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:	Creevelea House Nursing Home
Centre ID:	0129
Centre address:	Laytown
	Co Meath
Telephone number:	041-9827178
Fax number:	041-9813569
Email address:	creevlea10@gmail.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Creevelea House Limited
Person in charge:	Christina Carr
Date of inspection:	29 and 30 November and 1 December 2010
Time inspection took place:	**Day 1: Start:** 08:30 hrs to 14:30 hrs and 16:00 hrs to **Completion:** 20:30 hrs **Day 2: Start:** 10:00 hrs to 15:30 hrs and 16:45 hrs to 18:00 hrs and 19:40 to **Completion:** 20:00 hrs **Day 3: Start:** 10:40 hrs **Completion:** 17:30 hrs
Lead inspector:	Nuala Rafferty
Support inspector(s):	Florence Farrelly
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **Announced** ☐ **Unannounced**

About 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 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

About the centre

Description of services and premises

Creevelea House Nursing Home is a converted residential dwelling house providing care to persons up to and over 65 years with a range of complex needs which includes dementia care, challenging behaviour, physical and intellectual disabilities, mental health issues and end of life care.

The centre provides care for up to 44 residents. It is a single-story building consisting of 25 single (one bedroom has been converted into an office space and two other single rooms are now being used as a clinical room and store room), three twin-bedded, three three-bedded and one four-bedded bedrooms.

Two of the three-bedded rooms share an en suite shower, wash-hand basin and toilet. The four-bedded room has an en suite toilet and wash-hand basin. The remaining bedrooms do not have en suite facilities.

Other facilities include a small porch, a hallway, two sitting rooms, one dining room, one visitors' room with conservatory, one main kitchen, a laundry, a sluice room, three store rooms, one nurses' office, one office for the person in charge and an administration office, one staff changing area, an oratory, four assisted toilets, one non-assisted toilet, three assisted showers, one non-assisted shower and one assisted bath.

The centre is surrounded by a low wall at the front with two entrance/exits overlooking the sea. The centre is situated on approximately two acres which consists of a small front and large rear garden. The rear garden is enclosed by two six-foot high walls at the sides and a wooden fence at the back. It is predominantly lawned, with a small perimeter pavement around the edges of the building. There is a small enclosed garden for residents use.

There are a limited number of parking spaces at the main entrance and delivery entrance for staff and visitors use.

Location

Creevelea House is situated on the main Laytown to Bettystown Road in County Meath.

Date centre was first established:	1985
Number of residents on the date of inspection	28
Number of vacancies on the date of inspection	13

Dependency level of current residents	Max	High	Medium	Low
Number of residents	7	7	11	3

Management structure

Creevelea House Nursing Home is owned by Creevelea House Limited. The Provider is Mr. Peter Murphy. The person in charge is Christina Carr. All staff including nursing, care, household and ancillary report directly to the Person in Charge who reports to the provider.

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	2	5	3	3	1	2*

* One maintenance person and one activities coordinator

Summary of findings from this inspection

This was an announced inspection by the Health Information and Quality Authority (the Authority) in response to an application by the provider for the centre to be registered under the Health Act 2007 and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 (as amended). As part of the registration process the provider had to satisfy the Chief Inspector of his fitness to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). This registration inspection took place over three days.

Inspectors met with residents, the provider, the person in charge, staff nurses, care, household, catering and administrative staff. Records were examined including care plans, medical records, risk management documentation, accident and incident reports, the complaints log, financial records and staff records including, personnel files, training records and policies and procedures.

Inspectors had serious concerns for health and welfare of residents due to a failure by the provider to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

There were significant concerns for the care and welfare of residents due to:

- failure to ensure the general welfare and protection of residents
- lack of suitable and sufficient care
- lack of governance

During the inspection the provider was required to take immediate action to address these issues, particularly in relation to the lack of heat in the centre, the safety and security of the centre further to two recent unauthorised entries, several power outages and a gas leak.

Inspectors also identified that significant improvements were required in relation to maintaining the safety of residents, the transparency of financial processes and contingency arrangements in the event of an emergency. Further improvements were also required in the area of risk management, recruitment and vetting, the quality of assessment and care planning for residents presenting with complex needs and the design, layout and maintenance of the premises.

As a result of the Authority's concerns, additional inspections were carried out on 3, 7 14 and 23 December to monitor the safety and welfare of residents.

Subsequent to the follow up visit on 23 December 2010, a second emergency Action Plan was issued to the provider in relation to a smell of gas from defective equipment in the kitchen.

The Action Plan at the end of this report incorporates all identified areas where improvements are required to meet 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.*

Comments by residents and relatives

Following the inspection, 11 residents' questionnaires were returned to the Authority. Residents highlighted the things they liked to do such as watching TV, reading the paper and listening to the radio

The majority of comments were favourable and included for example, ''the staff are very good humoured and happy', ''if I have a problem I can ask somebody' and ''I am very happy here''.

Improvements residents would like to see were also highlighted. These included for example, ''all things to be properly fixed'', ''every person should have a toilet'' and ''access to the garden for Buxton chair''.

Five relatives' questionnaires were also returned following the inspection. Relatives comments included for example, ''it's nice to see the place getting a face lift'', ''good to see more activities taking place'' and ''perhaps if there were more staff my parents could be taken for a walk on the beach''.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

The recently appointed person in charge was a qualified nurse with appropriate experience in working with older people and a review of duty rosters confirmed that she worked full-time (40 hours per week). Arrangements were in place whereby an identified senior nurse deputised in the absence of the person in charge. During a follow up inspection on 3 December 2010, the person in charge informed inspectors that a new clinical nurse manager had been appointed and was due to take up post in approximately one month, this person would then deputise for the person in charge. Inspectors reviewed interview notes for the proposed clinical nurse manager and found that she has the relevant experience in older persons' services.

A fit-person interview was held with the provider and new person in charge following the inspection.

The provider did not demonstrate sound knowledge and awareness 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 found he had a limited understanding of his role and responsibilities and a lack of accountability for the serious issues and concerns found during the inspection.

The person in charge demonstrated some knowledge and awareness 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* and was aware of her level of accountability as person in charge. However, inspectors found she did not have sufficient experience at senior management level to identify, prioritise and manage the serious risks within the centre without considerable supports and guidance.

All required documentation was received in relation to references, Garda Síochána vetting and medical fitness for the person in charge and the provider.

Some improvements in organisational practices and management systems were found following initial inspection in March 2010. Improvements in supervision and monitoring of care delivery had been introduced and daily staff allocation sheets were in place to guide staff on their roles, responsibilities and duties throughout the day. Inspectors viewed the allocation sheets and found that staff on duty were working with identified residents and in the areas to which they were allocated.

A safe and confidential records management system was in place with residents records stored in the nurses' office that remained locked at all times when not in use.

Some improvements required

A risk management committee and procedures were in place and records of all accidents and incidents were reviewed and audited by the person in charge on a monthly basis. Medication audits were also in place and records reviewed showed that audits were carried out by both the person in charge and the pharmacist in relation to storage, disposal and refrigerated medication. Evidence of monthly clinical audit of care plans by the person in charge were also found. However, although the audits identified areas for improvements they did not identify trends, actions taken, outcome of actions and learning for staff.

Risk management continues to be a concern. During the period July to November 2010, a total of 28 accidents/incidents involving residents were recorded. Of these; 20 were recorded as 'falls'; 15 of which were unwitnessed. There were 10 falls recurrent in respect of the same two residents. The remaining 10 were recorded as; one epileptic seizure, one faint, one pressure ulcer. On two occasions residents slipped while being assisted by staff, one resulted in a fractured ankle. One resident had four incidences recorded where skin tears were noted on her lower limbs, reasons for the skin tears were not identified. The remaining incident was in relation to a resident complaining of a 'sore hand'. A fractured finger was identified further to clinical review and x-ray. A hand-written note accompanying the incident report indicated that a carer reported to a nurse that the residents' fingers were swollen and discoloured a number of days earlier but no action had been taken at that time.

Risk management processes which effectively identify, manage, control and reduce the risks to residents were not consistently found. For example, two residents were identified as being at risk of frequent falls. One of the residents had a condition which resulted in frequent falls and was identified on previous inspections as being at high risk of injury. Further to previous inspection findings and improvements required by the Authority measures now in place to control the risk of falls for this resident included; a care plan (last reviewed on 07 September 2010 by person in charge), a risk assessment, a falls diary, physiotherapy, a walking frame and cushion which alarmed when the resident stood up. The care plan in place for maintaining a safe environment indicated that the resident was to be encouraged to sit in the chair with the alarm cushion**.** A manual handling chart completed on 02 September 2010 identified the need for supervision with all activities of daily living and mobility. However, inspectors observed the resident did use this chair at all times and he was also observed to mobilise frequently without supervision and on occasion without his walking frame. Inspectors noted that a balance between choice and risk had been taken into account by staff on this resident's behalf and although he continues to fall, the frequency of falls have reduced.

However, during one fall on 20 September 2010, the resident narrowly missed a serious injury when he fell against a glass door which shattered. A further four falls occurred in October 2010, all of which were unwitnessed.

Another resident, whom inspectors identified with a recent history of frequent falls, also had a care plan in place to manage the falls risk. The care plan commenced on 19 September 2010 and included an evaluation/progress sheet. A review date of 19 October 2010 was indicated but there was no evidence that a review took place. Evaluation sheets from 23 October 2010 to 24 November 2010 were viewed. Two of the four most recent incidents in October 2010 were recorded as, 'slipped whilst being assisted to toilet' and 'fainted in shower'. Further to review, the general practitioner (GP) advised that the residents' blood pressure be monitored twice daily. However, there was no evidence in the residents file that this instruction was being carried out and the resident had 'fallen' on two more occasions in November 2010. On the last occasion the resident was found lying on the ground outside her room and following review by GP, staff were again advised to observe and monitor her condition.

None of these incidences were identified by the person in charge in the monthly audits and further actions to review the care plans or review effectiveness of interventions to control the risks for both residents were not found. Similarly actions, outcomes or learning for staff had not been identified by the person in charge further to the auditing process in relation to the incidences of recurrent skin tears, delayed treatment of the fractured finger or manual handling practices which resulted in a resident with a fractured ankle.

A contract of care was available and had been recently agreed with residents their families or advocate. However, the contract did not reference the current Health Act 2007 or the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009(as amended) nor did it outline the details of the service to be provided for residents or the fees to be charged.

A certificate of compliance with planning permission was provided to the Authority. However, the certificate did not confirm that the centre complied with the building codes or the Planning and Development Act 2000-2006.

An insurance certificate was available. However, the certificate did not include all of the requirements of Regulation 26 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) in that it did not reference the limit of residents' liability.

A directory of residents was available and found to be maintained. However, it did not meet all the requirements of Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) in that residents' gender or the name and address of any authority, organisation or other body who arranged the residents' admission was not included.

A record of all complaints was maintained in the centre. All verbal and written complaints were recorded. On review of the complaints record, inspectors found that all recent complaints were investigated and responded to in an appropriate and timely manner and the record indicated that all complaints were resolved. However, the record did not include details of actions taken, follow up, outcome and the satisfaction or otherwise of the

complainant in all instances. Furthermore, the arrangements for dealing with complaints did not contain all of the information as required under Regulation 39 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009(as amended). The complaints procedure did not identify a nominated person for dealing with complaints in the centre or a second nominated person to ensure all complaints were appropriately responded too. It did not provide details of advocacy services available to residents, nor did it contain the contact details of the Health Service Executive (HSE) or office of the ombudsman. Furthermore it inaccurately directed complaints to be made to the Authority which is not part of the Authority's remit.

A residents' guide was available which did not meet all legislative requirements, specifically in relation to information provided under accommodation, personal possessions and regular review of care plans. It did not contain a summary of the statement of purpose. The guide also included a summary of the complaints procedures which required improvement as outlined above.

Significant improvements required

Safe and good governance practices were not found to be in place.

Inspectors had serious concerns for the overall safety and general welfare of residents. Inspectors found there was a poor response to the issues raised during the inspection particularly in relation to the lack of heat in the centre. Inspectors also noted that neither staff nor senior management advocated on behalf of their residents when they themselves were complaining of feeling cold during very bad weather conditions. Other concerns were raised in relation to the safety and security of the centre further to two recent unauthorised entries, several power outages and a gas leak.

Inadequate Heating

Inspectors found that the heating in the centre was not sufficient to keep residents warm. Entries on a maintenance request log dated 27 and 28 November 2010 showed that one resident had complained of being unable to close her bedroom window and the heating system on the corridor at room 9 was, ''not working properly(off) and cold''. During conversation with this resident she informed inspectors that an agency nurse had 'taped up' the window on the night before the inspection commenced.

Inspectors monitored temperatures in communal and bedroom areas and found that temperatures were below the minimum of 18°C in bedrooms and 21°C in communal areas required by *the National Quality Standards for Residential Care Settings for Older People in Ireland.* Temperatures ranged from 16.5°C in corridors to 19.2°C in the sitting room and from 16.6°C to 18.9°C in bedrooms.

While three boilers were in place, none could identify or gauge the temperature at which heating was set. All were set on timers to come on for periods of between one and three hours and then to go off for intervals of between 30 minutes and one-and-a-half hours. This resulted in the temperature of the centre not being maintained at a sufficiently consistent or adequate level at any time day or night.

Inspectors outlined their concerns to nursing staff on the evening of the first day of inspection and requested that the heating be increased and residents be given extra blankets.

On the morning of the second day of inspection, inspectors checked temperatures in the corridors, communal areas and bedrooms and found that all areas apart from the corridor which accommodated rooms 31 to 34 remained below optimal temperatures and the minimal levels referenced in the Authority's standards. Inspectors were concerned regarding residents welfare and requested that nursing staff record all residents' body temperatures. Recordings indicated that seven residents' temperatures were below 36°C putting those residents at risk of hypothermia.

At 13.15hrs on 3 December 2010, inspectors met with the provider and the person in charge and outlined their serious concerns regarding residents care and welfare. While both the provider and person in charge acknowledged they were aware of the concerns, neither intervened to ensure residents were warm or provide adequate heating in the centre.

The provider stated he had spoken to the plumber the previous day regarding the heating and told inspectors that the plumber had turned the heating down as the provider was concerned that residents could burn themselves on the radiators. Inspectors advised the provider and person in charge to take immediate steps to remedy the situation for residents. The person in charge initiated the purchase of additional oil fired electric heaters and wool blankets and contacted the GP to review the seven residents identified by inspectors as being at risk of hypothermia. Inspectors told the provider the registration inspection was suspended until the risk to residents was addressed.

At 14:20 hrs, the person in charge advised inspectors that the GP had re-checked those residents identified by inspectors as being at risk of hypothermia. He advised the person in charge to give additional clothing to the residents and improve the heating. He expressed his concern for one resident in particular who had chronic circulatory impairment.

At 14:35 hrs, an immediate action plan was formally issued to the provider to address the heating in the centre.

At 16:45 hrs, five additional storage heaters had been placed on the coldest corridors. However, residents' bedrooms and communal areas remained cold. Inspectors observed that neither the person in charge nor the provider had considered what if any, other options could be used to minimise risk and discomfort to residents. As such, given their inability to mange the risks identified, specific direction was given to both the provider and the person in charge by inspectors in order for the immediate Action Plan to be appropriately addressed.

Inspectors gave the following directions to the person in charge and provider:

- heating to be turned up and taken off timers to ensure a constant heat
- residents in the coldest bedrooms to be moved to warmer bedrooms
- warm drinks to be offered to residents at hourly intervals, including through the night
- residents vital signs to be monitored every two hours

- families to be contacted and informed of current situation and actions being taken
- doors in all communal areas to remain closed to retain heat in the rooms
- provide residents with extra blankets
- contact the ambulance service to identify where to source specialist blankets should they be required.

On subsequent follow-up visits on 03, 07 14 and 23 December 2010, inspectors found the heating in the centre to be adequate. Residents stated they were warm and checks of both room and peripheral body temperatures were noted to be within an acceptable range.

Compromised Security
Residents' safety and security was not found to be assured. On review of documentation, inspectors found a number of serious incidences, none of which had been reported to the Authority and all of which posed a high risk of injury to both residents and staff.

Two unauthorised entries had taken place, one in September 2010 and one in November 2010. On 07 November 2010, a resident alerted staff at 03:00 hrs of someone being locked in the toilet next to her room, when staff opened the door the toilet was empty but the window had been opened. On the following day, maintenance staff reported an outside shed had been forced open and a hacksaw was found on the grounds.

A more recent incident occurred on 11 November 2010 at 23:00 hrs when a nurse observed a man running out of the back door of the centre. This door is unlocked throughout the day. An Garda Síochána were notified on both occasions.

Immediate risk management measures identified by the provider and person in charge to prevent further occurrences were:

- fit a stronger lock to the toilet window (same fitted on 07 September 2010)
- replace padlock on maintenance shed (same fitted on 07 September 2010)
- hourly checks on residents at night to be put in place
- back gate to be installed (same in place from 27 September 2010)
- change the code at the back door and the door was to be closed at all times and locked early evening
- a review of overall safety in the home.

Four of the six measures listed above were found to have been actioned. Of the last two measures, the need to change the code of the back door and keeping this door closed at all times and locked in the early evening was not being followed consistently, and a full review of the overall safety in the home was not found.

The person in charge informed inspectors that the back door was locked every evening at 18:00 hrs. However, the maintenance person said this did not happen until 20:00 hrs. This was confirmed by other staff who said the night staff usually used the back door entrance when coming on duty. Although this door was to remain closed at all times, inspectors found the door was open at various times throughout the inspection visits. No other security measures to optimise residents' safety were considered by the provider such as; closed circuit television (CCTV) or external sensory lighting.

On follow-up inspection on 7 December 2010, the inspector arrived to the centre at 10:45hrs and entered through the back door which was unlocked. On entering the building the inspector walked past the kitchen, dining room, sitting room, nurses and person in charge offices and several residents' bedrooms before meeting a nurse in the clinical room and informing her of the visit. The inspector subsequently advised the person in charge to have the back door locked at all times to ensure as far as possible the safety of residents in the absence of other security measures. The person in charge acted on this and prior to the end of the visit had instructed the maintenance person to lock the back door and place a sign on the door advising staff to lock at all times. The person in charge also ordered additional keys for the door which staff could quickly access to allow delivery of supplies etc. On subsequent inspection on 14 December 2010 the back door was found to be locked and a notice was placed outside directing all persons to call to the main entrance to gain access to the centre.

Gas Leak

Inspectors reviewed documentation which outlined a serious risk to residents, visitors and staff. Documents recorded that on 08 August 2010 the part-time chef reported that the oven was not cooking food thoroughly and meats had to be boiled to ensure they were cooked properly. The chef also told the staff nurse in charge that he was instructed to turn the gas off at the main switch for safety reasons. On 19 September 2010 at 09:00 hrs, kitchen staff reported a strong smell of gas and the supply was closed off by the gas technician who identified a leak in part of the cooker. Since then, only the left-hand side of the cooker has been in use. Evidence that there were measures taken to minimise the risk of a potential gas leak or explosion since the problem was first identified in August 2010 were not found. Inspectors were told that a replacement cooker had been ordered days before the registration inspection and had not arrived. Inspectors were subsequently told that delivery could take up to a month. On follow-up inspection on 23 December 2010 the cooker had not yet been replaced and was still in use. Inspectors noted there was an obvious smell of gas emanating from the cooker and was informed by staff that this was considerably stronger when the oven was in use.

The person in charge told the inspector that one member of the kitchen team had been ill with vomiting and headaches and had to leave work early on one shift the previous week. A gas technician was again called to check the cooker but could not confirm whether there was in fact a leak.

Continued use of the defective cooker was delaying meals for residents. At 13:00 hrs lunch had not yet been served although due to start at 12:30 hrs. Inspectors were told that the ham was not ready despite having started cooking at 09:00 hrs. All other elements of the meal were ready and the chef had to slice the ham to conclude the cooking process. Inspectors found similar difficulties with ensuring cuts of meat were thoroughly cooked in a timely manner were recorded by current and previous kitchen staff as far back as August 2010 and brought to the provider's attention. Due to the ongoing concerns and potential risk to residents and staff a further emergency Action Plan was issued to the provider to address this risk.

Inadequate emergency plan

An emergency plan was in place which identified the specific resources available in the event of evacuation and the contact details of staff. On enquiry staff demonstrated knowledge of the emergency plan and could identify the relevant people to contact and

the designated building to where residents would be evacuated. However, the plan did not cover all forms of emergency and was not linked to all other policies and procedures in place in the centre. This omission had the potential to cause inconsistency of approach and confusion for staff in potentially life threatening situations.

Electrical power supply failures had occurred on a number of occasions during recent months for example, in June, August and November 2010. An emergency procedure was in place for responding to situations such as loss of power or heat in the centre. The implementation date was August 2010 and approved by both the provider and person in charge. The procedure stated that, ‘‘the facility has an emergency generator that should be automatically activated in the event of a power outage’’. The procedure also covered what should happen in the event of a heat outage and stated provision must be made for portable heaters if ‘‘weather conditions dictates’’. Inspectors spoke to some staff members regarding the availability of a generator and were informed by one nurse that the centre had a generator however, the maintenance person and person in charge confirmed that an emergency generator was not available and portable heaters were only purchased during the period of the inspection.

During the 07 December 2010 follow-up inspection, the inspector was informed of two further power outages that happened on 04 and 06 December 2010 respectively, one when fuses blew on the older fuse boards and the other due to overload of Electricity Supply Board (ESB) supplies in the Laytown area. The person in charge subsequently hired an emergency generator. However, this generator did not have an automatic change switch and had to be manually connected to the centre’s power supply, a process which inspectors were told took approximately fifteen minutes. The maintenance man was the only person with the required knowledge to undertake this task and he lived approximately 25 minutes away. Therefore in the event of another power outage it would take approximately 40 minutes to connect to the generator. Guidance to staff had not been provided by the person in charge on what steps they were to follow to ensure a timely connection to the generator in the event of further power failures. The inspector advised the person in charge that a procedure for staff to follow should be implemented immediately. However on subsequent inspection on 14 December 2010 in conversation with staff on duty the inspector found this guidance had still not been provided.

The Authority carried out a further monitoring inspection on 14 December 2010 to ensure the safety and welfare of residents due to ongoing concerns. A burst water pipe had caused a leak in the laundry on the previous day. As a result, radiators had been turned off in the residents bedrooms situated on either side of the laundry. However only one resident had been moved from his bedroom to another bedroom in the centre. The inspector found that although the radiators had been turned off in two other bedrooms and these rooms were cold residents had not been moved to other vacant, warmer bedrooms.

Other bedrooms along the corridor where the laundry was situated and the corridor itself were noticeably colder than other areas in the centre. At 09:40 hrs the inspector noted that care staff were preparing to provide personal assistance to residents on this corridor to wash and dress. The inspector instructed care staff to bring the additional portable heaters into these bedrooms to warm the rooms prior to assisting residents and also instructed the person in charge to transfer these residents to the vacant warmer rooms until the leak was resolved and the bedrooms were suitable for occupancy again.

Poor knowledge of fire procedures

Fire policies and procedures reviewed by inspectors were found to meet legislative requirements. Fire records indicated that fire safety training took place regularly and fire escape routes and fire fighting equipment were checked in line with best practice.
On the second day of inspection, the fire alarm activated when one of the “break glass” units was inadvertently broken, all staff responded to the fire alarm and congregated in the hallway adjacent to the front door. However, while the person in charge and three other staff members checked the fire panel to identify where the ‘’fire’’ was located and checked the area to ensure there was no fire, other staff did not demonstrate sufficient knowledge of the emergency procedure to be followed in the event of a fire. One inspector spoke to the remaining staff members (a total of ten staff and the provider) and asked them which residents they would commence evacuating and how the procedure would be carried out. All, including the provider, were unable to describe the procedure to be followed.

On 14 December 2010, in conversation with a regular relief nurse, inspectors found that the nurse had not been informed and was not aware of the fire procedures in the centre or the means by which residents could be evacuated in the event of an emergency.

Subsequent to the fire alarm activation staff told inspectors that residents who were immobile could be evacuated using emergency transfer sliding sheets attached to bed mattresses. However they did not know how many of these types of sheets were available or which residents had been provided with them. Following the fire alarm activation, inspectors had to direct staff to reassure residents of their safety.

During the follow-up inspection on 7 December 2010, inspectors viewed a fire list of all residents in the centre which identified those who were mobile and those who were wheelchair users. Inspectors asked the person in charge and a staff nurse which residents were provided with emergency transfer sheets. The person in charge did not know and the staff nurse gave the inspectors names of those residents whom she thought were provided with the emergency transfer sheets. The nurse said there were about seven emergency transfer sheets available however, the inspector checked the three identified residents and found that only one of the residents had an emergency transfer sheet attached to the bed mattress. On further inspection on 14 December 2010, neither staff nor the person in charge could inform the inspectors exactly how many emergency transfer sheets were available or which residents had been provided with them. Furthermore, the fire list had not been updated since 07 December 2010 and was not now current. As one resident had since been transferred to hospital this posed a risk to any member of staff or emergency services in an emergency situation looking for a resident who was not actually residing in the centre.

Lack of financial transparency

All financial records in relation to reconciliation statements, receipts or invoices for monies transferred within and between accounts or monies lodged or withdrawn to/from accounts held in respect of some residents as required by the Health Act 2007 and (Care and Welfare of Residents in Designated Centres for Older People)Regulations 2009 (as amended) were not available.

Appropriate and transparent processes to safeguard residents’ finances were not in place.

A review of the financial controls took place on the first morning of inspection. The pensions of four residents were paid directly to Creevelea House business bank account. (formerly five pensions were paid in but one resident had since passed away). Monies paid in also included; HSE payments and private fee payments from residents' relatives. Staff wages, equipment, food and all other operational costs were paid out from this account.

Written authorisation for the transfer of the residents' pension to the centre was not available and neither the administration staff nor the provider could inform the inspector if authorisation had been sought or granted or how long the current arrangements were in place. The full amount of each of these residents pensions were being paid towards their fee. No "comfort money" was retained for private use by residents. Inspectors found evidence that in two cases, residents were originally only paying a portion of their pension in 2007, now the full pension was being put towards their fee.

The administration staff consisted of one full-time and one part-time person; both were in the process of setting up a commercial accounts package which would lead to a more transparent accounting process going forward. However, neither were familiar with the full accounts system currently in place. The team had also established an improved petty cash system which commenced in August 2010 to manage small cash transactions for some residents. Lodgements and withdrawals were documented and two staff signatures were recorded for each one. Receipts for purchases made on behalf of those residents were available.

Individual zip lock bags, labelled with the residents name were used to store the money, which were locked in a safe. A policy for "managing residents' monies" was available and limited the amount of money to be held for any individual to between €5 and €20 was in place. However, the amounts of petty cash were noted to be over the limits in some instances.

During discussions with the administrative staff and the provider on the first morning of the registration inspection, the inspector asked on several occasions if there were any other bank accounts held in respect of residents and was informed there were no other accounts. However, on the afternoon of the second day the inspector was informed of a second account called a "residents' comfort monies account". From the limited records available in the centre, this account appeared to be held in respect of 'comfort monies' forwarded from another agency on a monthly basis for two residents, (one now deceased). Bank reconciliation statements were not available to review transactions and receipts for monies taken out of the account. The most recent statement available was dated July 2010. A cheque book dating back several years revealed that monies had been taken out of this comfort fund and paid into the nursing home's business account.

Evidence of two such transactions were found, one in July 2009 and another in November 2006. Receipts, invoices or signatures for the authorisation by residents, their relatives or advocates for transfer of funds within or between the accounts were not available.

Inspectors noted that one of the residents whose pension was paid directly into the centre's business account had passed away in September 2010 in the local hospital. The hospital could not contact the resident's family and arranged the person's funeral service and burial. The bill was subsequently sent to the nursing home and the provider had agreed to pay it.

Inspectors had concerns regarding the financial viability of the centre following discussions with the provider when he informed inspectors that the centre was not financially viable for the past number of years and the family have been paying into the business to keep it going. Inspectors also reviewed minutes of a recent team meeting held on November 01 2010 when the provider informed staff that the financial situation was “desperate”.

A statement of purpose was available which did not meet any of the legislative requirements. Categories of care, range of need, type of nursing care to be provided and admission criteria were not included. All other information as required in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) was not included such as; qualifications and experience of the provider, the names and position of all of the management team, the maximum number of residents who will be accommodated and the size of rooms in the centre.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

Residents were enabled to contribute to life in the centre, views were sought and there was evidence that residents were influencing change was found. Residents' and relatives forums was established and were due to meet quarterly, evidence that some meetings were already held was found.

Further to a meeting held in July 2010 with both residents and their relatives, some improvements made included; a trip to the beach, a portable phone for residents use and a hairdresser to visit every month.

Inspectors viewed minutes of a meeting held on 16 September2010. Nine residents and two staff members were present. Issues discussed included; upcoming house maintenance and individual preferences of residents for activities. Some suggestions from residents were that sauces remain on the dining table at meal times so that residents could help themselves; this suggestion was found to have been actioned. Another suggestion from two residents was to have afternoon trips to the pub on occasion.

Inspectors found considerable improvements in the provision of meaningful activities for residents. A full-time activities coordinator had recently taken up position and had commenced a complete review of the activities programme. A new activities programme was now in place from Monday to Friday and included a knitting circle with residents knitting individual portions of a 'community blanket', Sonas therapy, reminiscence therapy, "fit-for-life", chair aerobics and a movie night. Inspectors observed some residents in the sitting room chatting to each other while knitting and others singing along to favourite songs playing in the background. Recent outings had also taken place with six residents going out to bingo and eight had attended mass in the local church.

An activities log had been commenced by the new coordinator which detailed participation of individual residents in each activity and/or reason for non-attendance.

Volunteers visited the centre each day to lead those residents who wished to attend prayers in the oratory. Mass took place every two months.

Residents' privacy and dignity was respected by staff who ensured doors were closed and screening was in place when assisting with personal care.

Inspectors also observed residents right to choice being respected by care staff who asked residents if they wished to get up for the day before beginning to assist them with personal care.

Care assistants were allocated to a group of residents each day and were responsible for reporting any issues to the nursing staff. This was a recent development in response to issues identified on previous inspections. The process in relation to allocating care staff on a daily basis to different groups of residents was still under review to determine its effectiveness.

Staff nurses were allocated responsibility for a number of residents and were directly responsible for carrying out three monthly re-assessments and reviewing of care plans.

Risk assessments such as falls risk, pressure sores, wound care, dependency, nutritional assessment, moving and handling and incontinence had been completed. Identified risks were reflected in residents care plans which were reviewed on a regular basis by nursing staff. This was confirmed by looking at residents charts and speaking with staff members. Efforts to personalise assessments and care plans were noted and included an individual activities assessment by the activities coordinator. Involvement of residents and their relatives, next of kin or advocates in care planning had commenced and minutes of care review meetings held were documented in residents' files.

Some improvements required

Medical and nursing documentation in respect of six residents was reviewed by inspectors. Overall improvements in the care planning and evaluation of residents care was found and evidence of referral and review by allied health professionals, where required, was noted. However, inspectors found that care plans and evaluation progress notes were not linked and recommendations made by allied health professionals and general practitioner were not included in all care plans.

Evidence that care plans were in place for every identified need or were updated to reflect residents changing needs was not consistently found. For example, one resident had a care plan in place for shortness of breath and smoking-related issues. The care plan had commenced on 29 September 2010 and was updated on 12 October 2010 and again on 10 November 2010. However, the progress evaluation sheet identified that the resident had commenced on a course of anti-smoking patches on 31 October 2010 and this therapy was not included in the care plan. This resident was also on medication for another identified need but a care plan was not in place to monitor the effectiveness of the medication therapy.

Another resident had a care plan in place for a chest infection which was commenced on 09 September 2010. The care plan indicated an antibiotic was ordered and commenced. The care plan had been re-evaluated six times between 09 September and 20 November 2010 but no entry had been made to indicate that the antibiotic therapy had been discontinued.

Policies and procedures were in place to protect residents from harm. Some staff spoken to were aware of the policies and could discuss the principles of the training received. Some staff could recognise the signs, explain the different types and knew what their responsibilities were in relation to reporting suspected abuse. However, not all staff had been provided with training on elder abuse and those who had not attended training were not aware of the signs of abuse or what constituted abuse.

Significant improvements required

Inspectors found that residents recently admitted had been assessed by the person in charge prior to admission. However, a comprehensive assessment which ensured each resident's individual needs could be met within the centre was not found. One resident with a psychiatric history was admitted within the previous two weeks without an assessment of challenging behaviour. This resident also had a diagnosis of Alzheimer's disease.

On review of this resident's nursing documentation, inspectors found that the pre-admission assessment completed by the person in charge did not detail any aspect of challenging behaviour. On admission, section nine of the residents physical and social assessment chart which documents verbal/physical aggression was not completed. Care plans were in place for confusion and wandering but neither referenced any signs or triggers for challenging behaviour. A specific care plan for management of challenging behaviour was not in place. Five entries in the daily nursing notes recorded episodes of wandering behaviour into other residents' bedrooms between 18 November 2010 and 26 November 2010 and the entry on 26 November 2010 also noted that there were outbursts of verbal aggression with wandering continuing during the night. A copy of a letter from the resident's psychiatric consultant to her former GP was viewed. The letter identified the difficulties family had experienced in caring for the resident at home due to the behaviour and the eventual acceptance of long term care and transfer into long term care. The consultant stated they would review in one month's time but that if there were any difficulties with agitation to make contact with the psychiatric team. Evidence of a request to prioritise review of the resident was not found.

During the inspection it was noted that the resident exhibited aspects of challenging behaviour which included wandering in and out of rooms including other residents' bedrooms on a repetitive basis. The resident also exhibited signs of aggression and was heard shouting at residents and staff. In conversation with other residents, inspectors learned that this behaviour was ongoing and many residents were frightened and annoyed by it.

Inspectors found that the residents' needs in relation to management of challenging behaviour were not being met. The rights of other residents to be protected from outbursts of aggression and to having their privacy respected were not being upheld. In conversation with nursing staff, inspectors found they did not recognise either the outbursts or wandering as signs of challenging behaviour and did not recognise the need to manage them.

Inspectors found that residents did not know the name of the carer allocated to them and the person in charge confirmed that a key worker system was not yet in place.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an on-going basis, within a care planning process that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

Improvements to the overall assessment and management of residents' healthcare needs were found for residents recently admitted to the centre who had transfer letters from the transferring organisation or their GP.

Residents' healthcare needs were met. Evidence of regular review by their GPs and referral to allied health professionals on an as-required basis was found. On reviewing a sample number of residents' medical and nursing documentation, inspectors found that residents who required interventions had been reviewed by the psychiatry of old age team, an occupational therapist, an ophthalmologist and a tissue viability nurse.

Regular monitoring of each resident's general health status was found. Blood pressure and blood sugars were recorded as required, and weight was monitored every month.

Improvements in medication administration were observed with safe practice in medication administration and recording of the drugs administered noted. Medication management was supported by specific policies and procedures reflected in practice. Controlled drugs were checked at the end of each shift and records confirmed this.

Residents looked well nourished and hydrated and special dietary needs were notified to the chef by nursing staff on admission and as changes occurred.

Inspectors visited the main kitchen and noted that access to the kitchen was restricted to catering staff. Adequate stocks of food with fresh fruit and vegetables were noted. A limited amount of meat was in the meat fridge for the following day, the chef told inspectors that a delivery was due but was delayed due to the bad weather.

The dining room had recently been repainted and also had new floor covering. The room was clean and the tables were attractively set with white table cloths. The menu was displayed on the notice board. Choices to dine in the main dining room or residents own rooms were accommodated. The lunch menu consisted of vegetable soup, choice of ham or pork with potatoes, vegetables and gravy and either semolina with fruit, banana mousse with fresh cream or ice cream and jelly for dessert. Bowls of fresh fruit were also provided on the tables. Milk, orange or water was available on the tables for residents to help themselves.

Residents were asked prior to eating what they wanted and were encouraged to maintain their independence where possible and to those who needed it assistance was offered in a respectful manner.

Significant improvements required

Although some improvements to monitoring of care practices and care planning and assessment were noted, inspectors found that further improvements were required.

Over the course of the three-day inspection process and on subsequent follow up inspections on 03 and 07 December, inspectors observed poor moving and handling practices by staff. In conversation with staff and with the person in charge, inspectors were told that all staff had received mandatory moving and handling training.

However, some staff did not demonstrate an understanding of safe moving and handling principles. In one instance inspectors observed two staff assisting a resident to firstly transfer from a wheelchair to an armchair by pulling on her arms, turning the resident around and letting her 'fall' into the armchair then 'assisting' the resident to sit higher up into the armchair by pulling on the waistband of her trousers and simultaneously placing her (the staff member's) arm under the resident's arm and dragging the resident back into the chair. In conversation later with one of the staff involved in the transfer, the inspector was told that this 'enabled' the resident to help herself instead of staff having to use the hoist. The staff member had been recently employed by the centre and stated they had received moving and handling training in their previous post. This was confirmed by checking their personnel record and speaking to the person in charge. Two other instances of staff using inappropriate and unsafe moving and handling techniques were noted and all were brought to the attention of the person in charge prior to the end of the inspection.

Wound management practices were in place but entries in care plans, reviews, referrals and follow up were not consistent or regularly updated.

One resident with ulcers on both feet had wound plans which included, grading measurement and dressing charts. Regular swabs were sent to monitor and control the infection and the resident was being reviewed by the tissue viability nurse. However, entries in the wound assessment charts and in the wound record/review chart were inconsistent. For example; entries on the wound record/review chart dated 22 November 2010 stated dressings were renewed on both feet and swabs were sent. However, the wound assessment chart for the right foot indicated that the dressing was not renewed between the 20 and 24 November 2010 and all entries on the assessment chart for the right foot stated the last swab had been sent on 11 October 2010. On 27 November 2010, an entry in the wound record/review chart stated, ''(name of resident) expressed pain at dressing when right foot dressing is done''. However, the entry on wound assessment chart for the right foot for the same date indicates no pain.

A wound care plan was in place. However, the plan did not contain all of the interventions required to address the identified need and was not updated to reflect changes on an ongoing basis. The care plan did not include the use of antibiotics commenced on 22 October 2010 or their discontinuation seven days later. The plan did not reference use of analgesia to manage pain prior to changing the dressings, frequency of review by the GP

or the tissue viability nurse or that the resident was referred to the vascular surgeon for review of wound management.

A care plan evaluation sheet commenced on 12 October 2010 was attached to the care plan, contained four entries and had not been updated since 12 November 2010.

End of life care requires review. An entry by the GP in the medical notes of one resident who had recently returned from hospital following acute illness stated that the resident was, ‘not for resuscitation’. However, on review of all other medical and nursing documentation for this resident, inspectors found no evidence of discussion with the resident, family, nominated next of kin or advocate in relation to this position.
On review of another residents’ file, inspectors viewed a handwritten note signed by the resident stating her wish not to be resuscitated, ‘should the need arise’. This note was dated 2008 yet evidence that a review of this request by the resident, family, GP and nursing staff was not found. Inspectors spoke to the person in charge and nursing staff and asked if many of the residents were currently ‘not for resuscitation’. The person in charge stated there was none, and two nurses mentioned different residents’ names.

Inspectors found that a policy and process was not in place to ensure consultation with residents and their families or advocates and/or regular review of previously made decisions regarding resuscitation.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

The day room and dining rooms provided adequate space for the number of current residents. The day room and one of the dining rooms overlooked the garden and had a lovely sea view.

The seating arrangements in the day room allowed for groups of residents to sit and chat together with ease.

A call-bell system with an accessible alarm facility was provided in each resident's bedroom and in communal areas.

Clinical and domestic waste was appropriately separated and disposal contracts for same were viewed.

Adequate storage areas were available throughout the centre with additional storage areas provided further to initial inspection.

Improvements to ongoing maintenance of the building were noted with re-painting of rooms, skirting boards and replacement of floor coverings in corridors and the dining room observed.

An improved level of cleanliness and implementation of infection control practices were noted. There was sufficient availability of alcohol rub and / or hand-washing facilities. Cleaning staff spoken to were knowledgeable regarding infection control procedures for rooms where residents had been identified as having an infection.

Adequate numbers of assisted showers, baths and toilet facilities were available for the number of current residents.

A portable telephone was available for use by residents.

Assistive devices were provided and included a hoist, walking aids, weighing scales, residents' call system, pressure relieving mattresses and profile beds. Servicing contracts for all equipment were in place and were reviewed by inspectors.

Significant improvements required

The design and layout of the centre and grounds were not appropriate to meet the assessed needs of residents.

Heating in the centre was inadequate and corridors communal areas and the majority of residents' bedrooms were found to be cold and draughty.

An electrical system which meets current safety standards was not in place. As already mentioned under governance, heating in the centre was found to be inadequate. In order to address the issue, the person in charge ordered the purchase of additional oil fired portable heaters. However, the maintenance person (a qualified electrician) cautioned the provider that the electrical system in the centre would not be capable of withstanding more than 10 extra heaters and was in danger of overload as it was an old system. Inspectors reviewed the system with the maintenance person and found there were four fuse boards only two of which meet current electrical standards. Inspectors were told that this had been raised with the provider at a recent health and safety meeting and a full review of the entire electrical system was required by a qualified consultant, minutes of this meeting were viewed by inspectors and confirmed the information provided by the maintenance person.

Outdoor space was not safe and secure for use by residents in that there was no secure perimeter at the front of the building. Two six-foot walls enclosed the grounds on both sides with the rear of the building enclosed by a picket wooden fence.

At the rear of the building pathways were not wide enough to accommodate wheelchair users and the internal courtyard was inaccessible to wheelchair users due to lack of ramping at door ways. The paving was uneven and unsafe for residents with mobility difficulties.

External lighting was limited. There were a total of four lights, these were positioned over the main entrance, the delivery entrance, the fire exit at the rear of the centre and at the side of the boiler house and there were two 'spotlights' situated in the grassed area at the front of the building.

In addition to the above, some improvements were also required to meet the *National Quality Standards for Residential Care Settings for Older People in Ireland*, as follows:

- there was inadequate screening in room one
- the laundry did not contain a stainless steel sink with double drainer, or work top space for sorting, there was inadequate space to separate clean and soiled laundry
- the dining rooms available were not sufficient to cater for 40 - 44 residents
- the sluice room was inappropriately located at the back of the building beside the main kitchen which results in commodes and urinals being transported along corridors and past the dining and sitting rooms and presents a risk of cross infection
- there was insufficient heating, corridors at rooms 1-9 and 20-30 were cold and draughty
- corridors were only wide enough to accommodate one person at a time
- there was inadequate ventilation to clear smoke from the smoking area

- separate cleaning areas for catering and non catering staff were provided but were not appropriate in that neither had ventilation, a sluice sink, a wash hand basin
- the identified cleaning room for catering staff did not have safe lockable storage for cleaning chemicals
- rooms 9,10,11,12,13,14,15,21,26,27,29,30,31,32,33,and 34 had limited access for carers and equipment where all beds did not have space on both sides
- single bedrooms did not meet the *National Quality Standards for Residential Care Settings for Older People in Ireland* in regards to usable floor space of 9.3m²(rooms 20-30)
- communal rooms did not contain two wash hand basins or provide minimum usable floor space of 7.4m² per resident
- a wheelchair accessible visitors toilet was not available
- an appropriate staff changing facility with toilet, shower and locker facilities was not available
- separate staff changing areas for catering and care staff were not available
- use of pictorial signage or colour cueing for residents with visual or cognitive impairment was not evident
- signs identifying the designated function of all rooms were not in place
- there was a lack of spaced seating or areas of interest or diversion for residents.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

A notice board situated on the wall at the front entrance provided information on activities on a daily basis.

Copies of the resident's guide were available to residents in their rooms.

There was evidence of improved communication links between nursing and catering staff. Special diets and residents' preferences were documented in the kitchen.

Inspectors observed instances of good staff engagement with residents. Many residents had cognitive impairment and some carers were observed providing personal assistance and explaining to residents how they were going to help them in a gentle and encouraging manner. Staff were also aware of residents preferred forms of address and used this when speaking to them.

Improvements in communication between staff and residents were observed, with staff chatting to residents while assisting them with their lunch or during the delivery of personal care delivery. In the sitting room, staff responded promptly to requests for help from residents and on several occasions when asked to do so the background music was changed to suit different residents' tastes. The TV channel was also changed to reflect residents' tastes in programmes.

Improvements to communication processes for staff were noted. A staff allocation sheet which outlined the roles and responsibilities of staff to a particular group of residents on a daily basis was introduced by the person in charge. In conversation with staff, they said they found it very helpful and gave them a focus to ensure all aspects of care were delivered to all residents.

Daily 'flash' meetings between the nursing staff and the person in charge were also introduced. These took place usually late morning or alternatively early afternoon and were used to update the nursing team on residents' current health status, any changes noted and referrals or reviews were discussed.

Minutes of staff meetings held in August, September and November were viewed. Issues discussed included; health and safety, laundry, confidentiality, rosters and roles and responsibilities. Meetings were attended by the provider and the person in charge.

Some improvements required

A comprehensive list of centre-specific policies and procedures was available which included implementation and review dates. However, not all of the policies which were in place were reflected in practice such as recruitment and vetting policy, personal property and finances policy and the emergency procedures policy. Staff were not knowledgeable with regard to the implementation of some policies specifically in relation to challenging behaviour, fire safety and emergency procedures.

Some of the policies did not meet all legislative requirements such as the complaints policy.

Access to the person in charge by all residents and relatives requires improvement. Documentation reviewed included evidence of care review meetings held by the person in charge with some residents and their relatives but not all could identify her or knew her name. It was noted however that the person in charge had commenced in post only within the three months preceding this inspection.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

Each staff grade were identifiable by their uniform, and some staff wore name badges. Some residents could identify staff by name.

Cover arrangements to ensure cover was available in the event of sick leave or other unforeseen absences were improved. Poor weather conditions existed throughout the inspection and yet staff strived to ensure they were on duty on time each day. On the few occasions when staff were unable to work their shift, the nurse or person in charge found replacements within a reasonable timeframe in the majority of cases.

Some improvements required

Although staffing levels and skill mix were appropriate to the numbers of current residents during the inspection, staff appeared to have difficulty ensuring personal care and medication was provided to residents in a timely manner. Inspectors observed that although there were two staff nurses administering medication to 29 residents this still took over two hours to complete. On some mornings, administration of medication did not commence until 10:00 hrs and was not completed until 12 noon. This resulted in residents receiving medication prescribed by their GP at incorrect times. This also resulted in the three care staff responsible for delivering all of the personal care to residents without any level of supervision or monitoring by the nursing team. It also resulted in some residents not being provided with assistance to get out of bed until lunch time.

Significant improvements required

Considerable staff training had been delivered further to the initial inspection and actions identified by the Authority which included mandatory training such as fire safety and evacuation and manual handling. Other training had also been delivered such as, management of challenging behaviour, recognising and responding to elder abuse, infection prevention and control and end of life care.

However, in conversations with staff and through observing practice, inspectors found that all staff did not demonstrate competency in either skills or knowledge despite the training received. Evidence of this was found when; nurses did not recognise signs of challenging behaviour associated with one resident's continued verbal aggression and wandering behaviour, poor manual handling practices observed on three separate occasions, inadequate response to activation of the fire alarm during the inspection. Inspectors also found that not all staff had attended the training. One carer told inspectors that although she had been offered training on recognising and responding to elder abuse on three occasions she had not yet attended. The carer when asked could not identify the signs associated with abuse or tell the inspector what constituted abuse.

Evidence of improvements to recruitment and vetting processes were found. A two day induction programme which included introductions to fire training, use of manual handling equipment, review of policies and procedures and provision of employee handbooks had commenced. Contracts of employment, job descriptions and a staff training record had been established. However, evidence that all of these processes were being implemented in respect of all recently employed staff was not found.

Staff appraisals were being introduced however, only some had been completed.

Inspectors looked at a sample of personnel files; there was evidence of preparations to meet the requirements of the legislation. However, the records did not contain all the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) in that photograph identification, three written references and evidence of medical fitness from a qualified medical practitioner were not available.

Inspectors also noted that where references were available, there was no evidence of these having been checked by the provider prior to staff commencing employment.

Evidence that all nurses employed were suitably qualified and registered with An Bord Altranais was not available.

There was a high level of staff turnover. Inspectors noted that 15 staff have left the centre in the preceding 12 months, of which five were care staff, one clinical nurse manager and two were previously the person in charge. On 16 December 2010, the current person in charge advised the Authority of her intention to resign her post. Lack of support from the provider, which included extreme budgetary constraints, and ongoing communication difficulties with the provider were cited as the main reasons for her departure. On 23 December 2010, some staff mentioned their concerns at the resignation of the person in charge whom they had found to be protective, supportive and ‘‘fair but firm’’.

Closing the visit

At the close of the inspection visit a provisional feedback meeting was held with the provider and 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:

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

10 January 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
31 March 2010, 1, 2 , 5 and 13 April 2010	☐ Registration ☐ Scheduled ☐ Follow up inspection ☐ Announced ☒ Unannounced
May 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☐ Unannounced
June 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☐ Unannounced
August 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☐ Unannounced
29, 30 November 1 December 2010	☒ Registration ☐ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
3,7 14 and 23 December 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to action plan

Centre:	Creevelea House Nursing Home
Centre ID:	0129
Date of inspection:	29, 30 November 1 December 2010 Follow up on 3,7 14 and 23 December
Date of response:	26 January 2011

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 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Action plan 1 reflects emergency action plan issued to the provider on 1 December2010

Action Plan 2 reflects emergency action plan issued to provider on 23 December 2010

1. The provider has failed to comply with a regulatory requirement in the following respect: All reasonable measures had not been taken to maintain residents' welfare and wellbeing. Inspectors found that the centre was not adequately heated and that a number of residents were suffering from the cold.
Action required: The provider shall transfer residents in danger of hypothermia and provide suitable accommodation to meet their needs.

Action required:

The provider shall ensure that an appropriate emergency response plan which meets the needs of residents is devised and implemented immediately.

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: Ensuring appropriate levels of heating throughout the home at all times is a primary concern: on 28 November 2010 the provider monitored the heat levels in the home. One radiator in one of the bedroom corridors was off and the heating in one bedroom required boosting. The provider discussed this with the maintenance man and requested the plumber to attend. The maintenance made adjustments to boost the heating level in the bedroom. The plumber came out on Monday afternoon (29 November), inspected the heat flow within the heaters and took temperature readings. The provider spoke to the PIC about the matter. On Tuesday morning (30th November) the maintenance man mentioned that the inspectors were also concerned with the heat levels in certain areas. The provider asked the maintenance man and the plumber to make the required adjustments to improve the heat levels. On Tuesday afternoon the inspectors communicated their concerns to the provider and the person in charge (PIC). Seven residents were reported by the inspectors to be at risk of hypothermia. The provider requested to know the temperatures – this was not provided. The PIC contacted the GP to review the identified residents. The temperatures of six of the residents were found to be in the range of normal. One resident with identified circulation problems had a recorded temperature of 35.4C. The inspectors communicated the seriousness of the situation and related that they needed to discuss the matter with the Authority. The inspectors communicated verbally that the Authority directed that all residents that they had identified to be at risk of hypothermia be transferred immediately and that we follow our emergency plan. The provider asked could this be provided in writing to avoid any confusion. The provider was informed that this was not possible at present as action must be taken immediately. (The written emergency action plan was provided the next day.) The PIC rang nearby nursing homes and centres according to the emergency plan. A relative, together with the PIC inquired if her	

father could be moved to another room within the nursing home. The relative inspected her father's room and was happy with the heat level. The provider inquired whether the residents could stay in/return to their own rooms if we can ensure correct temperature levels. The provider communicated to the PIC that we will not transfer any residents from the nursing home but that we will look to ensure sufficient recorded temperatures within the home; the provider then proceeded to purchase heaters and draught excluders. The identified residents were moved to areas in the house with appropriate temperature recordings. The next of kin of the residents were informed re the move to alternative rooms. The nurses checked the identified residents and temperatures were recorded two hourly. The temperatures of all residents rooms were checked two hourly during the night. Above minimum temperatures were recorded in all rooms. Staff offered hot drinks to residents throughout the night. Extra fire blankets were ordered by the PIC and distributed. All doors (excepting fire doors) were closed and ten portable radiators were purchased. The maintenance man ensured that all windows and window sills were sealed in bedrooms of the residents identified to be at risk and in the identified communal areas (30 November 2010). The sealing of the windows in the remaining bedrooms, as required, followed. The plumber attended to the boiler and adjusted the thermostat. Follow up actions: All room and corridor temperatures were monitored throughout the day and night for the following month and were found to above minimum levels. Curtains have been fitted to the bedroom hallway windows. A certified boiler heating technician has attended to the boiler. The boilers will be serviced regularly and certified and, a service contact will be signed. The heating technician will review and advise on the heating/insulation in the home in general.	30 November 2010 to January 2011 January-February 2011

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

All reasonable measures had not been taken to maintain residents' welfare and wellbeing. The Inspector found that there was a smell of gas in the kitchen from a defective gas cooker that posed a risk to staff and residents.

Meals were not provided in a timely manner due to length of time of cooking process on a defective cooker.

Action required: The provider shall put in place all and any measures required to resolve the gas leak.	
Action required: The provider shall put in place alternative measures for providing cooked meals to residents which does not compromise residents or staff in terms of health and safety.	
Action required: The provider shall ensure that an appropriate emergency response plan which meets the needs of residents is devised and implemented immediately.	
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 gas supply from the exterior tank source to and including the cooker was checked and certified safe for use by suitably qualified gas technicians earlier last year (tank and piping - 15/07/2010; cooker - 21/07/2010). A new gas cooker was ordered earlier this year (approved for purchase – in 2010) as (i) one of the ovens in the existing cooker was not functioning optimally and (ii) there are improved safety features on the newer cooker. Following the present Action Plan request the gas cooker fitter technician was requested to inspect the cooker. The technician had difficulty locating a leak and emphasised how low a level it was. The technician advised that the cooker was low risk and that the gas used is non-toxic. As an appropriate precaution the cooker was switched off and is presently not in use. Six electric hobs and an oven/grill were purchased and this was deemed sufficient for the interim by the chef. An electric oven (chosen by the chef) and concomitant specialist electrical installation were sourced by the provider (installed 30 December 2010 and 04 January 2011). The provider had previously suggested to the person in charge (PIC) and chef re obtaining an electric cooker to used as back-up – this had not been pursued. Following a number of phone calls from the acting PIC and the provider (to look to bring forward the delivery date), we are now assured that the new gas cooker will be installed and certified for use next week.	December 2010 January/February 2011

Follow up actions: The issue regarding the prompt and formal reporting of H&S concerns by staff will be raised at the next health and safety meeting, including the need for formal appropriate responses with timeframes and clear lines of accountability. A revised structure for the health and safety committee is proposed. A second nominated person will now periodically review H&S matters to ensure timely intervention takes place as and when required.	January 31 2011

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

The premises had not been suitably maintained in a good state of repair and equipment had not been maintained in good working order.

Action required:

Immediately replace all seriously defective equipment specifically the gas cooker, and repair or replace all other equipment currently not in full working order such as (but not exclusively) the main boiler, water pipes and electrical fuse boards.

Action required:

Provide safe and secure premises and equipment which ensures the general welfare and protection of residents at all times and complies with all relevant statutory provisions including health and safety, building and fire legislation.

Action required:

Establish clear policies and procedures on the provision and ongoing maintenance of the premises and equipment which meets evidence based practice and relevant statutory legislation.

Action required:

Ensure all staff are knowledgeable in respect of these policies and procedures.

Action required:

Establish safe systems for regular monitoring and review of all replacement, repair and maintenance programmes.

Action required: Initiate an immediate and thorough review of all aspects of the premises and equipment both internal and external and make a report on these reviews to the Authority within three months of receipt of this report. This review to be undertaken by persons with relevant expertise and qualifications and to include recommendations for improvement within reasonable timeframes.	
Action required: Undertake to implement all recommendations made by the qualified persons in the review within a reasonable timeframe to be agreed by the Authority.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A review of the heating system will take place by the boiler heating technician (arranged). A review of the electrical system will take place by a qualified electrical contractor (arranged). A review of the plumbing will take place by the plumbing contractor (date to be arranged). A preliminary service has taken place of one boilers. All boilers will be serviced and certificates supplied. A service contract will be signed. A new gas cooker containing improved safety devices will be installed and certified this week (or next week at the latest). All water pipes are functioning correctly. A policy and procedure for ongoing maintenance will be developed and staff will be asked to read the sections pertinent to their role. The policy will indicate who is responsible for which aspect of maintenance.	 February 2011 February 2011 January/February 2011 28 February 2011

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

Failure to ensure the general welfare and protection of residents at all times.

Action required:

Provide safe and secure premises, equipment and staffing which ensures the general welfare and protection of residents at all times through the provision of adequate security and all other protective measures as may be required.

Action required:

Ensure all protective measures currently in place are implemented at all times and that staff are familiar with and knowledgeable on all such measures.

Action required:

Establish clear policies and procedures on the provision and ongoing review of security and protection of residents and staff under health and safety and all other relevant legislative requirements.

Action required:

Ensure all staff are knowledgeable in respect of these policies and procedures.

Action required:

Establish safe systems for monitoring and reviewing all safety systems and protective measures put in place.

Action required:

Establish a system which audits and reviews such safety systems and protective measures on a regular basis and no less frequently than annually.

Action required:

Initiate an immediate and thorough review of all aspects of the premises and equipment both internal and external and make a report on these reviews to the Authority within three months of receipt of this report.

This review to be undertaken by persons with relevant expertise and qualifications and to include recommendations for improvement within reasonable timeframes.

Action required:

Undertake to implement all recommendations made by the qualified persons in the review within a reasonable timeframe to be agreed by the Authority.

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: The nursing home has generally been free of incidents such as this (a single incident in many years) prior to recent events. A number of places in the Laytown area were affected recently and the Gardai are aware of this. Following the present incident the acting PIC phoned the Gardai in Laytown. The acting PIC and the provider have had discussions with the Crime Prevention Officer (the CPO will attend the Nursing Home on 27 January 2011): he will survey the premises and advise regarding appropriate steps to take to enhance security. A report on the matter will be provided to the Authority. External sensory lighting was installed A key code access panel has been fitted to the back door (staff entrance). Window restrictors will be fitted to all windows. An inquiry has been made regarding the railing fence at the back of the home. It has been confirmed that this is the property of the HSE facility to the rear. The HSE administrator has put in a request that the fence be replaced. At present this part is secure – there is a further fence behind this fence and it is not possible to gain access to the nursing home from his point. An enquiry has been made to the gate manufacturer re making the new side gate more secure. Quotes are being obtained for a second key code access, a key pad, a magnetic lock and personal alarms for staff on night duty. Hourly checks, day and night, are carried out to ensure the safety of the residents.	27 September 2010 13 January 2011

5. The provider has failed to comply with a regulatory requirement in the following respect: The emergency plan in place was not comprehensive enough to guide staff on the procedures to follow in all emergency situations. The plan did not include details of all the resources available, specific contact details and arrangements to evacuate residents if required.	
Action required: Develop a comprehensive emergency plan for responding to all types of emergencies including loss of power and heat.	
Action required: Ensure all resources available, specific contact details and arrangements to evacuate residents if required are included.	
Action required: Ensure all staff are knowledgeable in respect of the emergency plan and competent in terms of the implementation of the plan.	
Action required: Establish a system to review the emergency plan on a regular basis and no less frequently than every three months.	
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:**
Providers Response: There is a new revised emergency plan being read and signed off on by staff. It contains emergency personnel and phone numbers, utility company emergency contacts and emergency reporting and evacuation procedures. We are assured that an electrical generator will be installed on Monday 31 January 2011. Sixteen evacuation sheets have been ordered for immobile residents and those with dementia and we are assured that the	31 January 2011

sheets will be delivered this week. Health and safety meetings take place once a month and the next meeting is scheduled for the 28 of January 2011.	 28 of January 2011

6. The provider has failed to comply with a regulatory requirement in the following respect: There was not suitable and sufficient care to maintain residents' welfare and wellbeing in regard to behaviour that challenges.
Action required: Implement the 'Challenging Behaviour' policy in full and develop individual assessment and individual intervention plans for all residents who present with behaviour that challenges.
Action required: Review supervision systems and practices in place to manage challenging behaviour in communal and private bedroom areas which ensures safety and also respects the privacy and dignity of all residents.
Action required: Establish a system which audits and reviews implementation of the policy and disseminates learning to all staff.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 21: Responding to Behaviour that is Challenging

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Challenging behaviour training (two full day courses) has taken place for nursing and care staff. A new policy on challenging behaviour has been put in place and disseminated to staff. The policy is currently being read and signed off by staff. Care staff have been given guidance on behaviour that challenges by the CNM and nursing staff. Behaviour charts are being used to record behaviour that challenges to monitor same, and attempt to predict trends in order to improve the management of these behaviours. The Cohen Mansfield Inventory of challenging behaviour is also being used to identify triggers for challenging behaviour.	

Root causes of challenging behaviour, e.g. poor communication, are being identified. The CNM is sourcing communication, pictorial cards which may help residents who have poor communication skill, and hence lessen frustration which can lead to challenging behaviour. A S.A.L.T was contacted to help with same (July 2010). The care plans of residents who present with challenging behaviour will be reviewed by the PIC and behavioural management strategies will be further developed for all residents in conjunction with the appropriate professionals and same will be recorded. A strategy for monitoring of communal areas is being put in place and the implementation will be recorded on our new allocation sheet. We are currently in the process of developing an Audit form for all accidents/incidents and also risk assessments.	

7. The provider has failed to comply with a regulatory requirement in the following respect: The provider and staff did not demonstrate knowledge of the procedures to be followed in the case of a fire. Adequate arrangements for the safe evacuation of all persons were not in place.
Action required: Ensure by means of fire drills and practices at suitable intervals that all persons working in the centre are aware of and competent in the procedures to be followed in the event of a fire.
Action required: Establish a system of regular review and audit of all fire practices and procedures which includes determination of staff knowledge.
Action required: Where reasonably practicable ensure residents are aware of the procedures to be followed in the event of a fire.
Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety

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

Provider's response: All staff received fire training in August and September 2010 (and earlier that year). Fire alarm testing will take place every Friday afternoon at 14.30 hrs. Fire drills, including recording, are to take place once a month to ensure that staff know how to respond in a timely manner and to facilitate the moving of residents, visitors and staff to safety.	 Complete Ongoing

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

Appropriate and transparent processes to safeguard residents' finances were not in place.

Written authorisation for the transfer of residents' pensions to the centre was not available.

Patient's private accounts held in respect of residents were 'pooled' and authorisation of transfers of monies from the residents account to the provider business accounts were not available.

Action required:

Put in place appropriate transparent accounting systems which meet best practice and safeguard residents' property, possessions and finances.

Action required:

Ensure all accounting systems meet the requirements of all statutory legislation including Section 2 of the Health (Repayment Scheme) Act 2006, HSE guidelines on patients private property accounts Health Act 2007 and all other relevant legislation.

Action required:

Provide written evidence of authorisation of the provider to manage residents' accounts on residents' behalf.

Action required:

Revise all policies and procedures on residents' personal possessions and property to ensure they meet evidence based practice and reflect all relevant statutory legislation and guidelines.

Action required:

Ensure by all means necessary that all staff are aware of the revised policies and procedures and knowledgeable in terms of their implementation.

Action required: Establish a system which properly records and accounts for any movements of monies held in safekeeping for clients.	
Action required: Establish a system which audits and reviews such accounting systems on a regular basis and no less frequently than annually.	
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 9: The Resident's Finances	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: A policy and procedure on managing residents' property and finances was introduced. We have a procedure on the management of petty cash and same is followed by appropriate staff. Sage Accounts is in place. Only three pensions are paid into the nursing home account. The pensions of the remaining residents are looked after by their families/representatives. There is a pension account on sage and when money is received through the bank it is allocated to the residents individual accounts. We also receive Comfort Money for 1 resident monthly by cheque and this is lodged to the comfort bank account and allocated to the residents' account on Sage. We have a manual file in place, which records the money, and possessions that we have in a safe especially for residents. Any transactions that take place is recorded in this file, signed, and witnessed. All accounting systems will be reviewed against the requirements of all statutory legislation including Section 2 of the Health (Repayment Scheme) Act 2006, HSE guidelines on patients private property accounts Health Act 2007 and written authorisation regarding pensions will be sought.	28 February 2011

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

A record of residents' financial accounts and the system in place to manage these accounts was not available for inspection.

Action required:

Make available for inspection all records, policies and procedures as required in the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Reference:

Health Act, 2007
Regulation 7: Residents' Personal Property and Possessions
Standard 31: Financial Procedures

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A policy and procedure regarding managing residents' finances is available. The provider is to be used as an authorised person to mind finances as a last resort only. Sage accounts have been set up as outlined above. Individual resident spreadsheets are being set up to record the movement of their personal monies i.e. for Haircuts, Chiropody, Prescriptions, etc. This was discussed at the recent residents' and relatives' meeting. A triple invoice book has been put in place to record chiropody, haircuts prescription fees etc.: one for issuing to next of kin - two for the resident's file and - three for the nursing home's records. Spreadsheets are being put in place and all transactions and movements of money will be recorded there.	In progress

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

An admission criteria was not included in the statement of purpose to assure the appropriate placement and management of the level of need of residents'.

Action required:

Devise an admission criteria and appropriate operational policies and procedures in relation to admissions to ensure appropriate placements of residents and that only those residents who meet the categories of care as outlined in the statement of purpose are admitted.

Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Following a referral, the person in charge visits the resident at their home or in hospital, if they are unable to visit the nursing home, and completes a pre assessment form. At this time, the resident's care needs are reviewed and the extent to which the resident's needs can be met by the nursing home is assessed. The person in charge meets the resident, their family and carers. Where possible, the new resident is invited to visit the nursing home. An admission date, a fee rate and a contract of care is then agreed. On the admission date, an admission record and physical and social assessment is completed by a staff nurse in agreement with the resident, family or carer. The new resident's individualised care plan, which includes a general risk assessment, is completed by the staff nurse within 48 hours. Nursing staff inform the GP that the new resident has arrived. The kitchen is advised about special diets.	Ongoing

11. The provider has failed to comply with a regulatory requirement in the following respect: An admissions process was not in place.
Action required: Establish an admission process to ensure that up to date information on the residents' condition is available for each admission.
Action required: Ensure residents needs are fully and comprehensively assessed on each admission.
Action required: Put in place a care plan to reflect the assessment findings on each admission.
Action required:

Put in place appropriate policies and procedures which underpins the admissions process and ensures it meets evidence-based practice.
Action required: Establish a system of ongoing audit and review which ensures policies and procedures established are implemented.
Reference: Health Act 2007 Regulation 10: Residents' Rights Dignity and Consultation Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have a developed an admission policy and procedure that is disseminated to all staff and signed off. The PIC will, where possible, do a comprehensive pre- assessment prior to admission and same will be documented. All potential residents will be invited to visit the home with their relatives or representatives/advocates prior to admission. The residents' guide and statement of purpose will be made available at this stage to provide information re our service. On admission the staff nurse will carry out a full assessment and document all findings on our admissions record. A comprehensive individualised care plan will be developed in conjunction with the resident and/or their relative/representative/advocate, based on our assessment, within 48 hours of admission. This care plan will be reviewed on a three-monthly basis or as required. The PIC has commenced an audit of existing care plans and same is ongoing.	In progress

12. The person in charge has failed to comply with a regulatory requirement in the following respect: Initial and continuous assessment, monitoring and evaluation of residents' changing needs was not reflected in the care plans. Care plans, risk assessments and nursing evaluations were not linked and are not consistent. Care plans were not specific enough to address and manage the identified need of the residents
Action required:

Ensure each resident has their needs set out in an individual care plan and keep it under formal review as required by the resident's changing needs or circumstances and no less frequently than every three months.

Action required:

Put systems in place to ensure that all residents' identified needs are set out in an individual care plan developed and agreed with each resident.

Action required:

Ensure that all issues such as falls, risks or challenging behaviour are addressed in the care plan and that the care plan is adequately specific to address the need identified.

Action required:

Ensure that care plans in place consistently reflect residents' current health status.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 10: Assessment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An individualised care plan is in place for each resident. The care plan is currently updated as changes occur in the resident's circumstances and health status. The nursing evaluation will be linked more closely to the care plan. The care plan is reviewed every three months by the nursing staff. Falls, risks and challenging behaviour are addressed in the care plan.	In place

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

A comprehensive assessment which ensured each resident's individual needs could be met was not obtained prior to admission.

Action required:

All necessary information relating to the residents' health, personal and social care needs is obtained prior to admission.

Action required:

Establish and maintain protocols which ensures appropriate continuity of care for all residents further to admission.
Action required: Review and audit such systems and processes established to ensure ongoing implementation.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The new director of nursing and the acting person in charge are currently working on a more comprehensive pre assessment with respect to new admissions. It was decided not to admit new residents at this time until the assessment is completed. The new system will be in place by the end of February 2011.	28 February 2011

14. The provider has failed to comply with a regulatory requirement in the following respect: Contracts of care did not meet the requirements of the legislation.
Action required: Amend the contract of care and ensure it meets all the requirements of the legislation.
Reference: Health Act 2007 Regulation 28: Contract for the Provision of services Standard 7: Contract/Statement of Terms and Conditions

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

Provider's response: The contract of care has been updated to meets the requirements of the legislation (Regulation 28) and Standard 7: The contract now references the Health Act 2007 and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The fees to be charged are stated on the last page of the contract of care. A more detailed outline of the service to be provided for residents will be provided.	Completed 28 February 2011

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

The management of complaints and the complaints policy did not meet all of the requirements of the regulations.

The complaints policy did not reflect the remit of the Authority in relation to complaints.

Action required:

Review the management and recording of complaints so that all complaints are documented in a timely and complete manner.

Action required:

Record all investigations, actions, outcomes and learning on each individual complaint and ensure that this record meets the requirements of the legislation.

Action required:

Record notification of the complainant of the outcome of the complaints and his/her satisfaction or otherwise of the outcome and any other follow up action taken.

Action required:

Amend the written policy and procedure and ensure it meets the requirements of the legislation and includes a nominated person, independent nominated person and independent appeals process.

Action required:

Amend the policy so that it accurately reflects the Authority's remit in relation to 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: The complaints policy is being revised to meet all the requirements of the legislation; the revised document will be disseminated to all staff. Complaints are being dealt with in a timely manner, not exceeding 28 days, and the outcomes are communicated to the complainant. A record of notification of the complainant of the outcome of the complaint (including his/her satisfaction or otherwise of the outcome and any other follow up action taken) will now be kept. The complaints procedure identifies the nominated person for dealing with complaints in the centre and a second nominated person who ensures all complaints are responded to in the appropriate manner. The contact details of (i) advocacy services available to residents, (ii) the Health Service Executive (HSE) (iii) the office of the ombudsman and (iv) the Chief Inspector of Social Services are provided. Our complaints policy and procedure allows the opportunity for appeal. Our complaints procedure is clearly displayed in the reception area. Complaints will be discussed at staff/team meetings to solicit feedback and to relay learning and improved procedures as required.	14 February 2011

16. The provider has failed to comply with a regulatory requirement in the following respect:
The statement of purpose did not include all of the information required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).
Action required: Amend the statement of purpose to incorporate specific admission criteria, categories of care, age range and gender of intended residents', level of need, complaints procedure

and management structure and all other matters as listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required:

Ensure the statement of purpose accurately describes the service provided.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The statement of purpose is currently being updated. In particular a clearer description of the categories of care, range of needs, type of nursing care to be provided and admission criteria will be provided. The names and position and qualifications/experience of all of the management team, the maximum number of residents who will be accommodated and the size of rooms in the centre will be detailed.	28 February 2011

17. The provider and person in charge have failed to comply with a regulatory requirement in the following respect:

Appropriate and timely access to relevant health care services based on residents' assessed needs was not facilitated.

Regular three monthly reviews of residents' general medical condition and medications by a general practitioner for all residents were not in place.

Action required:

Ensure all residents are facilitated to access relevant health care services as may be required.

Action required:

Ensure all residents are provided with appropriate medical care which includes regular three monthly reviews of residents' general condition and medication.

Action required:

Provide such services as may be required or enter into discussion with the health service executive to ensure the ongoing provision of services and/or supports which meets the needs of all residents in the current residents profile.

Action required:

Ensure that records are maintained of all actions referrals, recommendations and follow up appointments in a complete manner.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The GP is currently reviewing the residents' medication. This review will conclude in the first week of February 2011. The GP reviews the residents' current medical conditions during his visits to the nursing home on Tuesday and Thursday. The acting person in charge has applied through an optician for HSE approval for the residents to have their eyes checked. We are assured approval will come through in four weeks. Residents are currently attending a dentist for check-ups and to have their dentures adjusted. A dentist came to the nursing home on the 18 January 2011 to review two residents who were unable to travel. The chiropodist visited the nursing home on the 11 October 2010 and attended to the majority of the residents. The next chiropody appointment is on the 3 of February 2011. The acting person in Charge is currently sourcing an audiologist for some of the residents. One of our residents was assessed on the 10 December 2010 by a speech and language therapist. This service is available for other residents as needed.	04 February 2011

18. The person in charge has failed to comply with a regulatory requirement in the following respect:

End of life care was not managed appropriately.

Action required: Ensure that all appropriate care and comfort is provided to address each resident's end of life care needs and that each need is met.	
Action required: Facilitate where possible the wishes of the residents and their family, next of kin or advocates.	
Action required: Establish and implement suitable policies and procedures which underpin best practice in end of life care and review regularly.	
Reference: Health Act, 2007 Regulation 14 : End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An end of life care policy has been developed according to best practice and the policy will be signed off by all staff. Staff have also been provided with training in End of Life Care on 20 October 2011. We recognise the importance of palliative care and we will involve outside support as needed. We will facilitate the wishes of the resident and his/her family insofar as possible. This will be clearly documented on the resident's care plan and daily record. As per discussion during a meeting last year (PIC, CNM, GPs), our general practitioner is committed to work with care staff to provide comfort and care to our residents. All input of other professionals will be clearly documented and welcomed. Religious beliefs/wishes will be taken into account of the residents. Family and friends will be given support during this stage. Nurses will follow guidelines of the end of life policy.	In progress

19. The person in charge has failed to comply with a regulatory requirement in the following respect:

Staff members did not demonstrate knowledge of appropriate techniques in the moving and handling of residents.

Action required:

Establish best practice procedures in the moving and handling of residents, to include assessment of residents, individual moving and handling plans, staff training and monitoring of practice.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Early last year all staff received training in moving and handling of residents. Further training was provided on 21 September 2010 and 20 October 2010. Nursing staff are maintaining a moving and handling chart in the residents' files and are currently updating the care plans to reflect this. The new director of nursing and the acting person in charge are currently discussing the suitability of transfer belts to aid the moving and handling of residents. Nursing staff are maintaining a moving and handling risk assessment chart for residents in their individual files.	In progress

20. The person in charge has failed to comply with a regulatory requirement in the following respect:

All staff were not provided with access to training and education on areas of practice which meets the needs of the current resident profile specifically in the area of fire safety, moving and handling and elder abuse.

Where staff were trained they did not competently demonstrate sufficient knowledge or skills particularly in the area of fire safety, management of challenging behaviour elder abuse, moving and handling and end of life care.

Action required:

Provide all staff with training that maintains skills and ensures they are competent to carry out their role.

Action required:

Ensure that staff members have access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.

Action required:

Establish systems which monitors, reviews and audits learning achieved and ensures staff are competent in all aspects of their role.

Action required:

Ensure the staff training plan is linked to staff appraisals and performance management development assessments.

Reference:

Health Act, 2007
Regulation 17: Training and Staff Development
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: Extensive training has taken place in these and other areas: Fire training took place early last year for all staff and two further fire training sessions took place late last year (for all staff). Similarly all staff received training in moving and manual handling early last year and again later last year. Training was provided last year for elder abuse, dementia care, challenging behaviour and end of life care as followed: ▪ elder abuse (3 sessions, all staff) ▪ dementia care (1 session plus specific consultation) ▪ challenging behaviour (2 sessions, nursing and care staff) ▪ end of life care (October 2010, nursing and care staff) Adherence to our Induction policy will ensure all new staff receives appropriate induction training in mandatory areas. More specific training of a designated fire officer will enhance the	28 February 2011

in-house reinforcement of fire-training. A policy and procedure for assessing knowledge of training received and of evidence of putting training into practice will be established by the PIC. Learning in this manner will also be assessed during appraisals. A second nominated person will ensure that procedure in being followed on an ongoing basis.	

21. The person in charge has failed to comply with a regulatory requirement in the following respect: Adequate arrangements were not in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. The system of audit and review for the control of specified risk was not sufficiently comprehensive to ensure residents' safety.
Action required: Revise the accident and incident reporting processes to incorporate more detailed and reliable sources of information.
Action required: Put in place precautions to control identified risks and ensure these are adhered to at all times.
Action required: Revise the current system and establish a system which appropriately and comprehensively audits and reviews the control mechanisms in place to manage identified risks.
Action required: Ensure that the reporting and auditing systems established are linked to residents' care plans risk assessments and evaluations to ensure risks are managed on both an individual and collective basis.
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:	

Nursing staff currently complete the notification of accident/incident form post accident or incident which is reviewed and signed by the person in charge. Form NF03 is completed by the person in charge and faxed to the Authority. The falls assessment form (Cannard 1996) is updated monthly and post fall by nursing staff. Risk of falls is documented in the resident's care plan, risk assessment and evaluation which are kept up to date. One resident at risk of falling has an alarm mat attached to his chair which alarms when he moves from the chair. Staff are aware that he needs supervision when mobilising with his zimmer frame at all times. Nursing staff also maintain a falls diary which is kept with the residents' progress notes.	In place

22. The person in charge has failed to comply with a regulatory requirement in the following respect:

Not all reasonable measures were in place to identify, assess and manage the risks associated with ensuring the safety of mobile residents with cognitive impairment and tendency to wander.

Action required:

Commence a complete review of the identification and assessment of risks throughout the centre which takes account of each residents' individual nursing, medical and multi disciplinary care plans and assessments.

Action required:

Put in place precautions to control all identified risks and specifically those risks associated with mobile residents with tendency to wander and ensure these are adhered to at all times.

Action required:

Ensure that arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents are fully implemented at all times.

Action required:

Establish a system which audits and reviews the control mechanisms in place to manage identified risks on a regular basis and no less frequently than every three months.

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: The person in charge completes the risk assessment management form for each resident and updates it as changes occur in the resident's circumstances. Staff are aware of the need to supervise and support mobile residents with cognitive impairment who have a tendency to wander. Care staff currently report any incidents or concerns to the nurse on duty about same. Nursing staff will ensure that such incidents or concerns are documented in the individual care plan and the nursing evaluation and are currently documented in the progress notes. A flow sheet for the management of challenging behaviour is kept in the resident's file and a chart outlining the incident of challenging behaviour –triggers and resolutions, is maintained. Three residents were reviewed by psychiatry on the 21 of January 2011. During the reviews the residents' medication was checked and the psychiatrist will liaise with their GP. Some family members met with the psychiatrist at the nursing home.	21 January 2011

23. The provider has failed to comply with a regulatory requirement in the following respect: The physical design and layout of the centre and the level of equipment provided does not meet the needs of the residents.
Action required: Provide adequate communal and private space to meet the needs of each resident specifically in relation to, communal areas, private visitor's area, size and layout of nurses' office space.
Action required: A complete review of the design and layout of the premises and the provision of suitable and sufficient equipment required to meet the needs of all residents is required.
Action required: Review sluicing facilities and put in place sluicing facilities which meets best practice in

relation to infection prevention and control and is accessible from all areas of the building.

Action required:

Provide suitable and sufficient communal space which includes; sufficient dining room space and space for interest and diversion for residents.

Action required:

Provide separate cleaning facilities and separate cleaning equipment for catering and non catering areas.

Action required:

Provide adequate ventilation, lighting and heating in all areas of the centre.

Action required:

Ensure there are a sufficient number of assisted toilets and bathrooms having regard to the number of dependent persons in the centre.

Action required:

Review the layout of the laundry to ensure that the necessary sluicing facilities are provided and that adequate space is available to separate clean and soiled laundry.

Action required:

Provide an electrical, heating and lighting system which meets current safety standards.

Action required:

Provide safe and secure outdoor space with a secure perimeter and appropriate external sensory lighting.

Action required:

Ensure corridors are wide enough to meet the needs of all residents and are accessible for all wheelchair users.

Action required:

Ensure the layout and dimensions of all rooms provide full access for carers and equipment.

Action required:

Ensure all bedrooms meet the requirements of the *National Quality Standards for Residential Care Settings for Older People in Ireland* in regards to usable floor space and

provision of wash-hand basins.
Action required: Provide a wheelchair accessible visitors' toilet.
Action required: Improve the use of pictorial signage or colour cueing for residents with visual or cognitive impairment.

Action required: Signs identifying the designated function of all rooms were not in place.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A significant number of improvements have been made to the physical environment over the past year. Improvements will continue to be made; in achieving this and in implementing the items identified we have a need to establish short and medium term goals and a need to prioritise. A review of the heating, plumbing, electrical and security systems will take place in the near future. A nursing home provider with expertise in nursing home building requirements has carried out a preliminary review of our home. A further review will take place. Following the reviews a more formalised plan of action will be developed. Architect's plans are now available with planning permission approved. A provisional plan with a timeframe will be put in place to implement changes to the physical environment that will be required within the timeframe specified in the Standards.	

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

The premises were not in a good state of repair.

Action required:

Put in place a system for an ongoing maintenance programme which ensures the premises are kept in a good state of repair.

Action required:

Establish a maintenance programme to ensure the premises and all equipment is maintained in a good state of repair at all times and that equipment provided is maintained in good working order.

Action required:

Review the maintenance programme on a regular basis and no less frequently than every six months and update as required.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A considerable amount of maintenance work and improvements have taken place over the past year. A maintenance person is employed and a list of maintenance duties (job description) was drawn up. A list of items to attend to in this regard has been established but a more formalised ongoing maintenance program will be developed setting priorities and lines of accountability. A day to day maintenance book is also employed. A review of equipment maintenance needs is also being implemented. Hoisting equipment has recently been tested and certified – service contracts are available. A review of ongoing maintenance requirements will take place every six months.	28 February 2011

25. The person in charge has failed to comply with a regulatory requirement in the following respect:

All notifications were not submitted by the provider as required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required:

Maintain a record of all incidents occurring in the designated centre.

Action required:

Give notice to the Chief Inspector of Social Services without delay of the occurrence in the designated centre of all incidents as required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required:

All notifications should be submitted by the provider as required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required:

Policies and procedures should detail the notifications required and include timescales to guide staff with legislative requirements.

Reference:

Health Act, 2007
Regulation 26: Notification of Incidents
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A record of all incidents occurring in the centre is being maintained. A policy and procedure will be drafted in accordance with the Health Information and Quality Authority's document on notifiable events; three day, three month, other notifications and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Quarterly reports are being sent. The PIC will complete and send the Health Information Quality Authority quarterly reports for the last quarter by 31 January 2011.	28 February 2011 From 31 January 2011

A second nominated person will review incidents to ensure that all notifiable events are sent in a timely manner.	

26. The person in charge has failed to comply with a regulatory requirement in the following respect: An actual and planned staff rota was not available.	
Action required: The person in charge shall ensure that there is a planned and actual staff rota, showing the full names of all staff on duty at any time during the day and night and that it is maintained.	
Reference: Health Act 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The person in charge (acting) prepares the rota (weekly) and makes it available to staff on Friday. The rota shows the full names of staff on duty during the day and night. Any changes to the rota are made on the copy of the rota kept by the nurses at the nurses' station.	

27. The person in charge has failed to comply with a regulatory requirement in the following respect: The directory of residents did not include all of the information specified in schedule 3 of the (Care and Welfare of Residents in Designated Centres for Older People)Regulations 2009.
Action required: Review or replace the directory of residents to ensure it includes all of the information specified in Schedule 3 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The new Person in Charge will commence a review of the current directory of residents to ensure it includes all of the information specified in Schedule 3 of the (Care and Welfare of residents in Designated Centres for Older People) Regulations 2009. The review will commence on the 31 of January 2011 and will include the input of the nursing staff.	31 January 2011

28. The provider has failed to comply with a regulatory requirement in the following respect: The Insurance cover for the designated centre did not identify the limitation of liability in respect of residents' personal property.	
Action required: Review the insurance cover provided to ensure residents' liability meets the (Care and Welfare of Residents in Designated Centres for Older People). Regulations 2009 and that this is stated on the centres' insurance policy.	
Reference: Health Act, 2007 Regulation 26: Insurance Cover Standard 31: Financial Procedures	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Insurance company contacted and a meeting has been arranged for later this month – contract to be renewed next month – the new contract will specifically state the limitation of liability for any one personal item of the resident as per the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	28 February 2011

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

The residents' guide did not contain all of all of the information as required by legislation.

Action required:

Compile a residents' guide which contains all of the information required by legislation.

Reference:

Health Act, 2007
Regulation 21: Provision of Information
Standard 1: Information

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The residents' guide is being updated to meet all legislative requirements; information describing accommodation, personal possessions and regular review of care plans will be updated and the statement of purpose will be more clearly summarised.	28 February 2011

30. The person in charge has failed to comply with a regulatory requirement in the following respect:

Risk management policies and procedures in place were not consistently implemented.

Action required:

Ensure that a comprehensive risk management policy is in place and that it is implemented by all staff throughout the designated centre.

Action required:

Ensure all staff are aware of the policies and procedures in place to manage risks in the centre.

Action required:

Ensure staff are aware of their roles and responsibilities in relation to risk management and the safety and protection of residents at all times.

Action required:

Provide additional training or information sessions where necessary to update staff in

relation to risk management their roles and responsibilities.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Documentation of the current recordings of incident/accidents are being reviewed by the PIC and the CNM. A more comprehensive accident/incident book has been introduced. A full Audit of all accidents/incidents will be carried out each month by the PIC or her delegate.	

Every incident/accident is reviewed within three days by the PIC and dealt with appropriately e.g. the care plans are updated and a falls risk re-assessment is carried out. A risk management meeting is held after each Audit with key staff members, to review and discuss the findings of the Audit. This will also assist in identifying the risk and management of same. As a specific example a falls risk management plan was put in place for one resident deemed to be at high risk for falls. A seating mat with a call bell is utilised for this resident. The system alerts staff if the resident stands and needs assistance. This risk management plan has been successful resulting in a significant reduction in the number of falls. Nursing staff will report accident/incidents daily to the PIC to ensure timely management of same. The PIC will ensure that all required Heath Information and Quality Authority notifications are sent in a timely manner. The CNM has completed and sent the Heath Information and Quality Authority quarterly reports for the last quarter. Prompt action management and prevention of falls – the whole process was reviewed and training on appropriate actions and documentation of same was provided by the CNM in May, a periodic and full Audit was discussed at the staff meeting 15 July 2010. Further audits will be completed on a monthly basis. A risk management policy has been developed in line with best practice and will be disseminated to all staff to read and sign off. Challenging behaviour training has taken place for nursing and care staff. A new policy on challenging behaviour has been developed.	

The policy is currently being disseminated to staff to read and sign off. A falls risk assessment has been carried out on every resident. Residents deemed to be at high risk for falls have had a falls prevention programme implemented. This entails supervised mobilising, correct use of walking aids, wheelchair use, injury minimisation measures such as hip protectors, immediate cleaning of spills and minimal obstruction in rooms and corridors. The restraint policy is being updated to bring it in line with current best practice. The policy will then be disseminated to staff to read and sign off. Letters were sent to all relatives seeking permission to use side rails/lap belts. Residents currently using a lap belt are reviewed hourly by the nursing staff and restraint forms are completed. All policies and procedures in relation to care are available for all staff at the nurses' station and a copy in also kept in the PIC's office. Staff are currently being asked to read and sign off re- all policies and procedures. An external consultant assisted the PIC in delivering training on policies and procedures (12 August 2010). A monthly review by nurses, under the supervision of the PIC, of falls and restraints will be established. Relatives/representatives or advocates will be invited to a formal care review and in these meetings such issues will be discussed and recorded in conjunction with the resident's general practitioner. These meetings will take place at minimum every 6 months, or more frequently as the resident's needs change.	

31. The provider has failed to comply with a regulatory requirement in the following respect: The personnel records of some staff did not contain all of the required documentation as required in schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009(as amended).
Action required: Ensure that all staff records contain all the requirements listed in schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).
Reference: Health Act, 2007 Regulation 24: Staffing Records Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The administrator has put together a pack for new employees which contains a copy of Schedule 2 along with a Garda Síochána Vetting Form, Reference guidelines, job description, etc. and a letter requesting that they must have a doctor's medical report stating they are mentally and physically fit for the work they are required to do. Once a candidate is provisionally selected for a particular role the interviewee will be notified of the requirements above.	31 January 2011

32. The provider has failed to comply with a regulatory requirement in the following respect:
The range of policies, procedures and guidelines available in the centre were not in compliance with schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Not all of the policies and procedures which were available met the requirements of the regulations. Policies and procedures available were not implemented specifically in the areas of recruitment and vetting and risk management.
Action required: Put in place policies and procedures on all items listed in schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).
Action required: Ensure that all policies and procedures meet the requirements of the legislation.
Action required: Ensure staff are aware of the policies and procedures and knowledgeable in relation to their responsibilities towards their implementation.
Action required: Establish a system which audits and reviews implementation of policies and procedures and disseminates learning to all staff.
Reference:

Health Act, 2007 Regulation 11: Communication Standard 27: Operating Policies and Procedures.	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Mandatory policies and procedures as per schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 are in place. All policies will be checked against the requirements of the legislation and augmented where necessary. The PIC coordinates the annual (or as best practice dictates) review of the policies and procedures. Copies of the policies and procedures are available for all staff at the nurses' station and a copy in kept in the PIC's office. Two policies and procedures were sent to staff each week (with each weekly payslip) to read within a specified timeframe and sign off. Staff are asked to demonstrate an understanding of how the policies relate to their practice (appraisals, staff meetings) and to observe the corresponding procedures in practice. The PIC will ensure that the policies and procedures on recruitment and vetting, personal property and finances and risk management are followed. The PIC will ensure that all staff are knowledgeable wrt policies and procedures relevant to their role (in particular policies and procedures on emergencies, challenging behaviour and fire safety). A second nominated person will now periodically review evidence that staff learning has actually taken place and is being put into practice.	28 February 2011 From 31 January 2011

33. The provider has failed to comply with a regulatory requirement in the following respect: An appropriate induction process was not implemented in respect of all new staff.
Action required: Put in place an appropriate formal induction process for all staff and ensure this is implemented at all times.
Reference:

Health Act 2007
Regulation 18: Recruitment
Standard 22: Recruitment

Action required:

Put in place an appropriate formal induction process for all staff and ensure this is implemented at all times.

Reference:

Health Act 2007
Regulation 18: Recruitment
Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The provider developed induction protocols and checklists (and concomitant job descriptions) for the different staffing areas; staff from the different departments provided comments and suggestions on the documents relevant to their role and the documents were finalised. A review of the induction protocols and documents will take place for each staff role. The provider discussed with the administrator and the PIC regarding the implementation of the induction process in conjunction with Regulation 18: Recruitment and Regulation 17: Training and Staff Development. The role of implementation of the induction process is assigned to the PIC (or delegate) in accordance with the job description. The provider attempted to ensure that induction protocols were followed by providing written and verbal communication reminders to the PIC. A second nominated person will now ensure that the formal induction process is followed at all times.	August 2010 Completion date 28 February 2011 31 January 2011

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

A certificate which confirms that the centre complies with the building codes or the Planning and Development Act 2000-2006 was not provided.

Action required:

Provide a certificate which confirms planning permission complies with the Planning and Development Act 2000-2006 and all other relevant statutory legislation.
Reference: Health Act, 2007 Regulation 4: Application for Registration or Renewal of Registration Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Certificates available regarding the planning and development act sent. A further enquiry has been made to the architect regarding the above. The architect is currently pursuing the matter. Response awaited.	28 February 2011

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 29 Management systems	Review the management systems which support the delivery of quality care services to include a key worker allocation system.

Any comments the provider may wish to make:

Provider's response:

No response was received from the provider to this section.

Provider's name: Peter Murphy
Date: 26 January 2011