Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

Centre name:	St. Mary's Nursing Home, Pembroke Park
Centre ID:	0103
Centre address:	Pembroke Park, Ballsbridge Dublin 4
Telephone number:	01 6683550
Fax number:	01 6683425
Email address:	stmarysnurse@eircom.net
Type of centre:	☐ Private ☒ Voluntary ☐ Public
Registered provider:	Pembroke Park Association
Person authorised to act on behalf of the provider:	Ann Budd
Person in charge:	Ann Kavanagh
Date of inspection:	14 and 15 September 2011
Time inspection took place:	**Day-1 Start:** 09:50 hrs **Completion:** 19:10 hrs **Day-2 Start:** 07:00 hrs **Completion:** 19:00 hrs
Lead inspector:	Linda Moore
Support inspector:	Nan Savage
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **Unannounced**

About registration

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

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

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

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

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

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

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

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

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

About the centre

Location of centre and description of services and premises

St. Mary's Home is located on the south side of Dublin City, on its own grounds close to Herbert Park. It is within a few minutes walk from the bus stops and local shops in Donnybrook.

St Mary's Home is a three-storey building which was established as a residential care home for female members of the Church of Ireland and was subsequently registered as a nursing home. The centre has accommodation for 32 residents and there were 29 in residence on the day of inspection. All residents were female over 65 years with general care needs and many residents had dementia.

Accommodation for residents is provided on three floors, with stairs and lift access to the upper floors. The main entrance at the front of the building opens into a long hallway. Off the hallway is the main sitting room, a sun room, kitchen, waiting room, dining room, nuns' private dining area, laundry, two administrative offices and two staff toilets. There are two sluice rooms with one bedpan washer, one on the first and second floor.

There are no en suite facilities or wheelchair accessible toilets in the centre. Bedroom accommodation on the ground floor consists of four single bedrooms with wash-hand basins, and two separate toilets with sinks.

On the first floor, bedroom accommodation consists of ten single bedrooms, one twin bedroom with wash-hand basin and one three-bedded room with wash-hand basin. There are four separate toilets and an assisted bath room. There is a staff changing room with toilet on the adjoining half landing.

On the second floor there are thirteen single bedrooms with wash-hand basins, two separate toilets, one shower cubicle and one assisted bathroom. On the adjoining landing there are two toilets and an additional bathroom.

Residents have access from the ground floor to an attractive secure garden which is close to Herbert Park. There is on street parking with limited parking available on site.

Date centre was first established:			1923	
Number of residents on the date of inspection:			29 + 1 in hospital	
Number of vacancies on the date of inspection:			2	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents:	7	10	3	9
Gender of residents:			**Male (✓)**	**Female (✓)**
				✓

Management structure

The Provider is the Pembroke Park Association. The person nominated to act on behalf of the Provider is Ann Budd. The Person in Charge is Ann Kavanagh. She is supported in her role by the Administrative Manager Ciara Bevan and a senior staff nurse. Nursing staff and health care assistants report to the Person in Charge. Non clinical staff report to the Administrative Manager. The Person in Charge and the Administrative Manager report to the Provider.

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

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

Inspectors met with residents, relatives, and staff members, over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the person authorised to act on behalf of the provider, Ann Budd, and the person in charge, Anne Kavanagh both of whom had completed the fit person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation. They had identified some areas for improvement and these included focusing on fulfilment of residents and the introduction of an independent advocate for residents. Inspectors also reviewed all of the information provided in the registration application form and supporting documents. Both the provider and person in charge demonstrated their commitment and passion for the service and they welcomed the feedback from inspectors.

Inspectors found that residents had a good quality of life. Residents' privacy was promoted through staff practices. Residents were supported to exercise choice and personal autonomy and their views were generally sought and responded to.

The health needs of residents were met. Residents had access to medical cover and to a range of other health services and evidence based nursing care was provided.

The person in charge's knowledge in relation to 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* was demonstrated to inspectors during the inspection and the fit person interview. While there was good care of residents delivered, there was inadequate governance as the person in charge did not have adequate time to assume many of the legal responsibilities associated with the role of person in charge due to her workload.

Some amendments were required to the statement of purpose in order to accurately reflect the services and facilities currently available to residents. Other improvements were required and these are outlined under the outcome statements set out in the Action Plan at the end of this report.

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

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

1. Statement of purpose and quality management

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

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

Inspection findings

Inspectors were satisfied that some parts of the statement of purpose described the service that was provided in the centre and met requirements of Schedule 1 of the Regulations. However, the statement did not include such as the professional registration, qualifications and experience of the person in charge and the provider, the emergency procedures and fire precautions, religious services, complaints and the room sizes. The statement of purpose was not made available to the residents.

Inspectors found that the statement of purpose reflected the diverse needs of residents. In particular inspectors noted that the objectives of the statement of purpose were reflected in the inclusive, respectful and reassuring manner in which residents were engaged in the life of the centre. The staff training and development programme, and the design and layout of the centre were also accurately described. The provider stated that the service could provide convalescent, respite and long-term care, and this was reflected in practice and in the statement of purpose. There was one resident receiving respite services during the inspection. The person in charge and provider stated that a pre-admission assessment was used to determine if the centre could meet the needs of potential residents.

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

Inspectors found that there were some processes in place to review and monitor the quality of care of residents. However, these required considerable improvement.

In consultation with the general practitioner (GP) and the local pharmacist, all residents' medications were reviewed at three-monthly intervals. Inspectors read the results of these reviews and saw where medications had been discontinued as a result. The pharmacist also reviewed stock balances monthly and audited the service each month.

The person in charge had completed an audit on pressure sores and collected some information on falls. Unfortunately this information was not used to improve the service and there was no system to audit the quality of care provided. The person in charge had identified this as an area that required improvement but told inspectors she did not have the time to monitor and develop the quality of care and experience of the residents as she provided direct care to some residents.

Inspectors found the system to review and monitor residents' quality of life was informal in that the person in charge met the residents daily and the provider visited residents weekly. This practice could be further enhanced if this information was formally documented and used to improve the service.

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

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings
Inspectors found some evidence of good complaints management but this required improvement.

The complaints policy was read by inspectors and details of the complaints procedure were posted publicly near the entrance. The procedure provided clear guidelines on how to make a complaint or express a concern, and how these would be addressed. A named complaints officer was identified. However the policy did not identify an independent appeals process.

Inspectors reviewed the complaints log which showed there was only one complaint since 2010 and this had been resolved. This information did not include the complainant's level of satisfaction with how the complaint was managed.

There was no advocacy service available to residents. The provider, person in charge and administrative manager said they had discussed the need for this service and were currently in the process of recruiting an independent advocate.

2. Safeguarding and safety

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

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

Inspection findings
There were some measures in place to protect residents being harmed or suffering abuse. There were significant areas for improvement.

A policy was available but it was not centre-specific. The person in charge and many of the staff spoken to displayed sufficient knowledge of the different forms of elder abuse and were clear on reporting procedures.

The majority of staff had received training on identifying and responding to elder abuse but some non clinical staff could not describe how they would respond to an allegation of abuse. The administrative manager stated there was a plan to train the non clinical staff. The provider was knowledgeable of how to respond to an allegation of abuse.

The person in charge said she did not have the opportunity to monitor the safe-guarding practices in the centre. She said she regularly spoke to residents and relatives, but she did not have the opportunity to review the systems in place to ensure safe and respectful care, such as, monitoring the management of complaints, and ensuring that the staff understood the policy and procedure in relation to the prevention of elder abuse, including reporting procedures.

Residents spoken to confirmed to inspectors that they felt safe in the centre. They primarily attributed this to the staff being available to them at all times. They said that staff were respectful of them. They said there was always staff around to offer assistance as required.

There were no procedures for the safe keeping of residents' personal money or valuables. The administrative manager told inspectors that residents did not have access to their own money on a Sunday as the administration staff did not work on a Sunday.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures

Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings
Inspectors found that many aspects of the health and safety of residents, visitors and staff required improvement.

There were visitors' sign in books located at the entrance to the centre. This allowed the staff to monitor the movement of persons in and out of the building to ensure the safety and security of residents. The inspector observed visitors' daily signatures in the visitor's book.

There were significant improvements required in fire safety. Staff spoken with were clear about the procedure to follow in the event of a fire. Service records showed that the fire equipment was serviced in July 2011. The fire panels were in order and inspectors noted that fire exits were unobstructed. However, there were no routine inspections of fire exits carried out. Inspectors read the training records from July 2011 and found that not all staff had participated in the mandatory fire training within the past year. The administrative manager said she planned to organise training for October 2011 for the remaining staff. This was yet to be organised. There were no regular fire drills - the records showed that the last fire drill was carried out in May 2010. Although there were fire procedures, these were not sufficient. For example, the nearest assembly point was not identified on them.

There was an emergency plan which identified what to do in the event of any possible emergency. Alternative accommodation for residents was not available if evacuation was necessary. The person in charge and administrative manager said they were in the process of organising such a location.

There was no comprehensive risk management policy to guide practice. For example, the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents was not defined. The health and safety polices contained some aspects of the risk management policy which reflected the requirements of the Regulations. The behaviours that challenge policy covered assault, aggression and violence and self harm. There was no reference to these in the health and safety policy and it did not contain a policy on accidental injury.

Incident forms were used to record all accidents and incidents including falls. Inspectors found that there were no procedures in place for formal review of incidents to determine patterns and trends and to implement interventions to prevent them from reoccurring. The person in charge said she informally reviewed each incident with the staff and on some occasions recorded that the incident was closed. There were a number of "open incidents" and the person in charge said she did not have the time to review these.

There was document called a health and safety policy in place. However, there was no health and safety statement with risk assessments and control measures. A system to identify and assess environmental risks had been established since the previous inspection in that a risk management committee had been established to review non clinical risks in the centre. The administrative manager said the committee had met twice. This committee had identified some risks in the environment and relevant control measures which they were in the process of being implemented. For example, locks with key pads were installed on the doors throughout the building to minimise the risk of residents wandering.

Inspectors had concerns that some practices in relation to the management of risk did not sufficiently promote the safety of residents, staff and visitors and these had not been identified by the management. For example:

- there was a step into the sun room which could be a trip hazard
- the door saddle leading into the TV room had a raised section and was a potential trip hazard
- there was no self-closing device on the front door and no signage to remind those using the door to close this fully.

The environment was kept clean and well maintained and there were measures in place to control and prevent infection, including arrangements for the segregation and disposal of waste, including clinical waste.

Alcohol hand gels were available throughout the centre and staff had ready access to latex gloves and disposable aprons. The inspector saw staff utilising these infection control measures regularly.

Many staff had received training in infection control in 2009 but there were some practices which were not in line with best practice. For example:

- inspectors observed that cleaning trolleys were stored in the sluice rooms on both floors
- there was a lack of a consistent approach to the cleaning of commodes. Staff said they cleaned commodes daily but residents' care plans stated the commodes were to be cleaned twice weekly. The infection control policy included the procedures for the management of Methicillin-resistant *Staphylococcus aureus* (MRSA) only - this did not include the process for cleaning commodes
- the sink in the kitchen was used to wash dishes and the staff also used this sink to wash their hands
- there was no wash-hand basin in the sluice room. Staff were observed using the sluice sink to wash their hands
- the multi-task attendant worked in the kitchen and also performed cleaning duties while wearing the same uniform and only changed an apron between these tasks
- the was no personal protective equipment (PPE) available in the kitchen on the first floor and inspectors observed a staff member in this room without any PPE while food was being prepared.

Outcome 6
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings
Inspectors found evidence of good medication management processes but there were some areas for improvement. Inspectors observed the nurses on part of their medication rounds and found that medication was administered in accordance with An Bord Altranais guidelines.

Medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. These medications were counted at the time of administration and at the change of each shift. Nurses kept a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked the balances and found them to be correct.

The medication management policies guided the safe storage of medication but did not fully reflect the local practices in place for prescribing and administering medications. Nurses transcribed medication but there was no policy for the transcribing of medication to guide the practice. Staff members received telephone orders for residents' medication from the GP and there was no policy to guide this practice. Both of these practices were not in line with best practice. The nurses who spoke with inspectors were fully familiar with the medication policies and best practice.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents

Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings
Inspectors found a good standard of evidence-based nursing care and residents had access to appropriate medical and allied health care. Staff had undertaken considerable work in the area of care planning since the previous inspection. However, there were still some improvements required in the development of care plans and in the area of behaviours that challenge.

The person in charge and administrative manager completed the pre-admission assessments to ensure the needs of the potential resident could be met. The person in charge told inspectors how she and the administrative manager went to the hospital or home to meet prospective residents. Relatives confirmed that they had participated in a pre-admission assessment, including a visit to the centre to meet staff and residents before making a final decision to live there. There were no records maintained of the pre-admission assessment.

All residents had a file which included a range of assessments such as falls risk, pressure sore, manual handling and weight loss. Residents or relatives were involved in the process of care planning and inspectors read the relatives' signatures. Inspectors read a number of care plans and noted that the assessments did not always inform the care plan and while many of the care plans were person centered, some did not guide the care to be delivered. It was not always clear when the previous assessment had been completed.

Inspectors read care plans of a resident who had a wound and noted that there were adequate records of assessment and a plan in place to manage the wound. At the time of inspection, there were no residents with a pressure sore in the centre.

The centre had sufficient GP cover and residents were encouraged to retain their own GP. A review of residents' medical notes showed that GPs visited the centre regularly and the person in charge informed inspectors that GPs were contactable by phone any time to offer advice to staff. The sample of medical records reviewed also confirmed that the health needs and medications of residents were being monitored on an ongoing basis and no less frequently than at three-monthly intervals.

Residents' records confirmed that they could access a range of additional health services such as physiotherapy and occupational therapy in house on a weekly basis. Speech and language therapy, dietician, chiropody and optical care were available on a referral basis. Residents had been referred to the psychiatry of older age as required. Access to some of these services required an additional charge. The

inspector reviewed care plans and they contained details of referrals and appointments with the various health services. Staff promoted the residents' health by encouraging them to stay active. Residents were seen taking exercise during the day.

Inspectors found that there was a reactive approach to falls management. Residents were assessed for the risk of falling and inspectors reviewed the strategies in place for those residents who were at high risk. Measures in place to prevent falls or injury from falling included the use of profile beds and constant supervision of those at risk. The care plans for falls were in place and guided the care to be delivered. There was a falls management policy which had not been localised or fully implemented. Inspectors found the post falls assessments were not always completed after a resident fell.

The person in charge had not collected or analysed any information on falls, and information on the number of falls since January 2011 was not readily available. The person in charge had to contact the company supporting the computerised system to make this information available to inspectors. She had not accessed the information previously to identify trends and inform learning to improve the safety of residents.

There was a very comprehensive policy on the management of behaviours that challenge, but this had not been localised or implemented. A recognised assessment tool was referred to in the policy but was not used in practice. Inspectors reviewed residents' files and noted that the care plans for behaviours that challenge were not based on the individual assessed needs of residents. Residents' records did not include information regarding the triggers that prompted behaviours and the behaviour itself was not consistently recorded. This increased the potential for inconsistent response to these behaviours.

The person in charge and administrative manager said that a training session was planned for all care staff on the care of residents with dementia, which included behaviours that challenge.

Inspectors observed good practice in the management of restraint and an improvement since the previous inspection. Inspectors discussed the use of restraint with the person in charge and various staff members. The person in charge said she intended to receive training on the HSE national restraint policy to inform practice.

The person in charge said there was a considerable reduction in the use of bedrails since the previous inspection. Inspectors noted there was a full multi-disciplinary approach to the assessment and decision making process for the use of bedrails, which was in line with best practice.

The person in charge was not fully adhering to the policy on restraint in relation to consent for restraint. The inspectors read the restraint policy which stated that "family and others cannot insist or give permission to use restraint". Inspectors read consent forms for restraint signed by families.

The person in charge said there were ongoing discussions with relatives who had insisted on the use bedrails despite the staff nurses' clinical judgement to remove these.

There were risk assessments for those who required restraint. However, in the sample of care plans reviewed inspectors noted that the risk assessments did not include the alternatives tried. Inspectors read the policy on the use of restraint, which stated that "clear evidence that an extensive range of measures have been tried for a reasonable period of time and proved unsuccessful in maintaining safety".

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

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

Inspection findings
Inspectors were satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided in centre. Staff had received training in palliative/end-of-life care in 2009 and the person in charge said she planned to provide a refresher training session to staff in 2012 to enhance the good practice. However, the policy in this regard was not comprehensive or centre-specific and it did not guide practice. For example, the policy stated that overnight facilities were available, but this was not the case.

The person in charge described how she discussed the residents' wishes with their families. The local palliative care team also provided support and advice when required. These measures were not included in the policy.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings
Inspectors were satisfied that residents received a nutritious and varied diet. Mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff.

There was a dining room on the ground floor and a number of residents chose to eat in their own rooms. Staff were seen to assist residents with their meals discreetly and respectfully if required. Residents confirmed that they enjoyed the food.

Residents' dietary requirements were met to a high standard. The chef discussed with inspectors the special dietary requirements of individual residents and information on residents' dietary needs and preferences was recorded.

However, residents and relatives said that choice at the main meal was limited. Inspectors observed that residents were not offered a choice at the main meal but the chef said if a resident wanted some thing other than what was on the menu, she would provide this. This choice was not freely offered to residents.

Inspectors saw residents being offered a variety of snacks and drinks. Staff regularly offered drinks to residents. Residents told inspectors that they could have tea or coffee and snacks any time they asked for them. The chef did home baking daily and said she also used the vegetables from the garden in the cooking.

Weight records were examined which showed that residents' weights were checked monthly or more regularly if required. Nutrition assessments were used to identify residents at risk. Records showed that some residents had been referred for dietetic review. The treatment plan for the residents was recorded in the residents' files. Medication records showed that supplements were prescribed by a doctor and administered appropriately.

4. Respecting and involving residents

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

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

Inspection findings
Inspectors were satisfied that this outcome was achieved.

All residents had contracts of care and inspectors read a random sample of completed contracts. They noted that they set out the overall care and services provided to the residents and the fees charged, including any additional fees charged. Residents spoken with were aware of their contracts.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

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

Inspection findings
Residents' privacy and dignity were respected by staff. Inspectors observed staff closing screens tightly when attending to personal care, knocking on toilet and bathroom doors and waiting for permission to enter. Residents were dressed well and according to their individual choice. Inspectors observed staff interacting with residents in a courteous manner and addressing them by their preferred name. Inspectors also heard good humoured banter which the residents were enjoying.

There was one area of dignity that required improvement. Inspectors saw residents' toiletries in unlabelled containers in the bathrooms. This was identified at the previous inspection and was not addressed.

Residents' civil and religious rights were respected. Mass took place every Friday in the oratory. Several residents commented on how important this was to them. The person in charge said that residents from all religious denominations were supported to practice their religious beliefs.

The person in charge told inspectors how she promoted links with the local community. She said a sale of work was planned in a local school in September and all of the residents would be attending. Families told inspectors they were very involved in the care of the residents and often brought residents out for the day. The person in charge told inspectors of the garden parties held in the centre and that families were invited.

Residents who were independent had an excellent quality of life, from going out to buy the newspapers, helping out in the kitchen and dining room and one resident said she phones the library and requests books which are then delivered. Another resident had a laptop computer and she showed the inspectors the emails she received from friends. A schedule of activities was available and inspectors saw notices outlining the day's events in each of the areas. There were no activities planned for any morning. An activity person visited the centre once a week and some residents joined in this group. Inspectors observed care assistants providing hand

massage and manicures to residents. They described to inspectors how they read books to residents and chatted to them. Staff brought residents out for a walk in the garden. The provider visited the centre every Friday and played scrabble with the residents and residents confirmed they enjoyed this. This was observed by inspectors on the day of the inspection.

Residents who were confused or who had dementia related conditions were not encouraged to participate in the activities. The occupational therapist (OT) told inspectors of the plans to develop a programme of activities for these residents and she had provided informal education for staff in the provision of reminiscence and group work. Inspectors observed many residents remaining in their bedrooms for the day and while staff spent time with them, this could be further enhanced by providing meaningful activation appropriate to the needs of the residents.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings
There were arrangements in place for regular laundering of linen and clothing.

In some cases clothing was marked discreetly by relatives and all residents' clothes were folded and returned to the resident's cupboards by the laundry worker. Residents and relatives expressed satisfaction with the service provided and the safe return of their clothes to them. They said that there were no episodes of clothing going missing. Residents told inspectors that they were satisfied with the laundry arrangements.

Inspectors spoke to a staff member about the processes in the laundry and found that she were knowledgeable about infection control and the different processes for different categories of laundry.

Residents were well dressed and cared for in their appearance. The provider said they were in the process of implementing personal property lists for all residents. Samples of the property record were shown to inspectors but these were not yet completed. Inspectors observed the arrangements in place for residents to do their own laundry if they wish. While this was good practice, as it maintains the residents' independence, there was no risk assessment completed to ascertain the risks and control measures.

5. Suitable staffing

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

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

Inspection findings
The post of person in charge was full-time and held by a registered nurse with extensive experience and relevant knowledge on caring for older people and managing staff. She was a qualified general and psychiatric nurse and has been the person in charge since 1997.

The person in charge's knowledge of the Regulations and Standards and her statutory responsibilities was sufficiently demonstrated to inspectors both during the fit person interview and throughout the inspection. However, she did not have the authority, accountability and responsibility for the provision of the service. Inspectors observed that she was very involved and committed to the clinical aspect of her role. Apart from eighteen hours per week for three weeks of the month, she worked full-time on the floor delivering care to residents. She explained to inspectors that she knew her legal responsibilities as defined in the Regulations. However, inspectors noted that while she was competent in her role, her job description related more to the role of a senior nurse than that of a person in charge.

She was a member of the operational management team and senior management team but in practice she did not engage fully in the management and governance aspect of the role. The supervision of staff on a day-to-day basis was not formalised as the person in charge worked on the first floor and only visited the second floor if required or time allowed. There were no audits, informal complaints were not recorded and the person in charge did not have the opportunity to ensure evidenced based best practice was being delivered. The person in charge said she had difficulty getting time to manage her case load, meet the GPs and the relatives. The person in charge was on call at all times.

A senior nursing staff deputised in the absence of the person in charge and this staff member also had a case load and could not supervise the care delivered. This staff member did not know what she should do if there was an allegation of abuse.

Outcome 14
There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings
There was a written operational recruitment policy - this needed to be amended to reflect the actual practice.

Inspectors were not satisfied with the current staffing levels. There was one nurse and two carers on night duty. While negative outcomes for residents were not apparent on the day, there was no process to ensure that at all times the numbers of staff were appropriate to the assessed needs of residents and the size and layout of the designated centre. See Outcome 13 in relation to staffing and the role of the person in charge.

The person in charge told inspectors that she based staffing levels on the dependencies of the residents and the layout of the premises. However, she said she did not have control over the staffing levels at all times. There were three nurses on duty on the day of the inspection, which included the person in charge. There was an additional nurse on duty on the day of the inspection to free up the person in charge during the inspection. Non clinical staff were not included on the rota, as required by the Regulations.

Staff turnover was very low and most of the staff had worked in the centre for a number of years. They were knowledgeable about residents, had established a good relationship with them and inspectors saw them responding to residents' needs in an informed way.

Inspectors examined four staff files. All staff files contained some of the information required by the Regulations. However, the staff files did not contain three references and or a medical declaration as required by the Regulations.

Bank staff were used when required to cover planned and unplanned absences. These staff members' files were viewed and they did not meet the Regulations in that the only information contained within the files was a contract of service and the four nurses' An Bord Altranais registration for 2011. There was no evidence that these staff members had undertaken mandatory training.

There were some volunteers that visited the centre. The administrative manager said she had not considered the Regulation in the recruitment of volunteers, in that there was no vetting appropriate to the role.

Induction arrangements for newly employed staff were informal. The person in charge and administrative manager said they had completed four performance appraisals with staff and were rolling this out to all staff. Inspectors read one of the completed appraisals. This good practice could be further enhanced if the outcomes of the appraisals were linked to the training and development plans.

The provider and person in charge were committed to providing ongoing training to staff. Training had been undertaken in 2010 and 2011 including training on medication management, venepuncture, dysphagia, manual handling and cardio pulmonary resuscitation (CPR). Training records showed that 9 of the 14 healthcare assistants had Further Education and Training Awards Council (FETAC) Level 5 training or higher and 2 health care assistants had completed FETAC Level 5. Staff spoken with confirmed how much they had enjoyed doing this training and how it helped them in their work.

There were good communication among staff about residents needs during the day. This was further enhanced by formal staff meetings held frequently. The minutes of these meetings were viewed by the inspectors.

The provider attended the operational management team meetings which were held fortnightly. Inspectors read these minutes and noted they contained issues such as residents changing needs and environmental issues. The minutes were found to be comprehensive.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

For the most part the location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs. However, there were some significant areas for improvement. Please also refer to Outcome 5.

The décor was domestic, with warm colours and pictures on walls throughout. The building was well maintained externally but required some repainting in some of the interior. There was a good standard of private and communal space and facilities. Residents reported that the centre offered a homely comfortable environment and told inspectors that they enjoyed the lifestyle provided. Communal areas such as the day-rooms had a variety of pleasant furnishings and comfortable seating. These

spaces were not utilised very often by residents as many residents said they preferred to remain in their bedrooms.

Separate staff toilets and changing facilitates were provided for catering and care staff in accordance with best practice for infection prevention. Locker facilitates were provided for the storage of staff personal belongings.

Residents had access to the outdoors during the fine weather. A door on the ground floor led out to a secure garden which residents could use unaccompanied. Residents also had access to a larger garden where the garden parties are held. Residents told the inspector that they enjoyed spending time in the gardens during fine weather.

There was an insufficient number of assisted toilets, showers and baths provided to meet the needs of the residents. There were no accessible toilet facilities for visitors. While there were sufficient toilet facilities available for residents, there were no assisted toilets on the ground floor near the dining room or on the first and second floor.

There were two assisted showers for resident use, there was also a separate shower unit and bathroom for independent residents. However, the person in charge said they were seldom used as there were very few residents who were independent. The provider said the management team were planning a refurbishment and extension programme to address the lack of toilets and showers by July 2015 as required by the Standards.

The majority of bedrooms were single and the twin rooms were currently being used as single rooms. They were appropriate size to meet the needs of the residents. There was adequate personal storage space in all bedrooms. There was a three-bedded room on the first floor that did not meet the requirements of the Standards.

The inspector found that the temperature of hot water in room eleven was 55.9 degrees Celsius. The water temperature in the sink in room six was 53.1 degrees Celsius. This exceeded the recommended temperatures in the Standards and posed a burn or scald risk to residents.

There was appropriate assistive equipment available such as hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. Handrails were available to promote independence. While there was sufficient assistive equipment available, the provider had not ensures that the equipment was maintained in a safe condition for use by residents and relatives. There was no service maintenance contract available for the stairs lift and there was no evidence that hoists were serviced.

There was a lack of storage space, inspectors observed a Christmas tree stored in a resident’s bedroom.

7. Records and documentation to be kept at a designated centre

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

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

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

Resident's Guide

Substantial compliance ☒ Improvements required * ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required * ☐

General Records (Schedule 4)

Substantial compliance ☒ Improvements required* ☐

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required* ☒

Inspectors read a number of the centres polices as outlined in Schedule 5 of the Regulations and noted that they did not guide practice. Many staff were not aware of the content of these.

Directory of Residents

Substantial compliance ☒ Improvements required* ☐

Staffing Records

Substantial compliance ☒ Improvements required* ☐

Medical Records

Substantial compliance ☒ Improvements required* ☐

Insurance Cover

Substantial compliance ☒ Improvements required* ☐

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

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

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

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

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

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

Inspection findings
There were appropriate arrangements in place for the absence of the person in charge.

There was a senior nurse who deputised for the person in charge. The person in charge and provider were aware of their responsibilities to notify the Authority when the person in charge is absent for an extended period but as yet this was not required.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, person in charge and the administration manager to report on 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:

Linda Moore

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

16 September 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report

Centre:	St. Mary's Nursing Home
Centre ID:	0103
Date of inspection:	14 and 15 September 2011
Date of response:	11 November 2011

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

Outcome 1: Statement of purpose and quality management

1. The provider is failing to comply with a regulatory requirement in the following respect: The statement of purpose did not include all matters listed in Schedule 1 of the Regulations.	
Action required: Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.	
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 will be updated to include all matters listed in Schedule 1 of the Regulations.	Mid December 2011

Outcome 2: Reviewing and improving the quality and safety of care

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

The quality of care and experience of the residents was not monitored or developed. The person in charge had not collected or analysed any information to improve the service for example information on falls.

Action required:

Review the quality of care and experience of the residents on an ongoing basis.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Email sent by the Provider to the inspector on 13/10/2011 details the intention to recruit an additional staff nurse. Recruitment is in progress and we expect this to be completed by 30 November 2011. This will allow the director of nursing the time to analyse information to improve the service provided to residents through auditing and follow-up.	End November 2011

Outcome 3: Complaints Procedures

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

The complaints policy and complaints procedure did not comply with all the requirements of the Regulations. For example, the complaints procedure did not include an independent appeals process.

The complaint record did not include the complainant's level of satisfaction with or how the complaint was managed.

Action required:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Maintain a record of all complaints detailing the outcome of the complaint and whether or not the resident was satisfied.	
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 procedure will be updated and an independent person identified in the appeals process. Complaints log will be updated with the necessary information regarding the outcome of the complaint and the residents' satisfaction or otherwise with the outcome.	 End November 2011 Mid November 2011

Outcome 4: Safeguarding and safety

4. The provider is failing to comply with a regulatory requirement in the following respect: The policy on and procedures for the prevention, detection and response to abuse did not guide practice and inform staff.	
Action required: Put in place a policy on and procedures for the prevention, detection and response to abuse.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The policy on and procedures for the prevention, detection and response to abuse are being further updated.	 End December 2011

Outcome 4: Safeguarding and safety

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

Not all staff displayed sufficient knowledge of the different forms of elder abuse and were not clear about procedures in place for reporting an allegation of abuse.

There were no procedures for the safe keeping of residents' personal money or valuables.

Residents did not have access to their own money on a Sunday as the administration staff did not work on a Sunday.

Action required:

Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Develop policies and procedures relating to residents personal property and possessions.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 7: Residents personal Property and Possessions
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Training on elder abuse for non-clinical staff will take place early in the new year.	End January 2012
Policy is currently being written relating to the safe-keeping of residents personal money and valuables.	End November 2011
A procedure whereby residents for whom the home holds pocket money will be able to access that money at any time, including Sundays, is being put in place immediately.	Mid November 2011

Outcome 5: Health and safety and risk management

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

The risk management policy did not include all aspects of the Regulations and was not implemented throughout the designated centre.

The arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents, was not defined.
Action required: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Risk Management policy is currently being developed through the risk management committee. Training on risk management will be undertaken by the Director of Nursing and Administrative Manager early in 2012.	End March 2012
We have identified medication error as a clinical risk and have in place drug error recording forms, three-monthly GP Kardex reviews, monthly audits by the pharmacist with our nurse, updated anti-coagulant chart.	In place
Deviation from good infection control practice is a potential clinical risk. Staff are aware of local policy and adhere to this.	In place
Nursing staff are fully conversant with these practices and any relevant issues are discussed at nursing meetings. Following on from this, learning outcomes are developed as necessary. To date no issues have arisen.	In place
A further detailed review will take place following risk management training being undertaken in early 2012 by the Director of Nursing and Administrative Manager.	End April 2012

Outcome 5: Health and safety and risk management

7. The provider is failing to comply with a regulatory requirement in the following respect:
The records showed that the last fire drill was carried out in May 2010. Not all staff had attended fire training.

Action required: Make arrangements for persons working at the designated centre to receive suitable training in fire prevention.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Additional fire training for those staff who were unable to attend the previous session has been arranged. A fire drill will be carried out as part of this training session.	17/11/2011

Outcome 5: Health and safety and risk management

8. The provider is failing to comply with a regulatory requirement in the following respect: The emergency plan did not include alternative accommodation for residents should evacuation be necessary.	
Action required: Update the emergency plan to include alternative accommodation for residents should evacuation be necessary.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The emergency plan is currently being updated and arrangements are being put in place for alternative accommodation for residents.	End November 2011

Outcome 5: Health and safety and risk management

9. The provider is failing to comply with a regulatory requirement in the following respect:
There was a step into the sun room which was not identified and could be a trip hazard. The door saddle leading into the TV room had a raised section, which would be a potential trip hazard. There was no self closing device on the front door and no signage to remind those using the door to close this fully. There was no risk assessment completed to ascertain the risks and control measures for residents who do their own laundry.
Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
A reflective strip will be installed on the step into the sunroom	End November 2011
The door saddle to the TV room will be upgraded to remove the potential trip hazard.	End November 2011
A self-closing device for the hall door is under review and will be installed as soon as possible. Signage is now in place.	End November 2011
A risk assessment will be completed to ascertain the risks and control measures for residents who do their own laundry.	End November 2011

Outcome 5: Health and safety and risk management

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

Many staff had received training in infection control in 2009 but there were some practices which were not in line with best practice. For example:

- inspectors observed that cleaning trolleys were stored in the sluice rooms on both floors
- there was a lack of a consistent approach to the cleaning of commodes and the infection control policy did not provide adequate directions for staff
- the sink in the kitchen was used to wash dishes and the staff also used this sink to wash their hands
- there was no wash-hand basin in the sluice room. Staff were observed using the sluice sink to wash their hands
- the multi-task attendant worked in the kitchen and also performed cleaning duties while wearing the same uniform and only changed an apron between these tasks
- the was no personal protective equipment (PPE) available in the kitchen on the first floor and inspectors observed a staff member in this room without any PPE while food was being prepared.

Action required:

Develop and implement operational policies and procedures relating to heath and safety, including food safety of residents, visitors and staff.

Reference:

Health Act, 2007
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Alternative storage for cleaning trolleys is being sought in the context of planning for the provision of wheelchair accessible toilets.	End March 2012
Policies on the use, cleaning and infection control of commodes has been reviewed, updated and implemented.	In place
Installation of wash-hand basins in ward kitchens and sluice is under review with the intention to install these as soon as practicable.	End March 2012
Kitchen uniform has been ordered for multi-task attendants.	Mid November 2011

PPE is now available in both ward kitchens for staff.	In place

Outcome 6: Medication Management

11. The provider is failing to comply with a regulatory requirement in the following respect: The written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents did not guide the practice.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Relevant practices have been reviewed, are being updated, and will be implemented.	Mid November 2011

Outcome 7: Health and social care needs

12. The provider is failing to comply with a regulatory requirement in the following respect: A high standard of evidence based nursing practice was not delivered in the areas of behaviours that challenge and falls management. New practices in relation to restraint had not been implemented fully.
Action required: Provide a high standard of evidence based nursing practice.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Training in challenging behaviour is scheduled for early 2012 for all nurses and HCA's. Falls management and restraint practices are continuously under review by nurse, occupational and physiotherapist, in conjunction with residents, their families/representatives. These will be fully audited again by the person in charge when new staff have been recruited, as per response 2. Currently residents with behaviours that challenge are monitored daily. Care plans are appropriately reviewed and updated. The family/representative involvement is sought and through experience has been beneficial. Treatment and management is planned as evidenced in care plans. Assessment and treatment is by a multi-disciplinary team comprising of nursing home nurses and HCA's, GP, Psychiatrist, Community Psychiatric Nurse, Physiotherapist, Occupational Therapist and Activities Coordinator. Other services, such as Medicine for the Elderly, are accessed as appropriate.	 End March 2012 End January 2012 In place

Outcome 7: Health and social care needs

13. The provider is failing to comply with a regulatory requirement in the following respect: Resident's assessed needs were not set out in an individual care plan.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Assessments and care plans are being updated to provide cohesive care based on assessed needs, with appropriate care planning.	 Mid December 2011

Outcome 7: Health and social care needs

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

Residents who were confused or who had dementia related conditions were not encouraged to participate in the activities.

Action required:

Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Arts and crafts activities for the residents are now in place as part of a programme delivered by a qualified part-time (three days per week) activities coordinator.	In place

Outcome 9: Food and nutrition

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

There was no choice offered to residents at the main meal.

Action required:

Provide choice at each meal time.

Reference:

Health Act, 2007
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Meal choices are now displayed on the daily menu.	In place

Outcome 13: Suitable person in charge

16. The provider is failing to comply with a regulatory requirement in the following respect: The person in charge was not undertaking the role and functions of the person in charge with authority and responsibility for the provision of the service. She told inspectors that she could not undertake the role of the person in charge due to her case load.	
Action required: Make arrangements for the person in charge to fulfil her governance, operational management and administration duties in the designated centre on a regular and consistent basis.	
Reference: Health Act, 2007 Regulation 15: Person in Charge Standard 27: Operational Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As per response 2, recruitment is currently under way for a staff nurse in order to allow the person in charge carry out these duties more effectively.	End November 2011

Outcome 14: Suitable staffing

17. The person in charge is failing to comply with a regulatory requirement in the following respect: The numbers and skill-mix of staff were not appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
Action required: Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Staff levels and skill mix have been reviewed. Additional staff nurse is currently being recruited. The nurse who acts as deputy person in charge is to receive relevant management training and the authority of the deputy will be formalised.	 End March 2012

Outcome 14: Suitable staffing

18. The person in charge is failing to comply with a regulatory requirement in the following respect: There was a written operational recruitment policy - this did not reflect practice. All staff were not included on the rota, as required by the Regulations. Staff files did not contain all of the documents as specified in Schedule 2 of the Regulations. Volunteers were not vetted appropriate to the role. Their roles and responsibilities were not defined.	
Action required: Revise the recruitment policy to reflect practice.	
Action required: Obtain all documents for all staff as specified in Schedule 2 of the Regulations.	
Action required: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.	
Action required: Volunteers should have their roles and responsibilities defined. Volunteers should be vetted appropriate to the role.	
Reference: Health Act, 2007 Regulation 18: Recruitment Regulation 34: Volunteers Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response:	
The recruitment policy is currently being reviewed and updated.	End November 2011
Required documentation for all staff has been requested and is currently being gathered.	Mid December 2011
A roster has been established for all non-clinical staff.	In place
Roles for volunteers are being clarified and appropriate contracts have been drawn up.	End November 2011
Garda Vetting is being sought where not already obtained.	2012

Outcome 15: Safe and suitable premises

19. The provider is failing to comply with a regulatory requirement in the following respect: There was a three-bedded room on the first floor that did not meet the requirements of the Standards. There was an insufficient number of assisted toilets, showers and baths provided to meet the needs of the residents. There were no accessible toilet facilities for visitors. The inspector found that the temperature of hot water presented a risk of scalding to residents.	
Action required: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.	
Action required: Provide sufficient numbers of toilets, and wash-hand basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response:	
The current three-bedded room will be reduced to a two-bedded room by the required date of 2015.	2015
The number of assisted toilets, wash basins, baths and showers is currently being assessed and equipment, including thermostatic control valves, will be installed as appropriate.	2012
The thermostat on the hot water tank has been replaced.	In place

Outcome 15: Safe and suitable premises

20. The provider is failing to comply with a regulatory requirement in the following respect: While there was sufficient assistive equipment available, the provider had not ensures that the equipment was maintained in a safe condition for use by residents and relatives.	
Action required: Maintain the equipment for use by residents or people who work at the designated centre in good working order.	
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: Maintenance contracts are currently being put in place with the relevant suppliers for all equipment.	End November 2011

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

21. The provider is failing to comply with a regulatory requirement in the following respect: The centres polices as outlined in Schedule 5 of the Regulations did not guide practice. For example the end of life policy. Staff were not aware of the content of these.
Action required: Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.

Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All relevant policies listed in Schedule 5 will be put in place.	End February 2012

Any comments the provider may wish to make:

Provider's response:

St. Mary's is a small home, originally a residential home with some nursing care, which has been providing a service for many years in a listed building close to Donnybrook and Herbert Park.

We are striving to further upgrade our facilities in compliance with the new Regulations without diminishing the homely atmosphere of our Victorian buildings.

We were delighted that the inspectors recognised the commitment of our staff and the excellent relationship between staff and residents. We are anxious to fulfil the documentation requirements of the Regulations without reducing the quality of this relationship.

Provider's name: St Mary's Home Pembroke Park Association
Date: 11 November 2011