<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Deerpark House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>0221</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Seafield, Bantry, Co Cork</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>027-52711</td>
</tr>
<tr>
<td>Fax number:</td>
<td>n/a</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@deerparkhouse.ie">info@deerparkhouse.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>☒ Private ☐ Voluntary ☐ Public</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Patricia Kelleher Murphy</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Patricia Kelleher Murphy</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>23 June 2011 and 24 June 2011</td>
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| Time inspection took place: | **Day-1 Start:** 09:00hrs **Completion:** 18:15hrs  
|                      | **Day-2 Start:** 08:45hrs **Completion:** 16:00hrs |
| Lead inspector:      | Patricia Sheehan            |
| Support inspector(s):| Naomi Combe                 |
| Type of inspection:  | ☒ Registration              |
|                      | ☐ Announced ☐ Unannounced   |
About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider’s fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, “fit persons” and are legally permitted to provide that service.

Other elements of the process designed to assess the provider’s fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider’s capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the National Quality Standards for Residential Care Settings for Older People in Ireland. Resident’s comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority’s values of openness and transparency.
About the centre

Location of centre and description of services and premises

Deerpark House Nursing Home is located on the outskirts of the town of Bantry, County Cork. The centre, established in 1999, is a purpose built single-storey building. It provides long-term, respite, convalescence, post-operative and palliative care for 50 residents. At the time of inspection there were 47 residents and the person in charge informed inspectors that 16 of these residents had dementia.

There are 42 single rooms and four twin bedrooms, all with en suite containing wash-hand basin, assisted toilet and shower. There are four communal assisted toilets each with a wash-hand basin, and one communal assisted bathroom with a wash-hand basin and a full length reclining bath with whole side entry and access for hoist transfer.

Communal accommodation consists of three lounges, two dining rooms and a prayer room. A treatment room also serves as a hairdressing salon. Office space, a kitchen and well-maintained gardens completes the layout.

<table>
<thead>
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<th>Date centre was first established:</th>
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<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>47*</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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<tr>
<td>Dependency level of current residents:</td>
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<td>Gender of residents</td>
<td>Male</td>
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<tr>
<td></td>
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* One resident was in hospital at the time of inspection.

Management structure

Deerpark House Nursing Home is a partnership with two directors. Patricia Kelleher Murphy, one of the directors, is the Provider and also the Person in Charge. All staff formally report to the Provider. On a daily basis, catering and nursing staff report to the Deputy Person in Charge via the senior nurse on duty whereas housekeeping and maintenance staff report to the business partner who is the other director. The activities coordinator and the administrator provide line management to housekeeping and maintenance staff in the absence of the business partner.
Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007.

Inspectors met with residents, relatives, and staff members over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. A fit person interview was carried out with the provider who is also the person in charge. She had completed the fit person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

Inspectors found substantial 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.

There was evidence of effective governance and that residents received a good standard of evidence-based care with access to allied health services and with an emphasis on improving the quality of life. Staffing levels were appropriate and staff that inspectors spoke with were knowledgeable about residents’ individual health needs, and this was confirmed by the care practices observed. Residents were facilitated to exercise choice and personal autonomy and their views were sought and listened to. The feedback received from residents and relatives indicated a high level of satisfaction with the care provided.

Some improvements were required to enhance the findings of good practice, such as, implementing systems to monitor and develop the quality of care and the quality of life, risk management, medication management practices, care planning, policies, and the design of the premises. All of the improvements are described under the outcome statements and related actions are set out in the Action Plan at the end of the report under the relevant outcomes.
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 written statement of purpose was available and it accurately described the services provided in the centre, which reflected the diverse needs of the residents, and met the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

The statement of purpose set out the services and facilities provided in the centre and included the aims, objectives and ethos of the overall service. Inspectors observed that the centre’s capacity to meet the diverse needs of residents, as stated in the statement of purpose, was reflected in practice. In particular, inspectors noted the focus on meeting the social care needs of residents, competencies of staff and commitment to staff supervision and training. The statement is kept under review and is made available to residents on request.

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

There was no overall system in place to monitor and develop the quality of care and quality of life of the residents on a continuous basis.

Inspectors saw records of monthly reviews of aspects of an individual resident’s quality of care, which was confirmed by staff. There was evidence of a robust review of resident falls and assessment of the risks due to a high level of falls in the last six months. This had resulted in the implementation of action plans to improve outcomes for residents and reduce falls. A resulting reduction in falls in the last quarter was noted by the inspectors. However, there were not audits of clinical practice in, for example, care planning, or medication management practice, or audits of privacy and dignity to measure against the National Quality Standards for Residential Care Settings for Older People in Ireland that would allow for continuous quality improvement.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

Inspectors found that some improvements were required to make the management of complaints more effective.

Residents, their relatives and staff reported to inspectors that they had easy access to the person in charge and they could openly report any concerns. There was a written complaints policy and the process for making a complaint was outlined in the statement of purpose and the Resident's Guide. The complaints officer responsible for investigating complaints was clearly identified.

An inspector read records of complaints and there was appropriate documentation detailing the investigation and outcome of the complaint and whether or not the resident was satisfied. However, complaints resolved by the nurse in charge and not requiring the intervention of the complaints officer were recorded in residents’ files and not in the complaint log.

The notice displayed regarding complaints information stated that a copy of the policy was available upon request but did not clearly outline for potential complainants the different steps in the complaints process and associated timeframes. The information relating to the independent appeals process also referred inappropriately to the Health Information and Quality Authority.
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

There was evidence that all staff had received training in adult protection and residents with whom inspectors spoke confirmed that they felt safe in the centre. The policy on the prevention, detection and response to abuse required improvement.

Staff with whom inspectors spoke were able to appropriately describe their responsibilities with regard to reporting an allegation of abuse and the actions to be taken in the event of an allegation of elder abuse. Inspectors reviewed the policy on the prevention, detection and response to abuse. The procedures relating to responding to suspicions or allegations of abuse were not sufficiently detailed and comprehensive to effectively guide staff and management appropriately and there was no reference to the role of the Health Service Executive (HSE) social work service for elder abuse.

Inspectors reviewed the system for the management of personal property and funds and found it to be clear and transparent.

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

There was evidence of health and safety practices and the management of risk that promoted the safety of residents, staff and visitors. The risk management policy and procedures and risk assessments required some improvements.
Examples of practice regarding health and safety and the management of risk that promoted the safety of residents, staff and visitors were:

- a written emergency plan
- a current health and safety statement that identified hazards and the required controls with all staff signing an acknowledgment of their understanding of the safety statement
- a risk register for all clinical and non-clinical risks was in the process of being developed with risks added to the register following incident analysis
- regular health and safety meetings with a current focus on reviewing falls and taking appropriate action to improve outcomes
- review of fire records showed that all fire safety equipment, including the fire alarm and emergency lighting had been serviced at appropriate intervals
- records of fire drills were maintained and fire safety and evacuation training for all staff took place on an annual basis
- records indicated staff had received manual handling training which was confirmed in staff interviews
- the environment was extremely clean and well maintained with safe and appropriate floor covering, hand rails to promote independence and emergency exits were unobstructed
- appropriate sluicing facilities and infection control measures in place with arrangements for the segregation and disposal of waste, including clinical waste
- records indicated that equipment and services were checked and maintained regularly.

The risk management policy and procedures were not sufficiently comprehensive and did not detail the arrangements for the recording, investigation and learning from serious incidents involving residents. They did not cover the precautions in place to control the specified risks of unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm. Individual risk assessments had been completed for those residents who smoked; however, the overall risk relating to some residents smoking unsupervised in their bedrooms had not been assessed with the appropriate controls identified. The daily check of fire exits and the alarm panel was not recorded.

**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**

Some medication management practice required improvements in order to adhere to professional guidelines and regulatory requirements.

The medication policy for prescribing, administering, recording and storing of medication was not sufficiently comprehensive. Medication procedures were not sufficiently detailed or were omitted for:

- prescribing, recording and storing
- transcribing (transferring a prescription order to a medication administration record)
- self administration
- PRN (pro re nata) prescribing, administration and review

There were appropriate procedures for the handling and disposal for unused and out of date medicines. Controlled drugs were stored safely and recorded in a register in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1982; however, stock levels were only checked by two nurses at the evening shift handover and not at each shift handover.

An inspector observed during a medication round that prescription sheets did not have a photo of individual residents and did not always detail how the medicine should be taken.

**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
Residents had opportunities to participate in a wide range of meaningful activities appropriate to their interests and preferences. Inspectors found a good standard of evidence-based nursing care and appropriate medical and allied healthcare. The arrangements to meet residents’ assessed needs were set out in individual care plans, which were drawn up with the involvement of residents and their relatives. Improvements were required to achieve more comprehensive care planning as regards pressure ulcer care and medical reviews.

The centre has sufficient general practitioner (GP) cover, and the GPs provide out-of-hours services. Most residents use the local GPs who visit the centre. However, if they wish to retain the services of their own GP, this is facilitated. A sample review of residents’ medical notes showed that the health needs of residents are being monitored on an ongoing basis with GPs visiting regularly. The deputy person in charge informed inspectors that the GPs are available by phone any time to offer advice to staff.

Residents have access to a range of other health services, including physiotherapy, dietetic, speech and language therapy and dental services. When residents were transferred in or out of the centre, there was appropriate documentation reflected in residents’ notes. Discharges were planned for and discussed with residents, which was confirmed by a resident who was due to be discharged shortly.

Inspectors examined five care plans and found that comprehensive person-centered care plans were in place. Recognised assessment tools were used to promote health and address health issues. These included assessments for risk of pressure ulcers, malnutrition, and falls risk. Health promotion was assisted by suitably trained nurses annually taking of bloods for assessment to provide an overall health baseline of all residents. Appropriate measures have been put in place to manage and prevent risk.

There is a strong emphasis on social care, with prescribed interventions within care plans to promote residents’ social care needs, based on residents assessed preferences, interests and capacities. Some parts of the care plans are reviewed monthly with three-monthly complete reviews which were dated, and signed by staff and residents or relatives. Five residents had pressure ulcers and inspectors noted that appropriate care was being given as evidenced in nursing notes. However, three of these five residents did not have detailed care plans in place in regard to pressure ulcer care, and medication reviews by GP’s as part of the medical review of care plans, took place every six months and not on a quarterly basis.

The residents spoken to commented on the various activities available to them, including organised trips, exercise classes, music sessions and pet therapy. Inspectors observed a range of activities including a trip to a film festival, dancing and singing. It was clear to the inspectors that a lot of sustained effort goes into personalising recreational activities for the residents. Of particular note to inspectors was the manner in which residents with a cognitive impairment were encouraged to take part in activities, or where this was not possible, their attention was regularly brought to the activity, so that they could enjoy moments observing the enjoyment of others. For those residents with dementia there was evidence of activity-focused
care, the use of life stories, reminiscence, and Sonas (therapeutic activity to enhance interaction and communication). Inspectors observed a number of staff in the dedicated activities team and the activities coordinator interacting sensitively with residents who were cognitively impaired and saw genuine attempts to meet the needs of individuals. All observed interactions between staff and residents demonstrated respect, kindness and patience on the part of staff members.

The centre's policy on the use of restraint includes a direction to consider all other alternative interventions prior to using restraint. Bedrails were the only form of restraint observed. There was evidence in care plans and accompanying documentation that the use of restraint was subject to assessment and ongoing review. Risk assessments were undertaken before introducing bed rails and these were observed in resident documentation.

**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**

While no resident was receiving end-of-life care at the time of inspection, staff described the person-centred care that would be provided and the emphasis on providing appropriate care and comfort to any resident approaching end-of-life.

There was access to specialist palliative care services and family and friends were facilitated to stay overnight with residents at end-of-life, staying either in the resident's room or in another vacant room. Staff described how a move into a single room was facilitated whenever possible for residents in shared rooms and a prayer room was available for family members and residents to use.

The policy and procedures on end of life care required improvement. It was not sufficiently coherent and cohesive to effectively inform practice regarding meeting residents’ needs and consideration of residents’ autonomy in regard to wishes and choices.

**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**
Residents received a nutritious and varied diet that offered choice, and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff.

An inspector joined residents for lunch and observed that residents were provided with well-presented food and that the dining areas were bright with attractive table settings. There were two dining rooms; one for those who can dine independently and one for those who need assistance. Staff assisted some residents with dining in a respectful manner and used the time as an opportunity for social interaction. Residents dined in the dining room or their bedrooms, as preferred. Several residents confirmed that they enjoyed the food, that there were adequate amounts of it and that they enjoyed the dining experience.

The kitchen was clean, tidy and well organised. The cook was familiar with the personal preferences of the residents and there was a diet card for each resident stored in the kitchen outlining his/her dietary needs e.g. diabetic diet, soft diet and preference such as vegetarian diet. There were swallow plans, with clear instructions, for those who needed them. Inspectors observed a plentiful supply of fresh and frozen food, appropriately stored.

Inspectors observed fluids and snacks being offered to residents during the day. Juices and water were available in the shared areas. Each day a healthcare assistant is allocated the task of ensuring that residents are well hydrated. Residents confirmed that they were encouraged to drink regularly and that they were supplied with a cold drink or tea or coffee whenever they wished. Healthcare assistants were observed documenting residents’ fluid intake on the touch screen computer system.

An appropriate screening tool was used to identify residents at risk of malnutrition. Residents were weighted monthly or more often if considered to be at risk, and inspectors noted evidence of this in the residents’ notes and the availability of dietetic review as required. Nutritional supplements were prepared twice daily for residents who required them.

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**
Contracts were agreed with and provided to residents within a month of admission. They set out the overall care and services provided to the residents and the fees charged, including any additional fees charged. The administrator explained that there were three signed contracts outstanding as the relatives of these residents had yet to return them and these were being actively followed up.

**Outcome 11**

*Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.*

**References:**
Regulation 10: Residents’ Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

**Inspection findings**

Inspectors found evidence that residents’ privacy and dignity was respected. Their capacity to exercise personal choice and autonomy was maximised and their views were sought and listened to.

A residents’ committee met regularly as a forum for resident consultation in how the centre was planned and run. A review of the minutes of these meeting demonstrated that residents had been provided with opportunities to provide feedback and that their requests had been implemented. An advocacy service had been implemented to further assist in determining residents’ preferences.

Inspectors observed, and were also informed by residents and relatives, that the privacy and dignity of residents was respected by staff. For example:

- doors to bedrooms were kept shut while staff were assisting residents
- the manner in which residents were addressed by staff was appropriate and respectful
- inspectors observed staff taking the time to reassure residents with cognitive impairment, speaking slowly, clearly and sensitively
- a hairdresser was available to residents.
There was an open visiting policy and relatives and residents confirmed that visitors were made welcome at any time. Relatives interviewed said that they were always offered a cup of tea or the opportunity to eat with the resident whom they were visiting. There was a private area for residents to spend time alone and to meet visitors.

Daily life in the centre maximised the residents' capacity to exercise choice and personal autonomy. Residents told inspectors that they could choose the time to get up and go to bed. Breakfast is served from 08:00hrs to 11:00hrs to accommodate the wishes of various residents. Inspectors observed breakfast being brought to residents at various times during the morning. Residents' religious needs were facilitated as inspectors were informed by staff, residents and their relatives, that there were religious services held in the centre.

Residents, visitors and staff told inspectors that both the person in charge and the deputy person in charge were always available and they felt that communication was welcomed and encouraged. Relatives commented that they liked the fact that the deputy person in charge was based at a desk in the foyer and was thus highly visible and available to residents and staff. Inspectors observed good interactions between staff and residents. Residents stated that they could talk to staff at any time. Inspectors noted that staff were consistently engaged in the care of the residents.

There was an events notice board with up-to-date activities listed and other relevant notices posted. Inspectors observed that residents had access to televisions, daily newspapers and a portable phone. Inspectors noted evidence of community links, with local musicians and schoolchildren visiting the centre and resident involvement in community activities.

**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**

There were arrangements in place for regular laundering of linen and clothing and adequate space provided for residents' personal possessions.

There was a policy on the management of residents’ personal property and possessions which inspectors noted was consistent with the practice. Residents were
dressed well and according to their individual choice. Rooms were personalised with photos, plants and other personal possessions.

The laundry room was clean and efficiently run with suitable infection control processes in place for laundering soiled items. All clothes were labelled with residents’ names and stored in baskets marked with room numbers. One resident spoke of occasionally washing small items in her room and laundry staff provided detergent. Residents’ clothes were folded and returned to the resident’s cupboards by the laundry worker. Residents and relatives expressed satisfaction with the service provided and the safe return of their clothes to them.

5. Suitable staffing

<table>
<thead>
<tr>
<th>Outcome 13</th>
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<tbody>
<tr>
<td>The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.</td>
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<table>
<thead>
<tr>
<th>References:</th>
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<tbody>
<tr>
<td>Regulation 15: Person in Charge</td>
</tr>
<tr>
<td>Standard 27: Operational Management</td>
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Inspection findings

The person in charge was full time and she was a registered nurse with more than the required experience in the area of nursing of older people and sufficient clinical knowledge to ensure safe care. Throughout the two days of inspection the person in charge demonstrated very good knowledge 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.

Inspectors observed evidence of good leadership and that the person in charge was engaged in the governance and operational management on a regular and consistent basis. A post of administration manager had recently been introduced and a robust management structure was in place. The person in charge demonstrated sufficient clinical knowledge to ensure suitable and safe care and had identified in her self assessment the need for a quality assurance system to improve the quality of service and safety of residents.

Throughout the inspection process the person in charge demonstrated competence and a commitment to the delivery of person-centred care and to meeting the regulatory requirements.
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
All staff were Garda Síochána vetted or in the process of being vetted in accordance with best recruitment practice and were supervised on an appropriate basis. There were suitable staff numbers to meet the assessed needs of residents, and relevant to the size and layout of the centre. Improvements were required in respect of the obtaining of three references for all staff employed, staff training, and volunteer records.

Staff whom inspectors spoke with were clear about their areas of responsibility and the reporting structures and supervision arrangements. Inspectors viewed evidence of the induction programme which was confirmed by a new staff member. Nurses were being facilitated to actively supervise care assistants on a routine basis to ensure monitoring of practice. Staff informed inspectors that copies of both the regulations and the standards had been made available to them and expressed an adequate understanding of the content. There were monthly staff committee meetings with representatives from nursing, care assistants, activities, kitchen, housekeeping, and administration with minutes of such meetings maintained, and staff confirmed that these arrangements were satisfactory. Inspectors noted that staff turnover was low and that staff facilities were adequate.

There was evidence that the provider and person in charge were committed to staff education and training to enable them to provide care in accordance with contemporary evidence-based practice. Over half of the care staff had completed a Further Education and Training Awards Council (FETAC) Level 5 or higher care assistant programme and the person in charge outlined the plan for the remainder of care staff to be facilitated to complete the qualification. Records indicated that education and training for all staff was continuous and relevant with mandatory training in manual handling and adult protection up to date and the delivery of ongoing training in areas such as nutrition, continence promotion, dysphasia, venepuncture, end of life, first aid, and food hygiene. However, managing
challenging behaviour and infection control training had not been provided in the last two years.

A review of five personnel files found that not all staff had provided three references. Volunteers were Garda Síochána vetted appropriately and received supervision and support. However, their roles and responsibilities were not set out in a written agreement between the centre and the individual volunteer.

6. Safe and suitable premises

<table>
<thead>
<tr>
<th>Outcome 15</th>
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<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>References:</td>
</tr>
<tr>
<td>Regulation 19: Premises</td>
</tr>
<tr>
<td>Standard 25: Physical Environment</td>
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</tbody>
</table>

Inspection findings

The centre was purpose-built, with a good standard of private and communal space and facilities. The environment is bright and well maintained throughout. Inspectors noted that the centre is very clean and is suitably decorated. Residents reported that the centre offered a homely comfortable environment and told inspectors that they enjoyed the lifestyle provided. Communal areas such as the day-rooms had pleasant furnishings and comfortable seating. Some improvements were required regarding garden access and safety, screening in shared rooms, signage, and call-bell accessibility.

The premises and grounds are well maintained and inspectors observed no significant hazards. There was sufficient private accommodation and several communal spaces with adequate number of toilets, bathrooms and showers to meet the needs of the residents. There were 42 single and four twin bedrooms, all with en suites containing a wash-hand basin, assisted toilet and assisted shower. Residents’ bedrooms were spacious, comfortable and personalised. There was appropriate assistive equipment available such as hoists, pressure-relieving mattresses and cushions, wheelchairs and walking frames and a functioning call-bell system in place.

There were a number of improvements required.

The landscaped garden was very well maintained with colourful flower beds and green areas and residents and relatives told inspectors that they enjoyed spending time out there during fine weather. However, the door from the main lounge to the garden area remained locked during the two days of inspection and therefore residents had to approach a staff member if they wish to enter the garden. The garden did not have a secure perimeter which resulted in residents with dementia or
a cognitive impairment not being able to safely access the garden without supervision. The person in charge said that due to the lack of a secure garden, potential residents who were mobile with dementia were not admitted as stated in the statement of purpose. However, inspectors noted that the majority of residents were low to medium dependency and that a number of these residents were mobile and had some cognitive impairment.

The screening in shared rooms did not completely surround the beds to ensure maximum privacy.

There was an insufficient use of signage and colour schemes to assist in independence of those with cognitive impairment.

The call-bell accessibility in the lounge adjoining the main lounge was not sufficient.

7. Records and documentation to kept at a designated centre

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

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

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

**Resident’s guide**

Substantial compliance □ Improvements required* ☒
Records in relation to residents (Schedule 3)
Substantial compliance ☒ Improvements required* ☐

General records (Schedule 4)
Substantial compliance ☒ Improvements required* ☐

Operating policies and procedures (Schedule 5)
Substantial compliance ☐ Improvements required* ☒

Directory of residents
Substantial compliance ☒ Improvements required* ☐

Staffing records
Substantial compliance ☐ Improvements required* ☒

As outlined in Outcome 14

Medical records
Substantial compliance ☒ Improvements required* ☐

Insurance cover
Substantial compliance ☒ Improvements required* ☐

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

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

Inspection findings
An inspector reviewed a record of all incidents that had occurred in the centre and found the documentation to be comprehensive. However, notice had not been given to the Chief Inspector of serious injuries to three residents resulting from the development of grade two plus pressure ulcers.
**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**

There were appropriate arrangements in place for the absence of the person in charge as the deputy director of nursing deputises for the person in charge. Inspectors were informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.
Closing the visit

At the close of the inspection visit a feedback meeting was held with both partners, the administrator, activities coordinator, and deputy 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

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

6 July 2011
Provider's response to inspection report*

<table>
<thead>
<tr>
<th>Centre:</th>
<th>Deerpark House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>0221</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>23 June 2011</td>
</tr>
<tr>
<td>Date of response:</td>
<td>12 July 2011</td>
</tr>
</tbody>
</table>

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 2: Reviewing and improving the quality and safety of care

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

There was not an overall system in place for reviewing and improving the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Action required:

Establish and maintain a system for reviewing and improving the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

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

Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

**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:**

<table>
<thead>
<tr>
<th>Provider's response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First action required:</td>
</tr>
<tr>
<td>As outlined in my self-assessment document we are developing a formal quality and safety of care provided audit process. This is a work in progress at present. I envisage final Document available and implemented week ending 30 November 2011</td>
</tr>
<tr>
<td>Second action required:</td>
</tr>
<tr>
<td>Following any review arising from this document / process the copying and / or reporting to the appropriate personnel including the Inspectorate will be encompassed within the process.</td>
</tr>
<tr>
<td>Third action required:</td>
</tr>
<tr>
<td>Consultation has been taking place through our Resident Forum and Advocacy Group meetings. To further enhance this and include family members and interested parties(where appropriate) on a more formal and consistent basis, the quality audit process will include the further development and enhancement of satisfaction questionnaires on a six monthly basis.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Timescale:</th>
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<tbody>
<tr>
<td>30 November 2011</td>
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<tr>
<td>30 November 2011</td>
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<tr>
<td>30 November 2011</td>
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</table>

**Outcome 3: Complaints procedures**

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

Not all complaint records were maintained in the complaints log book and the displayed complaints information did not outline the different steps in the process and the independent appeals process inappropriately referenced the Authority.
Action required:
Ensure the displayed complaints information outlines the different steps in the process and associated timeframes.

Action required:
Ensure all complaint records are maintained in the complaints log book as distinct from a resident’s individual file.

Action required:
Ensure the independent appeals process does not reference the Authority.

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:

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First action required:</td>
<td>Done</td>
</tr>
<tr>
<td>The ammended document displaying the process and time frames is displayed on the notice board. Copy sent to the Authority</td>
<td>Done</td>
</tr>
<tr>
<td>Second action required:</td>
<td>Done</td>
</tr>
<tr>
<td>All complaints will be recorded in the complaints log book in addition to the relevant resident / staff file.</td>
<td>Done</td>
</tr>
<tr>
<td>Third action required:</td>
<td>Done</td>
</tr>
<tr>
<td>Any reference to the Authority in our complaints document has been removed.</td>
<td></td>
</tr>
<tr>
<td>As these three matters had been brought to my attention during the inspection they were attended to immediately. I attach a copy of the completed reviewed and ammended policy. Duly signed and dated appropriately.</td>
<td></td>
</tr>
</tbody>
</table>

Outcome 4: Safeguarding and safety

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

The procedures in place for the response to abuse were not sufficiently detailed and comprehensive to effectively guide management and staff appropriately.
**Action required:**

Revise the procedures in place for the response to abuse and ensure they are sufficiently detailed and comprehensive to effectively guide staff and management appropriately.

**Action required:**

Ensure the revised procedures include the role of the Health Service Executive case worker for elder 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:**

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I attach a copy of the completed reviewed and amended Elder Abuse Policy. This document highlights the immediate and succinct response required to any allegation and / or suspicion of Elder Abuse. The contact details of the HSE Case worker are also included.</td>
<td>Done</td>
</tr>
</tbody>
</table>

**Outcome 5: Health and safety and risk management**

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

The risk management policy and procedures were not sufficiently comprehensive and did not detail the arrangements for the recording, investigation and learning from serious incidents involving residents. They did not cover the precautions in place to control the specified risks of unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm. The risk relating to some residents smoking unsupervised in their bedrooms had not been assessed with the appropriate controls identified. The daily check of fire exits and the alarm panel was not recorded.

**Action required:**

Ensure that the risk management policy and procedures are sufficiently comprehensive and detail the arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

**Action required:**

Ensure that the risk management policy covers the precautions in place to control the
following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

**Action required:**

Ensure that the risk management policy covers the precautions in place to control the risks associated with residents smoking unsupervised in bedrooms.

**Action required:**

Document the daily check of fire exits and the alarm panel.

**Reference:**

Health Act 2007  
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:**

<table>
<thead>
<tr>
<th>Provider’s response:</th>
</tr>
</thead>
</table>
| The complete review of our risk management policy has commenced. This review is noting specifically the matters mentioned in the actions required numbers one to two | Timescale: 31 August 2011 for policy document  
| Third action required:  
We have completed a risk assessment with regard to the residents smoking in their rooms. I attach a copy of the outcome and implementations. | Action three done  
| Fourth action required:  
We have commenced documenting our daily check of fire panels and fire exits. | Action four done.  

**Outcome 6: Medication management**

**5. The provider and person in charge are failing to comply with a regulatory requirement in the following respect:**

Not all of the medication management practice adhered to professional guidelines and regulatory requirements.

**Action required:**

Revise the medication policy to ensure it is sufficiently comprehensive and contains detailed procedures for prescribing, recording and storing of medication and to include
procedures for transcribing, self administration and PRN medication prescribing, administration and review.

**Action required:**

Ensure that the stock levels of controlled drugs are checked and recorded by two nurses at each shift handover.

**Action required:**

Ensure that prescription sheets contain a photo of individual residents and always detail how the medicine should be taken.

**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:**

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First action required:</strong> The revision of the medication policy has commenced. This will be completed on or before 31 August 2011</td>
<td>31 August 2011</td>
</tr>
<tr>
<td><strong>Second action required:</strong> Our controlled drugs register is checked and recorded by two registered nurses at each shift handover. As this matter was mentioned during the Inspection process it was addressed with immediate effect.</td>
<td>Done</td>
</tr>
<tr>
<td><strong>Third action required:</strong> The recording of the route of administration of all medications was addressed with immediate effect as again this was highlighted during the inspection process. The action required to attach a photograph of each resident to their medication sheet in being undertaken at present.</td>
<td>Done</td>
</tr>
<tr>
<td></td>
<td>All photographs to be attached on or before 31 August 2011.</td>
</tr>
</tbody>
</table>

**Outcome 7: Health and social care needs**

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

The care plans in regards to pressure ulcer care were not sufficiently comprehensive for all residents and did not include a medical review at three-monthly intervals.
**Action required:**

Ensure care planning in regards to pressure ulcer care for all residents is sufficiently comprehensive.

**Action required:**

Ensure that there are quarterly reviews of residents’ medications by GPs.

**Reference:**
- Health Act 2007
- Regulation 8: Assessment and Care Plan
- Standard 10: Assessment
- Standard 11: The Resident’s Care Plan

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s response:</td>
<td></td>
</tr>
<tr>
<td>First action required: As this matter was highlighted during the inspection process it was attended to immediately.</td>
<td>Nursing care plan ammendment done</td>
</tr>
<tr>
<td>Second action required: We have contacted the GPs, to arrange a full review of residents medications and to continue this review on a quarterly basis going forward. I envisage that this first review will be completed for all residents within three months:</td>
<td>GP review 12 October 2011</td>
</tr>
</tbody>
</table>
### Outcome 8: End of life care

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

The policy for end-of-life care was not sufficiently comprehensive and coherent.

**Action required:**

Develop more comprehensive, coherent policy for end-of-life care.

**Reference:**

Health Act 2007  
Regulation 14: End of Life Care  
Standard 16: End of Life Care

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
</table>
| Provider’s response:  
The policy for End of Life Care is under review for redevelopment and redrafting | 30 November 2011 |

### Outcome 14: Suitable staffing

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

Managing challenging behaviour and infection control was not part of the ongoing training programme, not all staff had provided three references and volunteers’ roles and responsibilities were not set out in a written agreement between the centre and the individual volunteer.

**Action required:**

Ensure the management of challenging behaviour and infection control are part of the ongoing training programme.

**Action required:**

Make sure all staff provide three written references.

**Action required:**

Make sure volunteers roles and responsibilities are set out in a written agreement.

**Reference:**

Health Act 2007  
Regulation 17: Training and Staff Development  
Regulation 18: Recruitment  
Standard 24: Training and Supervision
### Standards 22: Recruitment

<table>
<thead>
<tr>
<th><strong>Please state the actions you have taken or are planning to take with timescales:</strong></th>
<th><strong>Timescale:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s response:</td>
<td></td>
</tr>
<tr>
<td>First action required:</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Challenging Behaviour courses have been sourced and booked. The first staff members will be attending a course at St Lukes Home, Cork on 14 July 2011. This will be ongoing until all staff have attended a training session. The Infection Control Training will recommence for all staff within the Autumn training cycle.</td>
<td></td>
</tr>
<tr>
<td>Second action required:</td>
<td>Ongoing</td>
</tr>
<tr>
<td>All relevant staff have been contacted to supply a third reference as soon as is possible. (35 out of 56 staff involved) Unfortunately this matter arose due to a misunderstanding between the standards requirements and the regulations requirements.</td>
<td></td>
</tr>
<tr>
<td>Third action required:</td>
<td>31 October 2011</td>
</tr>
<tr>
<td>Role and responsibilities of volunteers documentation is under development at present.</td>
<td></td>
</tr>
</tbody>
</table>

### Outcome 15: Safe and suitable premises

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

The physical design and layout of the premises did not allow for safe and independent access to the garden, sufficient screening in shared rooms and signage and call bell accessibility in all communal spaces.

**Action required:**

Ensure that residents can access the garden independently and that the garden is safe for all residents to include those with cognitive impairment.

**Action required:**

Ensure screening in shared rooms surround the bed to ensure maximum privacy.

**Action required:**

Review the use of signage and colour schemes to assist in the orientation of residents and independence of those with cognitive impairment.
**Action required:**

Make sure that accessibility to the call-bell in the lounge adjoining the main lounge is adequate.

**Reference:**

- Health Act 2007
- Regulation 19: Premises
- Standard 25: Physical Environment

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
</table>
| Provider’s response:  
First action required:  
We are currently assessing the development of a secure garden. and that the design and construction of this area will be completed this year  
In the meantime we have created an area that can be accessed by all residents independently. The remainder of our gardens continue to be available to all our residents to enjoy, supervision shall continue where the individual resident so requires it (i.e high risk of falling, or wandering off the premises) This area is situated off our second lounge, where the door to the garden remains open / unlocked during daylight hours. At present due to the fine weather we have also left our front door open for all to come and go as they wish.  
Second action required:  
Full around bed screening has been ordered for our shared rooms.  
Third action required:  
We are currently investigating and sourcing best evidence based practice with regard to the use of signage and colour schemes.  
Fourth action required:  
The nurse call bell in the lounge adjoining the main lounge is in place. This was addressed immediately following the feedback session of the Inspection. | 31 January 2012  
Done 26 July 2011  
12 August 2011  
Ongoing  
Done |
**Outcome 16: Records and documentation to be kept at a designated centre**

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

Policies were not all sufficiently comprehensive and coherent in order to effectively guide the practice of staff and there was not always evidence that staff had read them and the Residents’ Guide did not include the most recent inspection report and complaints procedure.

**Action required:**

Review all policies and review any instances of inappropriate language and make more comprehensive specifically the policies on:

- managing behaviour that is challenging to include identifying and alleviating the underlying causes of this behaviour
- nutrition
- recruitment.

**Action required:**

Make sure all staff have read and understood the policies.

**Action required:**

Ensure the Residents’ Guide includes the most recent inspection report and complaints procedure.

**Reference:**

Health Act 2007
Regulation 27: Operating Policies and Procedures
Standard 29: Management Systems
Regulation 21: Provision of Information to Residents
Standard 1: Information

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s response:</td>
<td></td>
</tr>
</tbody>
</table>
| First action required:  
A full and comprehensive review of all our policies and procedures has commenced. We have started this process with the specific policies mentioned. | 30 November 2011 |
| Second action required:  
Read and understood forms are now attached to all revised policies and all staff have been notified of same and the requirements therein | Done |
Third action required:  
The Resident Guide attached includes the Complaints Procedure and the 2009 Inspection Report as required.  
(2009 report will be replaced when this recent Inspection Report is published.)

<table>
<thead>
<tr>
<th>Outcome 17: Notification of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>11. The person in charge is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Notice was not given to the Chief Inspector without delay of serious injuries resulting from the development of grade two plus pressure ulcers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident to include injury arising from grade two plus pressure ulcers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Act 2007</td>
</tr>
<tr>
<td>Regulation 36: Notification of Incidents</td>
</tr>
<tr>
<td>Standard 29: Management Systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s response:</td>
</tr>
<tr>
<td>This was a complete oversight on my behalf and has been rectified with immediate effect. It has been noted to eliminate any reoccurrence of similar events.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timescale:</th>
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</thead>
<tbody>
<tr>
<td>Done</td>
</tr>
</tbody>
</table>

Page 33 of 34
Any comments the provider may wish to make:

**Provider’s response:**

I would like to thank the Inspectors for their interaction within the House during their Inspection Process.

I attach relevant documentation completed following the Inspection and required in the Action Plan.

If you require any further information and / or clarification please do not hesitate to contact me.

**Provider’s name:** Patricia Kelleher Murphy RGN MBS

**Date:** 26 July 2011