be signed with one shortly.	30 April 2010

20. The provider has failed to comply with a regulatory requirement in the following respect: Staff had not been provided with training in the prevention, detection and response to elder abuse.	
Action required: Make all necessary arrangements, by training staff or by other measures, to prevent residents being harmed or suffering abuse or being placed at risk of harm or 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: All staff will be given further training in the area of elder abuse	30 April 2010

21. The provider has failed to comply with a regulatory requirement in the following respect: The laundry room was not kept in a good state of repair and was not designed to meet the needs of residents. It also compromised the health and safety of staff.

Action required: Improve laundry facilities so that they adequately cater for the size of the residential care setting and the needs of residents.	
Reference: Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Laundry facilities will be reviewed and upgraded.	By 30 June 2010

22. The provider has failed to comply with a regulatory requirement in the following respect: Inadequate communication systems were in place for catering staff to be able to meet residents' special dietary requirements.	
Action required: Make arrangements to ensure that residents are provided with food and drink that takes account of special dietary requirements, including effective communication systems for catering staff.	
Reference: Health Act 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This is being reviewed and updated constantly as the needs of the resident can change. Communication systems will be examined to see if any improvements can be made.	15 April 2010

Any comments the provider may wish to make:

Provider's response:

The view of the inspectors has bordered on a polemic attack on a centre that has provided consistent care for the citizens of Cork for some 26 years. Significant changes and improvements have been made since I took over in 2005. A comprehensive maintenance programme has been implemented including capital expenditure. Fire safety was deemed a priority and a significant expenditure was approved to exceed current fire safety guidelines. There are many other improvements being made.

It would appear that because the centre queried the requirements for double registration (and did so in a formal and considered manner) that the inspection teams have focused solely on negative aspects of the centre only. It is my view that a good and impartial inspection team can report both in a positive and negative manner so that good work can and is recognised and poor practices and conditions can be eradicated and that residents can be respected and their lives improved.

As a matter of courtesy the inspection team had residents examined by an external consultant. At no time did they seek consent from the residents or informed their next of kin and in particular the wife of one of the residents. She was hurt by being ignored and treated as if she was irrelevant. This contrasts with the proper insistence that care plans are discussed with the resident at all times by the centre.

As stated previously the residents are my number one priority.

Provider's name: Joseph Peters
Date: 19 March 2010