Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report Designated Centres under Health Act 2007

Centre name:	Larchfield Park Nursing Home
Centre ID:	0056
Centre address:	Monread Road, Naas, County Kildare
Telephone number:	045 875505
Fax number:	045875277
Email address:	info@larchfieldpark.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Larchfield Park Nursing Home Ltd
Person authorised to act on behalf of the provider:	Sara Dillon
Person in charge:	Sara Dillon
Date of inspection:	5, 6, 7, 18 and 20 July 2011
Time inspection took place:	**Day-1 Start:** 09:40 hrs **Completion:** 19:30 hrs **Day-2 Start:** 07:45 hrs **Completion:** 19:30 hrs **Day-3 Start:** 08:30 hrs **Completion:** 19:30 hrs **Day-4 Start:** 09:00 hrs **Completion:** 19:00 hrs **Day-5 Start:** 09:05 hrs **Completion:** 14:30 hrs
Lead inspector:	Nan Savage
Support inspector:	Angela Ring (5, 6 and 7 July 2011) Carol Grogan (18 and 20 July 2011) Vicky Blomfield (18 July 2011)
Type of inspection:	☒ **Registration** ☒ **Announced**

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

Larchfield Park Nursing Home is located on the Monread Road approximately 2.5 kilometres from Naas town centre, County Kildare. Larchfield Park is a single storey purpose-built residential centre which opened in 1987 and is registered for 57 places. Bedroom accommodation consists of 29 single rooms, 11 two-bedded rooms and two three-bedded rooms.

Communal areas consist of a main day room and separate dining room, a smaller day room located in the west wing and a combined sitting/dining room referred to as the sun room. There are three enclosed courtyards. Smoking facilities are provided for residents in a glazed corridor area.

Car parking is available to the front of the centre.

Date centre was first established:			1987	
Number of residents on Day-1 of inspection:			51 + 2 in hospital*	
Number of vacancies on the day 1 of inspection:			4	
Dependency level of current residents on Day-1 of inspection:	**Max**	**High**	**Medium**	**Low**
Number of residents	17	11	7	16
Gender of residents			**Male (✓)**	**Female (✓)**
			16	35

* Over the course of the five day inspection the number of residents ranged from 47 to 53.

Management structure

The Provider is Larchfield Park Nursing Home Ltd and Sara Dillon, one of the Directors, is the person named to act on behalf of the company. Sara Dillon is also the Person in Charge. The Person in Charge is supported in her role by a General Manager, Bernadette Dillon, who is also the Financial Controller. In the Person in Charge's absence a Senior Staff Nurse deputises for her. Care assistants and housekeeping staff report to the senior nurses on duty. Catering staff and the maintenance person report to the Person in Charge. There is an administrative support person and a receptionist during the week.

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

This report sets out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority (the Authority) for registration under Section 48 of the Health Act, 2007. Significant safety and care issues were identified during the initial stages of the inspection and the process was subsequently extended over a 15 day period while inspectors ensured that the provider had adequately responded to these concerns.

Inspectors met with residents, relatives and staff members over the five days of inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Fit person interviews were carried out with the provider in her dual role as provider and person in charge. The fit person self-assessment document was completed in advance of the inspection. The person in charge informed inspectors that the she had completed this document in conjunction with the general manager. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

Although there was evidence of good practice in some areas during this inspection, inspectors were very concerned that appropriate measures were not in place to manage the use of restraint and this had resulted in serious injuries occurring to some residents. Inspectors were also very concerned that some residents had experienced a high number of falls and yet there had been no learning to improve practice and reduce the risk of falls for these residents. As a result of inspectors concerns, the registration inspection was suspended on day two and an immediate action plan was issued requiring the provider to address these risks. The provider responded appropriately to the significant risks identified in the immediate action plan. Practices were reviewed and new systems were put in place to promote residents' safety. Inspectors visited the centre on 7 July 2011 to further monitor the management of risks to the safety of residents and the registration inspection was resumed on the 18 and 20 July 2011.

Improvements were required to some aspects of the medication management process. While some residents' care plans were adequate, significant gaps were identified in other parts of the care planning process that resulted in the current needs of some residents not being met. The provider responded to these areas during the inspection. Inspectors found that residents had good access to allied health services and had regular medical reviews by their general practitioner (GP). Residents had access to a range of activities and interesting events and were supported to exercise choice in most areas.

Improvements were required to the centres' statement of purpose in order to accurately reflect the services and facilities currently available to residents. Other improvements were also required. For instance, the risk management policy did not include risk assessments for all areas of the centre and some operational policies did

not reflect contemporary, evidence based practice and did not guide staff practice. These are discussed under the outcome statements and related actions 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

The statement of purpose did not meet all of the requirements in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

While inspectors received an amended copy during the inspection which addressed most of the gaps identified, there were still some areas that required improvement. For example, inspectors found that the statement of purpose did not accurately reflect the range of needs that the centre intended to met. The needs of some residents who were currently living in the centre were not included such as those with an intellectual disability and residents with dementia. Inspectors also noted that under nursing care the type of post operative care was not clearly described.

Additional issues included inaccurate provider details in the organisation structure and the arrangements made for dealing with complaints did not include an independent appeals process. Inspectors also noted that other required information was absent such as the arrangements for the separate day-care centre.

Outcome 2

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

References:

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

Inspection findings
There were no systems in place to review the overall quality and safety of care and quality of life of residents.

Inspectors found that there were no audits carried out in areas such as complaints management, falls, incidents and accidents to identify trends, target improvements and inform learning in the overall quality and safety of care. While the person in charge had begun to gather statistics on falls, this information had not been analysed and used to educate staff and improve practice. Inspectors also noted that some of this information was not accurate.

The person in charge and general manager had informed inspectors that she planned to put in place methods to review the quality of life of residents. For example, the general manager told inspectors during the feedback meeting at the end of the inspection that they were in the process of completing a resident satisfaction survey.

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
Improvements were necessary in the management of complaints. For instance, inspectors were concerned that some issues raised by relatives had not been acted upon and that there was not an effective appeals procedure in place.

The complaints policy was displayed and not a complaints procedure as required by the Regulations. The policy was in small print and therefore not clearly visible. The complaints policy did not fully comply with the requirements set down in the Regulations. For example, the appeals process was confusing and not clearly outlined. The policy identified the person in charge as the person who completes an investigation into the complaint if the complainant was not satisfied with the initial response. During the fit-person interview the person in charge stated that residents would be referred to advocacy groups if they were not satisfied with the outcome of the complaint investigation. However, no arrangements were in place with an advocacy group to carry out this role. Inspectors also noted that a second nominated person had not been appointed as required in the Regulations to ensure complaints were properly recorded and inspectors noted that the Authority was incorrectly included as part of the centre's own complaints policy.

All complaints made to staff were not being recorded as a complaint in the complaints register. Inspectors reviewed narrative nursing notes which confirmed that some issues had been raised by relatives but had not been viewed as a complaint. For example, inspectors noted that a relative had expressed

dissatisfaction with the management of falls and accidents and suggested that this be reviewed. This had not happened.

Inspectors found that complaints that were recorded had adequate detail of the issue but the satisfaction level of the complainant with the outcome of the investigation was not consistently recorded. Some relatives who completed questionnaires indicated that they had never any complaints while others confirmed that they had made complaints and one of these residents stated that their complaint was dealt with to a limited extent.

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

Specific arrangements were in place to protect residents from abuse and the provider and person in charge monitored some safeguarding practices in the centre. They regularly spoke to residents and relatives and ensured that the staff had received training on the prevention and detection of elder abuse. However, some improvements were identified to improve safeguarding arrangements and comply with Regulations.

The acting director of nursing and the general manager had completed a "train the trainer" course on the prevention and detection of elder abuse. Training records confirmed that staff had received training in this area. When questioned, staff on duty demonstrated knowledge of the different types of elder abuse and clearly described the reporting procedures.

Inspectors reviewed the policy on the prevention of elder abuse and found that the information was general and did not include clear guidance on the prevention, detection and response to abuse. The policy also stated that the Authority can be contacted directly by staff. However, this was not in line with the Regulations which state that the person in charge is legally responsible for informing the Authority without delay of any allegation of abuse, whether suspected or confirmed.

Financial arrangements were in place for managing residents' monies but these arrangements were not robust. Up-to-date statements were maintained for two residents' accounts that were being managed by the person in charge. Although the person in charge was responsible for the management of residents' monies, she was not clear what personal monies were maintained on behalf of some residents. An inspector viewed a sample of residents' monies and found that the balances tallied with the records maintained. However, safeguards such as having all individual

transactions clearly recorded and signed by two staff members were not in place. Inspectors also noted that one resident's personal money was not maintained in accordance with procedures outlined in the centre's own policy on residents' personal property and was instead held by a nurse. The inspector also noted that arrangements were not in place at weekends to enable residents to have access to their money.

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
Systems were in place relating to the health and safety of residents but these systems did not fully promote or ensure the safety of residents, staff and visitors.

The provider had taken specific fire precautions to protect residents, staff and visitors' safety. Fire safety equipment was adequately serviced and maintained. Service records showed that the fire alarm system was serviced on a three-monthly basis, the emergency lighting and fire equipment on a yearly basis. The person in charge stated that monthly fire drills now took place and records viewed confirmed this to be the case. On day one and two of the inspection, procedures to be followed in the event of a fire were not displayed in a prominent place in the centre that was visible to residents and visitors. Prior to the completion of the inspection the person in charge had addressed this matter.

However, some new staff that had been employed since January 2011 had not received formal fire safety training. Records viewed also confirmed that these staff members had not received induction training on fire safety. An inspector spoke to one of these staff members who stated that he/she had not received fire safety training. During the feedback meeting the general manager informed inspectors that fire safety training had now been arranged for 22 and 26 August 2011.

Written confirmation from a competent person confirming that the centre was in substantial compliance with all fire and building control regulations as part of the application for registration was submitted prior to the inspection. However, this letter did not confirm that the new extension was also in substantial compliance.

Health and safety audits were completed by the general manager and covered areas including fire safety and physical hazards. The most recent audit carried out on 16 June 2011 identified areas of risk such as the car park which was uneven due to ongoing building works. The hazardous part of this car park had been screened off and the general manager informed an inspector that works to this area would be

completed by 9 August 2011. The general manager had also identified the need for infection control training and staff were provided this training on 23 June 2011.

The provider had developed a centre-specific risk management policy. While the policy included risk assessments for most areas in the centre, some areas had not been assessed and this posed a risk to residents', staff and visitors' safety. For example, a risk assessment had not been carried out for the internal courtyards and garden. Inspectors identified some hazards in these areas that posed a risk to residents' safety such as uneven paving. Also, on a number of occasions during the inspection the side gate from the enclosed garden was left open and this lead to the front car park and adjacent busy road. Other areas such as the kitchenettes in the sun room had not been fully risk assessed. Inspectors also noted that a risk assessment had not been undertaken for the new extension. The general manager informed inspectors that plans were in place to update the risk management policy.

Some other risks were identified during the early stages of the inspection. For instance, cleaning chemicals were left unattended in a wall rack which posed a risk to vulnerable residents. Risks to residents' safety were also identified as a result of some unsafe practices while contractors worked in the centre. There were no warning signs displayed in the vicinity of where a contractor was working to advise staff or residents of this risk. These matters were addressed prior to completion of the inspection.

The risk management policy included measures to identify, record, investigate and learn from serious or untoward incidents or adverse events involving residents. However, these measures had not been implemented into practice as outlined in outcome seven. Inspectors also found that an accident report form was not completed for all accidents and incidents that had occurred which meant that the statistics gathered by the person in charge were not accurate. Inspectors noted that other aspects of the risk management policy did not inform practice. For instance, the policy stated that a hazard analysis form would be discussed at staff meetings to inform staff of learning from untoward incidents but this was not happening in practice.

Although the general manager and a senior staff nurse were qualified moving and handling instructors, safe practices had not been fully established and not all staff had received this training in the past two years, as required. Inspectors noted that training had been planned for staff who had not been trained within the past two years. The course content and certificates of training for other staff were available and reviewed by inspectors. However, inspectors observed one incident where two staff were lifting a resident from a chair in a manner that could have resulted in injury to the resident and staff.

An emergency plan for the centre was in place but inspectors found that it required some improvement. The plan included details of the premises to which residents could be evacuated in the event of an emergency. Contact telephone numbers of management and emergency services were also included as well as arrangements in the event of the centre having to be evacuated. Staff were familiar with the plan and what action they would take during an emergency. The person in charge had also put in place adequate controls to monitor all visitors to the premises. However, the

plan did not contain guidance for specific emergencies such as power outage and flooding.

Inspectors identified some practices which posed a risk of infection. For example:

- a residents' communal bathroom was also used to wash and store commode basins. A stainless steel sink including a storage shelf below the sink was located in the bathroom. Staff informed inspectors that this sink was used to wash commode basins and also for hand-washing

- inadequate facilities were provided for staff to change into their uniforms which resulted in staff changing in a staff toilet. Staff outdoor clothing and uniforms were also stored in the staff toilet

- adequate facilities were not provided to wash and disinfect cleaning equipment. Inspectors found that cleaning equipment including mop buckets were stored in the laundry room.

Inspectors noted that the provider had planned to address these issues with the provision of new facilities in the extension that was being completed at the time of inspection.

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

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

Inspection findings
Some good practices were noted in medication management but inspectors found that some aspects of the medication management processes required improvement.

Medications were administered appropriately and medications which required strict controls were securely stored and managed appropriately. They were checked and signed by two nurses at each change of shift. The register of controlled drugs was reviewed and found to be well maintained, completed and up-to-date. Medications that required refrigeration were stored appropriately in a fridge.

An inspector reviewed the medication policy and a sample of residents' medical records. Some issues were identified in the medication management processes. The policy on medication management did not include arrangements for medications used as required (PRN). The time of administration was not recorded on residents' medication prescription sheets and crushed medications were not individually signed by the GP. Inspectors also noted that one GP had not signed residents' individual medications on his/her prescription sheet.

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
Each resident's wellbeing and welfare was not maintained with a high standard of evidence-based nursing care and as a result inspectors were significantly concerned that the health and safety of some residents was compromised, as discussed below. Significant improvements were required in the area of restraint and falls management in order to protect the safety of residents. An immediate action plan was issued on 7 July 2011 which required the provider to address these concerns within a specified timeframe. Prior to completion of this inspection the provider had taken significant steps in addressing these areas of concern.

The person in charge had failed to put adequate systems in place to manage the use of restraint with the result that residents' safety was seriously compromised due to the inappropriate and unsafe use of restraint measures. For example:

- the person in charge and staff demonstrated a very worrying lack of understanding of the risks associated with the use of bedrails. One staff member described the use of bedrails as "great even if they caused distress to a resident because it kept them safe" and the person in charge did not regard bedrails as a form of restraint

- the centre's policy on the use of restraint was very basic and did not reflect evidence based practice. The policy stated that "we do not consider cotsides as a form of restraint at Larchfield Park nursing home" even though inspectors noted

that bedrails were being used as a form of restraint for a number of residents. The policy did not contain adequate guidelines for staff to follow.

- inspectors viewed records which confirmed that restraint was used inappropriately and resulted in physical harm to some residents and created an increased risk to other residents' safety. Inspectors noted that the bedrails had contributed to some accidents and continued to be used without proper assessment even though these residents had sustained injuries.

- safety risk assessments had not been undertaken to determine the suitability of this form of restraint and the duration of the use of restraint was not documented

- inspectors noted that some residents had expressed views that they did not want bedrails but yet bed rails continued to be used

- the person in charge was unable to demonstrate that any alternatives to the use of restraint had been considered.

Inspectors found that the management and use of bedrails posed a significant risk to the safety of residents. The provider was required to submit an immediate action plan to review and assess all residents who used bedrails. Subsequently, a number of these residents had the bedrails removed and appropriate alternatives were put in place such as alarmed mats, floor mattresses and low-low beds. The provider reviewed the restraint policy, however, the updated policy did not provide sufficient guidance to staff on some newly introduced management tools such as the new risk assessment tools.

Falls prevention measures were not adequate and as a result some residents experienced a high number of falls. Care plans for falls management were in place for residents but some were very generic and consisted of pre-printed interventions which had not been individualised and updated to reflect the changing needs of these residents.

Residents were not reassessed after a fall to reduce the risk of further falls. For instance, inspectors noted that one resident had 14 falls from 26 June 2010 to 23 November 2010. During this period, the three-monthly care plan review stated that there had been no change in the resident's condition and no interventions to prevent further falls had been put in place. One of these falls had resulted in the resident sustaining a serious injury.

Inspectors issued an immediate action plan requiring the provider to undertake a review of falls prevention care plans and 39 falls prevention care plan reviews were completed. A sample of these care plans were reviewed by inspectors and found to accurately reflect the assessed needs of the residents. An inspector also noted that two recent falls had been appropriately responded to and the relevant care plans had been updated.

The policy on managing residents with behaviour that challenged was reviewed by inspectors and found not to be in line with contemporary evidence based practice. Care plans were in place for residents who displayed behaviour that challenges but some were not adequate to guide staff practice. While the underlying cause or triggers for this behaviour were identified in some care plans others were general and not based on assessed need.

Some aspects of residents' healthcare needs were well managed. Inspectors noted that appropriate healthcare measures were in place for other clinical issues. For example, risk assessments on areas such as nutrition, pressure ulcers and dependency levels were completed on a three-monthly basis and care plans reviewed were reflective of residents assessed needs. Inspectors noted that changes in healthcare needs and in particular acute clinical episodes for these residents were responded to appropriately and that good quality care plans were in place for identified needs such as oxygen therapy. Residents were also medically reviewed by their GP and allied health professionals, as required. Inspectors viewed records that confirmed residents or their representative were consulted in the development and review of these care plans.

Daily activities were available which created interest and variety in residents' daily routine. Residents described their preferred activities which included music, walking and chatting to other residents and staff. The provider had employed two full-time activities coordinators and inspectors noted that they provided meaningful and stimulating activities for residents including those with higher dependencies. Well documented and person-centred resident's profiles had been completed for each resident and this was used to inform the activities that were made available.

An open door visiting policy was in place which encouraged residents to receive visitors to the centre. A visitor's book was kept at reception and maintained up-to-date. Relatives commented that they were made to feel very welcome and were always offered refreshments and snacks.

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
Arrangements were in place for residents to receive care at the end of life to meet their needs.

There was a comprehensive policy on end-of-life care which guided staff practice. The policy included information on how to assess residents' wishes for end-of-life care, care of a resident approaching end of life and care following the death of a resident. Inspectors noted that appropriate plans were in place to care for the needs

of residents at end of life. The person in charge informed inspectors that arrangements were in place with the local hospice team for palliative care.

While there were no specific overnight facilities for family and friends, inspectors were told by the person in charge that facilities were made available to them. She also stated that they would have access to meals and beverages.

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

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

Inspection findings
Residents received a varied diet that offered choice. Residents' preferences were catered for and food was nicely presented. Residents were complimentary of the quality of food available to them.

Inspectors found that there was a plentiful supply of drinks during the inspection. Staff were observed encouraging residents to take drinks and during a morning handover, nursing staff instructed care staff to replenish drinks in residents' bedrooms.

The dining experience was unhurried and this afforded opportunities for residents to interact with each other and staff. Inspectors observed the midday meals and found that residents were offered a varied diet. Some residents required special or modified diets and these needs were met. The quality and presentation of the meals were of a good standard. All residents and relatives spoken with and who had completed questionnaires were pleased with the quality of food provided. Inspectors who sampled the food found that it was suitably heated and flavoursome. Some residents informed inspectors that they preferred to have their meals in their bedrooms and this was accommodated. Residents who required assistance with their meals received this in a dignified and unhurried manner.

Kitchen staff were well informed of residents' dietary requirements and their likes and dislikes. The chef had implemented a four-week menu cycle and there was a choice of meals available. Inspectors were informed by staff and residents that some vegetables and fruits offered to residents were grown by a resident in the garden including cabbages and tomatoes.

4. Respecting and Involving Residents

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

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

Inspection findings
Contracts of care were available for most residents but did not meet all the requirements in the Regulations. Contracts were not in place for three residents but the provider showed an inspector a copy of a letter which was sent to these residents' next of kin regarding this matter.

The majority of contracts reviewed by inspectors had been dated and signed by the resident or their representative, the person in charge and another director of the company representing the provider.

However, contracts of care did not effectively communicate the details of the services to be provided. Contracts viewed did not set out clearly what services were included in the weekly fee and what services were at an additional cost.

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

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

Inspection findings
Residents were consulted in the organisation of the centre and inspectors observed specific practices which enabled residents to exercise choice and control over aspects of their lives.

Residents' meetings took place on a monthly basis which gave residents an opportunity to bring forward suggestions. Minutes reviewed by inspectors confirmed that discussions took place on topics such as activities and meals.

During the fit-person interview the person in charge told inspectors that residents had influenced decisions made in relation to the extension. She stated that some residents had requested a bowling/putting area in the courtyard of the new extension and inspectors were shown this area.

Inspectors observed how staff practices respected residents' privacy. Staff were seen knocking on residents' bedroom doors and seeking permission before entering. Signs were also in use on residents' bedroom doors and bathrooms to control access to these rooms.

Despite this good practice, inspectors noted that screening curtains did not fully extend around each resident's bed in the shared bedrooms which compromised the privacy and dignity of residents who shared these rooms. This was contrary to information provided by the person in charge in the fit-person entry programme submitted prior to the inspection. The person in charge stated that for residents in shared rooms, there were curtain rails which fully encompass the living area of each resident and were totally screened off. Inspectors also noted that some practices did not promote the dignity of residents. Commode chairs were used in some shared bedrooms which compromised the dignity of these 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
Residents' bedrooms were individualised with residents' belongings including family photographs and personal effects. Adequate space was provided for residents' personal possessions. Residents had facilities to store their own clothes. However, one resident mentioned that the space was barely enough. Residents did not have a private lockable space in their bedroom and one resident mentioned that he/she would like to have this facility. The person in charge stated that plans were in place to provide lockable space within two months.

Adequate arrangements were not in place for the laundry of residents' own clothes. An inspector noted that some residents' clothing was not labelled with the resident's name. Some residents and relatives who completed questionnaires and were spoken with during the inspection expressed dissatisfaction with the service provided. Some

residents stated that clothes sometimes went missing while a relative mentioned that soiled underwear had been left in their family members' wardrobe. Inspectors noted that a new laundry facility was in the process of being built.

5. Suitable staffing

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

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

Inspection findings

The person in charge worked in a full-time capacity and had a minimum of three years experience in the area of geriatric nursing within the previous six years, as required in the Regulations. She worked from 9.00 am to 5.00 pm Monday to Friday and she stated that she was available outside of these hours and at weekends. The person in charge informed inspectors that she planned to undertake a gerontology course in September 2011.

The person in charge knew residents well and informed inspectors that when on duty she chatted to all residents. During the fit person interview and inspection she demonstrated knowledge of specific regulatory requirements and gave examples of some improvements brought about as a result of completing the fit person entry programme. Inspectors also found that she had not updated herself on contemporary evidence based practice in areas such as restraint management.

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

Inspectors found that the normal staffing levels were adequate to meet the needs of residents. Four nurses and ten care assistants were on duty from 8.00 am to 2.00 pm to meet the needs of 53 residents. An extra nurse and care assistant were on duty on the day of inspection. From 2.00 pm to 8.00 pm there were three nurses and seven care assistants on duty. Night duty staff consisted of two nurses and two care assistants from 8.00 pm to 8.00 am. Most residents and relatives spoken to and who completed questionnaires were satisfied with the staffing levels. Some relatives felt that occasionally there were not enough staff during the day and at night time.

In response to the action plan from the previous inspection, a formal system had been put in place to ensure residents were adequately supervised in the communal rooms during the day. The two main day rooms were supervised throughout the day and inspectors noted that a staff member supervised most residents who smoked in the smoking area. Inspectors also noted that an additional staff member had been recently rostered from 7.00 pm to 11.00 pm. The person in charge stated that this was in response to feedback from a relative questionnaire which had been completed for the Authority as part of the registration inspection process This relative stated that there was no supervision in the day room during the evening and had identified this as an area for improvement.

Staff were knowledgeable about residents and had established a good rapport with them. During the inspection, inspectors found that staff responded to their daily needs in an informed way. When questioned, staff were clear about their roles and responsibilities.

The provider had arranged some ongoing training for staff including training on PEG feeding and nutrition in April 2010. Some training needs had been identified in the area of food safety and plans were in place to provide this training. Some care assistants had Further Education and Training Awards Council (FETAC) Level 5 training in care of the older person and eight staff were currently completing this course. The general manager stated that new staff who did not have this qualification or staff employed within the last 12 months will be required to attend this course.

Inspectors viewed the recruitment, selection and vetting of staff policy and found that the policy included information on the organisation requirements but did not fully inform practice. Procedures were in place for areas such as the interview procedure and termination of employment. However, the policy did not specify required items such as evidence of mental and physical fitness. The policy also stated that an exit interview would take place on termination of employment but this was not happening in practice.

A sample of personnel files was reviewed and the files were found to contain the majority of the information required by the Regulations. Information obtained included photographic identification, information on employment histories and Garda Síochána vetting. However, evidence that some staff were physically and mentally fit for the purposes of their work had not been obtained. Prior to the inspection the person in charge had not been aware of this requirement. During the inspection she had obtained self declarations from some staff to confirm that they were physically

and mentally fit for the purposes of their work. However, sufficient evidence had not been obtained.

Inspectors found that communication processes for staff were not robust and that general staff meetings had not taken place on a regular basis. Some meetings had taken place during the lead up to the inspection in June 2011 but prior to these meetings the last staff meeting was held on the 11 August 2010.

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

Although the centre was purpose-built and comfortable, some areas did not comply with the Regulations and the Standards. As described in Outcome 5 and 12 some aspects of the design, layout and size did not promote safe practices and meet the needs of all residents.

The system in place for the maintenance of bedrails was not adequate and posed a risk to residents' safety. During the inspection, inspectors found that some metal framed bedrails were very loose and continued to be used. In-house maintenance records indicated that a number of bedrails had been broken and were subsequently fixed. Inspectors were shown a certificate of repairs and service of beds by an external contractor which took place on 15 June 2011. Metal bedrails were not included as part of this service contract.

Prior to completion of this inspection the person in charge carried out a formal assessment of the physical condition of all bedrails and this assessment identified further defects. The defects to bedrails that were in use were repaired. The person in charge informed inspectors that she planned to carry out this assessment on a monthly basis.

Other assistive equipment was provided to meet the needs of residents, including seated weighing scales and hoists. Inspectors viewed the maintenance and servicing contracts and found the records were up-to-date and confirmed this type of equipment was in good working order.

On day one and two of the inspection, inspectors heard hammering and drilling noises coming from the extension. The person in charge informed inspectors that this work did not commence until approximately 10.00 am but yet inspectors heard

building work at approximately 7.50 am and 8.30 am. One of the residents had complained to the person in charge about the noise and the person in charge informed inspectors that arrangements had been put in place to ensure works would not commence until this resident had left his/her bedroom. However, an inspector noted that this resident was in bed when some of the noisy building work was taking place early in the morning. This issue was addressed prior to completion of the inspection.

Some parts of the centre were not maintained in a clean and hygienic condition. During the inspection a smell of urine was noted in some areas of the centre and sections of carpet were stained. Inspectors also found that there was a strong smell of urine in the vicinity of the residents' toilet located in close proximity to the kitchen and main dining area. This toilet was also inadequately ventilated.

Adequate laundry facilities were not available. Insufficient space was available in the laundry for the sorting and ironing of laundry. The person in charge informed inspectors that clothes were mostly sorted in a linen room. Staff informed inspectors that clothes were sorted in both the laundry room and the linen room.

Two of the bedrooms exceeded the maximum occupancy of two residents contained in the Standards. At the time of inspection the provider did not have plans in place to address this issue but was aware of the requirement to meet this Standard by 2015. Inspectors also noted that some other bedrooms did not meet the required sizes in the Standards.

Storage space for assistive equipment was inadequate and resulted in this equipment being stored along corridors and in one of the residents' dining rooms. This increased the risk of injury to residents. Inspectors were informed that storage facilities would be made available in the new extension.

7. Records and documentation to kept at a designated centre

Outcome 16

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

References:

Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures

Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

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

Resident's guide

Substantial compliance ☐ Improvements required* ☒

The Residents' Guide did not comply with all the requirements of the Regulations. For example, the complaints procedure outlined in the Guide did not identify the independent appeals process.

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required* ☒

While the majority of records relating to residents were maintained in the centre some records relating to residents were not comprehensive.

General records (Schedule 4)

Substantial compliance ☒ Improvements required* ☐

Inspectors viewed a sample of general records that are required by law to be maintained in the centre and found that these records were available.

Operating policies and procedures (Schedule 5)

Substantial compliance ☐ Improvements required* ☒

The provider had put in place the policies required in Schedule 5 of the Regulations. Inspectors viewed a sample of polices and found that some were not based on evidence based practice such as the policy on behaviour that challenges. As stated in Outcome 3, 4, 5 and 7, some policies did not contain adequate instructions to guide staff practice.

Directory of Residents

Substantial compliance ☐ Improvements required* ☒

Some required information was not recorded in the directory of residents and the person in charge confirmed that there was no system in place to ensure that the register was kept up-to-date. For example, the time of death and cause of death was not recorded for some residents who had died in the centre. Transfer details had not

been kept up-to date - information pertaining to the transfer of two residents who were currently in hospital had not been recorded in the register. This issue had been identified in the Action Plan of two previous inspections.

Staffing records

Substantial compliance ☐ Improvements required* ☒

As detailed under Outcome 14, some staff records reviewed did not contain all the information required in Schedule 2 of the Regulations.

Medical records

Substantial compliance ☐ Improvements required* ☒

There were some issues identified in medication management that did not comply with the Regulations and An Bord Altranais guidelines. These issues are outlined in Outcome 6.

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
Inspectors found that some notifications of incidents had not been submitted to the Authority in accordance with the requirements set down in the Regulations.

Inspectors reviewed a record of incidents that had occurred in the designated in May 2011. Quarterly returns had been submitted in 2011 which stated that there was nothing to report yet some notifiable incidents had occurred during this time and were not reported. For example, inspectors noted that one resident had two serious injuries, one of which resulted in the resident being hospitalised but this had not been notified to the Authority, as required. Inspectors also noted that a different resident also had a serious injury which also resulted in hospitalisation and this had not been notified either.

As part of the immediate action plan, the person in charge was required to notify the Authority immediately of all incidents from 7 July 2011 to 18 July 2011. Inspectors were informed by the person in charge that there were no notifiable incidents during this period and this was confirmed during the remainder of the inspection.

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. A senior staff nurse deputised for the person in charge in her absence and was supported in this role by the general manager. However, during the fit person interview the person in charge in her role as provider was not fully aware of her responsibilities to notify the Authority but as yet this was not required.

Inspectors were informed that there have been no absences of the person in charge for such a period that required notification to the Chief Inspector.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge and the financial controller 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:

Nan Savage

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

21 July 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Larchfield Park Nursing Home
Centre ID:	0056
Date of inspection:	5, 6, 7, 18 and 20 July 2011
Date of response:	16 September 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 fully reflect the service provided in the centre and did not meet all of the requirements 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

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The statement of purpose and function has been updated to include the accurate range of needs that the centre is intended to meet, including intellectual disabilities, residents with dementia and the type of post operative care we provide. The statement has been revised to include the accurate provider details in the organisational structure, as Larchfield Park Nursing Home is a limited company, the company is now seen as the registered provider not Ellen Dillon. The independent appeals process has been included in greater clarity in the complaints policy and this has been included in the statement. The arrangements for day-care facilities have been clearly defined in the statement of purpose of function.	 Completed Completed Completed Completed

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

2. The provider is failing to comply with a regulatory requirement in the following respect: There were no systems in place to review the overall quality and safety of care and quality of life of residents.
Action required: Establish and maintain a system for reviewing and improving the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.
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: We have in place a weekly quality monitoring and continuous improvement system and the person in charge audits this on a monthly basis.	 Commenced August 2011

Any areas of concern arising from this are acted upon appropriately. Unfortunately up until the inspection this was not adequately documented. Going forward we intend to document all information relating to these monthly audits and any actions required.	
We have now implemented a root cause analysis system to help educate staff and improve practice, especially in the areas of falls and behaviour that challenges. Accidents and complaints will be discussed, together with outcomes and satisfaction levels, at our six-weekly meeting between senior staff nurses and management.	Commenced August 2011
A resident's satisfaction survey has been implemented and results will be reviewed and acted upon as necessary.	Commenced August 2011

Outcome 3: Complaints Procedures

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

The complaints policy did not comply with all the requirements of the Regulations in that it did not outline an independent appeals process and there was no nominated person responsible for ensuring that all complaints are appropriately responded to and records maintained.

The complainant's satisfaction level with the outcome of the complaints investigation was not consistently recorded.

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.

Action required:

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Action required:

Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have updated our complaints policy to include a clearly outlined appeals process and an independent person to deal with complaints. A second person has now been nominated and so stated in the policy. We have also updated our complaints procedure. The complaints procedure is displayed in prominent places around the nursing home, in large print. We will ensure in the future to keep a written record of the complainants satisfaction level following the closure of the complaint. As stated above, we have updated our complaints policy and we have included contact details of independent advocacy groups for use by the complainant.	Completed Commenced August 2011 Completed

Outcome 5: Health and safety and risk management

4. The provider is failing to comply with a regulatory requirement in the following respect: Not all staff had received suitable training in fire prevention.	
Action required: Provide suitable training for staff in fire prevention.	
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 with timescales:	**Timescale:**
Provider's response: All current staff have been provided with suitable fire training.	22/08/2011

We endeavour to provide all new staff with basic fire training on induction.	Commenced August 2011

5. The provider is failing to comply with a regulatory requirement in the following respect: Deficits were identified during the inspection that posed a risk to the safety of residents, staff and visitors. For example, all areas in the centre had not been risk assessed and some hazards were identified by inspectors in these areas.	
Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.	
Action required: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.	
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: Fire training for all staff has been fully completed. Risk assessments are being carried out on the internal courtyards, garden and kitchenettes. Any deficits in the courtyards and gardens will be addressed in an appropriate manner. The lock on the side gate to the garden has been replaced with an electronic lock with key-pad access. A risk assessment will be carried out on the new extension with the assistance of the designers.	 22/08/2011 31/10/2011 30/09/2011 31/10/2011

The financial controller/general manager is undertaking a three-day health and safety and risk management course as approved by the national safety authority.	23/09/2011
The risk management policy has been updated to reflect the identification and assessment of risks and how to put precautions in place to control risks identified.	Completed
The risk register will be updated on a regular basis.	Commenced September 2011
All actively employed staff have received training in the safe practices for manual handling and moving.	28/08/2011
The emergency plan has been updated to include specific emergencies such as power outage.	Completed
We have plans to convert existing rooms and create separate changing facilities for our staff, a separate sluice room for the west wing and a separate room for the storing and cleaning of domestic equipment.	To commence January 2012

6. The provider is failing to comply with a regulatory requirement in the following respect: The emergency plan did not contain guidance to follow for specific emergencies such as power outage.	
Action required: Put in place an emergency plan for responding to emergencies.	
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: An emergency plan is now in place for specific emergencies such as power outage. This plan is displayed in prominent positions around the house.	Completed

Outcome 6: Medication management

7. The person in charge is failing to comply with a regulatory requirement in the following respect: Some aspects of the medication management policy and practices were not in line with Regulations, the Standards and An Bord Altranais guidelines.
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:	
We have an updated policy for medications as required (PRN) in place.	Completed
All crushed medication is now signed for individually by the residents GP.	Completed
We will revert to our previous practise of requesting the GP to sign all medication individually.	30/11/2011

Outcome 7: Health and social care needs

8. The person in charge is failing to comply with a regulatory requirement in the following respect: Each resident's wellbeing and welfare was not maintained by a high standard of evidence-based nursing care and subsequently the health and safety of some residents was compromised. The management of restraint and falls did not ensure the safety of residents. Safe moving and handling practices and procedures had not been fully implemented.

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:	
The restraint policy has been updated and includes evidence based practice.	Completed
All staff have received training in restraint management since the inspection.	27/07/2011 + 05/08/2011
Risk assessments have been carried out on all residents requiring bedrails and the suitability of bedrails for each of these residents has been documented.	Completed
It was always the policy of Larchfield Park Nursing Home to discuss the use of bedrails where bedrails were deemed necessary. However, we have since reviewed this practice and put in place alternatives where appropriate. Bedrails will now only be used where all other avenues of accident prevention have been exhausted.	
To demonstrate our commitment to accident prevention, Larchfield Park Nursing Home has invested a significant amount in purchasing low-low beds, crash mats, alarmed mattresses, bedrail protectors and fall prevention wedges for residents following updated risk assessments.	Completed July 2011
We are reassessing all residents following falls and have a learning document in place which includes detailed discussions with the resident and/or relatives, the proposed interventions and a follow-up assessment.	Commenced July 2011

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

Some issues were identified in the care planning process.

An adequate assessment to identify any underlying cause or triggers for behaviour that challenges had not been completed for residents with behaviour that challenges.

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
Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All care plans for residents with behaviours that challenge are being updated, to include the underlying causes or triggers. We have always ensured that all our residents and/or their families are consulted with on the initial comprehensive assessment and then the development of their care plans. All care plans are reviewed every three months, in conjunction with the residents and/or their family members.	31/10/2011

Outcome 10: Contract for the Provision of Services

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

Contracts of care did not meet all the requirements outlined in the Regulations.

Action required:

Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The contracts of care have been updated and all costs for additional services have been included.	Completed

Outcome 11: Residents' rights, dignity and consultation

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

Adequate measures had not been taken to ensure that the privacy and dignity of residents who shared bedrooms was not compromised.

Action required:

Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

Reference:

Health Act, 2007
Regulation 12: Visits
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All our sharing bedrooms have curtain dividers between each bed. However, we will now ensure that curtains dividers will encompass the entire area of each individual. We are currently in the process of installing these dividers.	31/10/2011

Outcome 12: Residents' clothing and personal property and possessions

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

Adequate laundering of residents clothing was not provided.

Aadequate space was not available for the sorting and ironing of laundry and these facilities would not be sufficient if there was a full compliment of residents.

Action required: Provide adequate facilities for each resident to appropriately store, maintain and use his/her own clothes.
Reference: Health Act, 2007 Regulation 13: Clothing Standard 4: Privacy and Dignity Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A personal lockable space is in place in all residents bedrooms. We endeavour to ensure that all residents' laundry is carried out to a satisfactory level.	Completed

Outcome 14: Suitable staffing

13. The provider is failing to comply with a regulatory requirement in the following respect: The recruitment, selection and vetting of staff policy did not detail adequate information on the selection of staff and sufficient evidence had not been obtained to ensure that staff employed were physically and mentally fit for the purposes of the work that they carry out in the centre.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.
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 with timescales:	**Timescale:**

Provider's response: We have updated our recruitment policy to include the requirement that all staff must have evidence that they are physically and mentally fit to work at Larchfield Park Nursing Home. We have requested all staff employed since July 2009 to furnish us with a medical certificate stating they are physically and mentally fit for the purpose of the work that they are to perform at Larchfield Park Nursing Home. We will ensure that all new staff employed from September 2011, will obtain a letter from their GP stating that they are physically and mentally fit for work. Exit interviews have taken place with any staff who have left since the inspection in July 2011 and we will ensure that we will perform an exit interview with all staff, in the future.	 Completed 30/11/2011 Commenced September 2011 Commenced July 2011

Outcome 15: Safe and suitable premises

14. The provider is failing to comply with a regulatory requirement in the following respect: Some parts of the centre were not maintained in a clean and hygienic condition. Some aspects of the physical design and layout of the building were not suitable to meet the residents' individual and collective needs.	
Action required: Keep all parts of the designated centre clean and suitably decorated.	
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.	
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: As always, we will endeavour to keep Larchfield Park in a clean and comfortable condition. Any areas that require improvement will be addressed immediately. Extra ventilation has been installed in the "toilet located in close proximity to the kitchen".	 Ongoing 10/08/2011

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

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

Some records and documents did not comply with all the requirements set down in the Regulations. For example:

- the Residents' Guide and directory of residents did not comply with all the requirements of the Regulations
- some policies did not inform practice and were not based on evidence-based practice while others did not contain adequate information to guide practice.

Action required:

Produce a Residents' Guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.

Action required:

Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

Action required:

Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.

Reference:

Health Act, 2007
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
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 Residents' Guide has been updated to include a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector. In relation to the updating of the residents register we have appointed a senior staff nurse to check the register weekly to ensure it is maintained as required by the Regulations. As stated in the report we had put in place, prior to the inspection, all the policies required in Schedule 5 of the Regulations. However, as referred to in Outcomes 3, 4, 5 and 7 these policies have now been updated to contain instructions to guide staff practice.	Completed Commenced August 2011 Completed

Outcome 17: Notification of incidents

16. The person in charge is failing to comply with a regulatory requirement in the following respect:
The person in charge did not notify the Chief Inspector of some serious injuries that had occurred as required in the Regulations.
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems 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: Notice will be given to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.	Commenced July 2011

Any comments the provider may wish to make:

Provider's response:

The management would like to thank the inspectors for their courteousness throughout a very trying, stressful and lengthy inspection. The tension in the nursing home could be felt throughout the house and what is normally a very pleasant and peaceful environment became fraught with worry and anxiety.

Management and staff at Larchfield Park Nursing Home are big advocates of the person-centred care approach. We note from the report that the inspectors commented that one resident had numerous falls in a short time frame. As explained to inspectors, the particular resident in question expressed her wish to mobilise. It was her choice and the implications and risks involved were fully explained to her.

We accept that we looked on bedrails as an enabler, rather than as a restraint. We have gained a considerable amount of knowledge during and following the inspection process and have implemented many changes. We have demonstrated our commitment to this and have invested a significant amount in purchasing low-low beds, crash mats, alarmed mattresses, bedrail protectors and fall prevention wedges for beds.

All our staff are trained on a regular basis, by our in-house manual handling instructors, who are very vigilant in the application of the correct way to handle residents. We are very disappointed to note that the inspectors observed the incorrect handling of one of our residents and we will endeavour to ensure that this will not happen in the future.

Overall we welcome the opportunity to be inspected by the Authority, as it enhances our learning and ensures the continuous improvement to both our resident's environment and their quality of life.

Provider's name: Sara Dillon RGN, Managing Director/Director of Nursing
Date: 16 September 2011