Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Castle Gardens Nursing Home
Centre ID:	0696
Enniscorthy	Drumgoold Enniscorthy Co Wexford
Telephone number:	05392-35566
Fax number:	05392-36635
Email address:	Sheila@keyhealthcare.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Key Healthcare Ltd.
Person authorised to act on behalf of the provider:	John Devoy
Person in charge:	Sheila Power
Date of inspection:	11 October 2011
Time inspection took place:	**Start:** 10:10hrs **Completion:** 21:00hrs
Lead inspector:	Tom Flanagan
Support inspector(s):	Catherine O'Keeffe
Type of inspection:	☐ **Registration** ☒ **Announced** ☐ **Unannounced**

About the inspection

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

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

Additional inspections take place under the following circumstances:

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

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

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

About the centre

Location of centre and description of services and premises

Castle Gardens Nursing Home is located close to the N11 and is approximately 1.5 kilometres from the town of Enniscorthy, Co Wexford. It was first registered on 12 November 2010 to provide services to older people over the age of 65 years.

The centre is a purpose-built, single-storey building and is registered for 63 residents. On the day of inspection there were 44 residents, all of whom were over the age of 65 years, and there were 19 vacancies.

Residential accommodation for residents comprises 52 single and 7 twin-bedded rooms and is located on the two sides of the communal areas. Each of the bedrooms has en suite toilet, wash-hand basin and assisted shower facilities. The communal facilities are located in the centre of the premises. There are three lounge/seating areas, a large dining room adjacent to the kitchen, an oratory, an activities' room, a visitors' room and a smoking room. There are four assisted toilets for the use of residents and one for visitors. Inside the entrance is a reception area, an administration office and the office of the person in charge. An area towards the rear of the building contains a hairdressing salon, the laundry and the staff facilities, which comprise a dining area and male and female facilities, each of which contains a toilet, wash-hand basin and shower and a changing area with lockers. There is an enclosed service yard and a number of rooms which house equipment necessary for the operation of the premises. There are two nurses' stations, each located near a residential area of the centre. There is a sluice room, a number of storage rooms and an assisted bathroom, which also has toilet and wash-hand basin facilities.

The centre is located on the grounds of a retirement village complex, the entrance to which is controlled by an electronic barrier system. The grounds are landscaped and there are two enclosed gardens, both of which contain circular walkways. There is ample car parking to the front of the premises.

Date centre was first established:			2010	
Number of residents on the date of inspection:			44	
Number of vacancies on the date of inspection:			19	
Dependency level of current residents as provided by the centre:	**Max**	**High**	**Medium**	**Low**
Number of residents	0	13	15	16
Gender of residents			**Male (✓)**	**Female (✓)**
			15	29

Management structure

The centre is owned by Key Healthcare Ltd. The nominated Registered Provider is John Devoy, one of the directors of the company. The Person in Charge is Sheila Power. The Key Senior Manager is Teresa Byrne, who is a Clinical Nurse Manager. Denise Murray and Lorraine Warren are also Clinical Nurse Managers.

The care assistants, nurses, catering, administration and maintenance staff report to the Clinical Nurse Manager, who reports to the Person in Charge. The Person in Charge reports to the Registered Provider.

Staff on duty on the day of inspection

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	3	5	3	4	1*	3**

* The nominated registered provider.
**One maintenance person and two activities coordinators.

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 inspection was the second inspection of the centre. The first inspection was a registration inspection which took place on 5 August 2010 and 6 August 2010, prior to the opening of the centre.

On 5 August 2010 and 6 August 2010 the inspectors found that the premises and the furnishings were of a high standard and considerable preparation had been made by the provider, the person in charge and the key senior manager for the opening of the centre and for the registration application.

There were a number of areas where improvements were required. These included:

- updating some key documents, such as the statement of purpose, the complaints procedure and the Resident's Guide;
- further development of policies;
- development of supervision structures;
- review of the induction programme to ensure that all staff receive the necessary training;
- development of a more person-centred care planning process; and
- a number of issues regarding the premises.

On this inspection, the inspectors met with residents, relatives, and staff members throughout the day. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Inspectors found that the premises was fit for its stated purpose. A complaints policy was in place and it provided for an independent appeals process. An end-of-life policy was also in place and facilities were provided for relatives to stay with the resident if they wished. Food was nutritious and residents were offered a choice of meals. Residents were treated with dignity and respect and enjoyed a good quality of life. Adequate arrangements were in place for storage of residents' property and possessions. The person in charge was suitably qualified and experienced and an adequate management structure was in place to support her. Staff members were suitably qualified, staffing levels and skills mix were adequate and residents commented that staff were kind and caring. Records were maintained well and the person in charge had notified the Authority of any incidents in the centre as required.

There were a number of areas where improvements were required. These included:

- an overall system to review the quality and safety of care provided to residents
- the protection of residents
- risk management and fire safety
- the management of controlled drugs
- care plans
- the provision of an activity programme for residents with cognitive impairment

- contracts
- staff files and training for staff
- Resident's Guide
- policy on infection control.

The Action Plan at the end of this report identifies areas where improvements are required in order to comply with the Health Act 2007 and 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.*

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 viewed the statement of purpose which accurately described the services and facilities that are provided in the centre. It outlined the staffing complement and the organisational structure. It also described the arrangements for consulting residents about the operation of the centre and the development and review of their care plans. However, it did not meet all the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Omissions included the following:

- the details of the professional registration of the person in charge and the registered provider
- the registration details of the centre
- the conditions attached by the Chief Inspector
- the maximum number of residents who will be accommodated
- the age range of residents for whom it is intended to provide a service
- the criteria for admission
- the size of rooms in the centre
- the therapeutic techniques used in the centre and the arrangements for their supervision.

Following the inspection, the person in charge submitted an updated statement of purpose to the Authority which meets the requirements of the regulations.

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 a number of audits had been carried out in the centre but there was no overall system in place to review the quality and safety of care provided to residents.

An inspector viewed the records of accidents and incidents and the minutes of the falls committee, comprising nursing and care staff, which met monthly. The records showed that the staff learned from the incidents and that measures were put in place to reduce the risk of falls for individual residents. The person in charge told inspectors that the pharmacy had conducted an audit of medication management but there was no report available. Audits were also carried out on meals/mealtimes, infection control and staff presentation.

There were no formal management meetings and there was no overall system in place to ensure that the quality and safety of care and the quality of life of residents was reviewed and monitored at appropriate intervals.

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

There was a complaints policy and procedures in operation. The person in charge told inspectors that no complaints had been received since the centre opened.

Inspectors observed that the complaints policy was displayed prominently in the entrance lobby and that a comments/suggestions box was in place. A complaints book was also maintained. The policy was clear. It outlined the steps to be followed in the making of a complaint and the procedures involved in any investigation. An independent person was available for appeals.

Residents and relatives reported to inspectors that they had easy access to the person in charge and they could report any concerns to her or to other staff members. Residents were familiar with the complaints policy. The person in charge told inspectors that she would welcome any complaints and that she maintained an open door policy so that residents, their relatives or staff members could come into her office to talk to her if they wished to do so.

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

Inspectors found that there were measures in place to protect residents from being harmed or suffering abuse. Residents who spoke with inspectors confirmed that they felt safe in the centre.

An inspector viewed the policy on the elder abuse which was centre-specific. It detailed the various types of abuse and was clear on the steps to be followed by a staff member should they have any concerns in relation to the protection of residents.

One of the clinical nurse managers had attended a Train the Trainers course on elder abuse in 2010 and she told the inspector that she had provided training on this subject to other staff. The training records showed that all staff members had received training on 10 November 2010 during their induction. A number of staff members who were interviewed by an inspector demonstrated their knowledge of the subject. However, two staff members who spoke to the inspectors had not received the training since they took up their posts earlier in the year.

There was a policy and procedures on residents' property and possessions. An inventory was maintained of all residents' property. An inspector observed that small amounts of money were maintained in safekeeping for some residents. Residents were given receipts for any transactions. However, the records were maintained on loose sheets and not in a bound book. Transactions were signed for by two members of staff but not by residents or their representatives.

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

Practices in relation to the health and safety of residents and the management of risk promoted the safety of residents, staff and visitors. However, the risk management policy and procedures needed further development and training records needed to be updated.

There was a health and safety statement in place and there was an associated risk register which was centre-specific. There was an emergency plan in place which met the requirements of the regulations. There was a procedure in place for the safe evacuation of residents and notices regarding evacuation procedures were displayed at appropriate places throughout the centre.

There was also a risk management policy. However, it did not include the precautions in place to control the specific risks outlined in the regulations and the arrangements for identifying, recording, investigating and learning from serious incidents involving residents was not outlined.

An inspector viewed fire safety documentation, including records of fire drills and maintenance of fire safety equipment and the fire alarm. Fire-fighting equipment was located throughout the premises and was last serviced in September 2011. Notices in prominent places outlined detailed procedures to be followed in the case of fire and/or evacuation. Fire doors within the building had magnetic holders. Fire exits were designed to unlock in the event of a fire. A fire panel was located close to the reception and a certificate from a fire alarm company stated that the fire alarm system met standard IS:3218. The records showed that the fire alarm had its quarterly inspection on 12 August 2011. The fire register showed that a fire drill was held monthly. The last fire drill took place on 30 September 2011 and was attended by 12 staff. Daily checks on the escape routes and the keypad doors were also maintained. Adequate means of escape were provided and all fire exits observed during inspection were unobstructed. However, two staff who were interviewed by an inspector had not received fire training since they took up their posts.

Measures were in place to facilitate the mobility of residents and to prevent accidents. These included the provision of handrails in circulation areas, grab-rails in assisted toilets, non-slip flooring and a secure garden. The corridors were sufficiently wide to enable residents in wheelchairs or walking frames to move easily around the premises. Inspectors observed many residents moving independently around the corridors, some using their individual mobility aids. However, the inspectors observed that there were two hoists left on the corridor while their batteries were being charged. This could constitute a trip hazard for residents.

There was a policy and procedures in place on infection prevention and control. Staff who were interviewed told inspectors that they had received training on infection control and demonstrated knowledge of the correct procedures to be followed. However, the policy was not based on the most up to date guidelines available. Hand gel dispensers were located throughout the premises and supplies of personal protective equipment were evident. A staff member told an inspector that the person in charge undertakes regular spot checks on the hand hygiene practices

of staff. Cleaning materials were colour-coded and the cleaning trolleys had lockable covers. Hand gels and dispensers for gloves and aprons were located throughout the premises. Colour-coded bins were available for clinical waste and there was a large, locked colour-coded bin in the service yard. A contract was in place for this material to be collected by a licensed operator.

The kitchen was clean and well organised. There was a food safety management system in place and there was no evidence of significant non-compliance with the requirements of food safety authorities.

The environment was observed to be bright and clean. A number of relatives who spoke to inspectors commented on the cleanliness of the centre. The outside of the premises was well maintained.

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 that processes were in place for the safe administration and regular review of medication and nursing staff demonstrated an understanding of appropriate medication management. However, the management of controlled drugs needed to be reviewed.

A detailed and comprehensive policy on medication management was in place. The policy was centre-specific and it was signed and dated by the person in charge. An inspector spoke to one of the nursing staff who demonstrated knowledge of the policy and explained how it was implemented.

Medications were delivered to the centre once a month and the medication was contained in individual pouches for each resident. Labels on the pouches contained the residents' details, the dates and times of administration, a list of the medication contained in the pouch and a description of each tablet. When changes were made to medication, the pouches for that resident were returned to the pharmacy and a new supply was delivered to replace them. Medication for individual residents was reviewed every three months by the general practitioner (GP), the pharmacist and a staff nurse. An inspector viewed the results of a medication management audit which was comprehensive. Prescriptions and discontinuations of medication were signed and dated by the GPs. The policy stated that transcriptions should only take place when necessary and that they should be signed by two nurses. The use of PRN (as required) medication was described in the policy. PRN medications were kept separately from regular medications. When medications needed to be crushed for

individual residents, the written consent of the resident's next of kin was sought and the GP signed and dated the order.

Appropriate arrangements were in place for the storage of controlled drugs. The stock levels were checked twice a day by two nurses. Returns of controlled drugs were recorded and they were signed for by a nurse and a pharmacist. However, two keys of the controlled drugs cupboard were in use in contravention of the professional guidelines.

An inspector observed a nurse as she administered medication, which was done in accordance with professional guidelines. Medications were stored in the drugs trolleys, which were locked and secured in the nurses' office when not in use. A fridge was used for medications only and records of the temperature were maintained.

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 that an adequate standard of evidence-based nursing care and appropriate medical care was provided to residents. Residents also had good access to a range of health and social care professionals. There was ample opportunity for residents to participate in meaningful activities. However, the care plans needed further development to ensure that they were person-centred. Links with the community needed to be developed.

The admission policy stated that that the key senior manager carried out pre-admission assessments on prospective residents in hospital or in their own homes and the person in charge told inspectors that these assessments were carried out. However, copies of these assessments were not maintained in the residents' files.

The centre had sufficient GP cover and an out-of-hours service was also provided. GPs from four practices in the area visited residents. Residents were given the option of retaining their own GP. Where this was not possible, the person in charge assisted them to transfer to a local GP. An inspector viewed the care plans of four residents in detail. Each resident had been reviewed by their GP within the previous three months.

An inspector found that recognised assessment tools were used to promote health and address health issues. These included the Barthel Index, the Waterlow Scale, MUST (Malnutrition Universal Screening Tool), mini mental state assessment and falls risk assessment. Weight was measured every month. Care plans were reviewed at least every three months. Nursing progress notes were written twice daily on each resident and care staff recorded any interventions they made regarding the hygiene of residents. However, an inspector viewed a falls risk assessment on one resident which was not signed or dated by the staff member carrying out the assessment. There was a policy on behaviour that challenges. However, the file of one resident whose behaviour was challenging did not have a care plan which addressed this issue. Relatives who spoke to inspectors said that they were aware of the care plans and that nursing staff had kept them informed of any changes in the condition of the residents. However, residents who spoke to inspectors were not aware of their care plans and a number of the care plans viewed by inspectors were not signed by the residents or their representatives.

Residents had access to a range of other health and social care services. Each resident was assessed by a dietician and a physiotherapist following admission and there was evidence of regular input from these professionals. There was also evidence that residents had access to a speech and language therapist, the psychiatry of old age services, the Wexford palliative care team, a chiropodist, an optician, a dentist and hairdresser.

There was little use of restraint. Consent forms were signed for the use of bedrails and residents for whom bedrails were used were monitored every two hours. One of the clinical nurse managers attended a Train the Trainers course on restraint on 30 May 2011 and a new policy on restraint had been implemented.

There were two activities coordinators and inspectors observed that residents had opportunities to participate in a range of meaningful activities such as discussion of news items, exercise to music, knitting, singing, dancing and reminiscence. Games such as bingo and skittles were also played. The inspectors observed that the majority of residents were engaged in activities in the day room. An inspector interviewed one of the activities coordinators who demonstrated a person-centred approach to the provision of the activities programme. She told the inspectors that the programme was varied and depended on the preferences of the residents on any

particular day. The activities for the day were listed on a whiteboard in the day room. She said that some residents were provided with one to one time and that life story work, hand massage and nail painting were among the activities engaged in. The activities coordinator recorded the involvement of each resident on a daily basis and told the inspector that the records were read by the person in charge. Inspectors spoke to several residents who expressed satisfaction with the activities programme. However, the care plan of one resident, who had a cognitive impairment, recorded that the resident was to be encouraged to participate in activities but no particular activities were mentioned. There was no evidence that the particular interests of that resident had been adequately assessed and that adequate provision had been made for her participation in the activity programme.

Links with the local community had not yet been developed. There were no volunteers working in the centre and residents told inspectors that there were no activities such as music sessions in the evenings. No outings had been organised for residents since the centre opened.

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

At the time of inspection no resident was in receipt of end of life care. There was an end of life policy in place and inspectors found that the reflected a person-centred approach to the provision of end of life care.

The person in charge described to an inspector how the policy is implemented. Following diagnosis, a new care plan is drawn up and this is discussed with the resident concerned and/or their representative. She said that arrangements are made with the palliative care team from the HSE in Wexford to provide appropriate intervention and that the families and relatives of residents are facilitated to visit the resident and remain with them prior to their death. She said that a number of relatives have stayed overnight in the centre with their loved ones.

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 found that residents were provided with food and drink at times and in quantities adequate for their needs. The food was nutritious and mealtimes were unhurried social occasions. Residents told inspectors that they enjoyed the food.

An inspector joined residents for lunch, which was a pleasant experience. The dining room was spacious and well decorated. Each table was set for four residents. The food was nutritious and good to taste. It was also well presented. There was a choice of main courses on the day and residents told inspectors that they always have choices available to them. They also said that the food was excellent. Inspectors observed that fresh fruit was available and was offered to residents each day. The atmosphere at mealtimes was relaxed and that there was good social interaction between staff and residents. The menu for the day was also displayed clearly on a white board in the dining room. One of the kitchen assistants told an inspector that she informs residents each morning of the menu for the day.

The chef came into the dining room to check that residents were satisfied with their meal. Residents told an inspector that they have lots of choice regarding food and that if they do not like or cannot eat what is on the menu the chef will prepare something different for them.

The dietary needs of residents were assessed on admission and these are communicated to the chef by the nurse in charge. Inspectors viewed a typed list of the dietary needs of all residents on the wall of the kitchen. A folder was maintained in the kitchen of care plans for residents who had difficulties with swallowing.

Jugs of drinking water and glasses were present in the rooms of residents and a catering assistant told an inspector that she was responsible for bringing water to the bedrooms twice a day. Inspectors observed that residents in the day rooms had glasses of water with them and that they were offered drinks by staff throughout the day. Residents were also offered a choice of drinks and snacks at set times during the day. Visitors were also offered tea or coffee and snacks. Facilities were available for residents to make hot drinks for themselves thereby increasing their independence.

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

An inspector viewed the contracts for all residents. For the majority of residents there were two documents in place: a signed confirmation that the person had read and understood the agreement and details of who was responsible for paying the fees of the resident. However, the contracts did not provide sufficient detail on the care and welfare of the resident in the centre and the details of the services to be provided. It was not clear what services were covered by the fees and what other charges might apply. Moreover, it was stated in the documentation that the contract should be signed within eight weeks of admission and not within one month as required by the regulations.

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

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

Inspection findings

Inspectors found that residents received dignified and respectful care. There was good communication between staff, residents and relatives. Contact between residents and their relatives and friends was facilitated and encouraged. Residents commented that they were facilitated to exercise choice with regard to their lifestyles. However, a dedicated residents' committee was required.

Residents and visitors told inspectors that they knew the person in charge and that she was very available to them. They felt that communication with her was welcomed and encouraged. Residents said that she often came to them and asked them if everything was okay. Inspectors observed that she was very familiar with each of the residents. Residents who spoke to inspectors said that they had privacy in all aspects of personal care. They also said that staff treated them with great respect. Inspectors observed that staff knocked and waited for permission before entering residents' bedrooms.

Relatives told inspectors that there was very good communication between the person in charge, staff and relatives and that they were kept informed

regarding the healthcare and general wellbeing of the residents. The person in charge had undertaken a survey of residents' satisfaction in the area of meals and mealtimes. There was a suggestion box in place near the entrance and the person in charge told inspectors that she frequently left her office door open so that residents or visitors could call in to speak to her if they wished.

The residents/family committee met one evening each month and gave feedback on the service provided. No minutes were kept of these meetings. The person in charge told an inspector that a member of the management team met briefly with the committee after each meeting to receive feedback. However, inspectors spoke to a number of residents and none were aware of the residents'/family committee meeting. A dedicated residents' committee was required to ensure that the residents were consulted on an ongoing basis regarding the operation of the service.

Residents told inspectors that they could choose the time to get up and go to bed and that they could choose their own time for breakfast. One resident said that he liked to have his breakfast at 06:00hrs. Inspectors observed that four residents were having breakfast in the dining room at 10:20hrs. Residents also told inspectors that they could decide when they wanted assistance with showering. A number of residents said that they had exercised their right to vote in the general election earlier in the year.

The provider supplied a selection of daily and weekly national newspapers and local weekly newspapers. Inspectors observed that several residents were reading newspapers during the day and that the activities coordinator read the newspapers with a group of residents. Residents had access to televisions and radios. Telephones were available in residents' rooms.

The spiritual needs of residents were addressed. Mass took place each week in the oratory and a Church of Ireland clergyman visited once a month.

Residents and relatives told the inspectors that there were no restrictions on visiting, that visitors were made feel very welcome, and that contact between residents and their families/visitors was facilitated and encouraged. Inspectors observed residents with their visitors throughout the day. Residents could see their visitors in private if they wished either in their bedrooms or in the visitors' room.

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 had adequate storage space for their clothes and possessions. Their rooms were personalised and arrangements were in place for the regular laundering of linen and the safe return of clothes to residents.

There was a policy on residents' property and possessions in place. Inspectors viewed a number of bedrooms and found that they were personalised with photographs and personal belongings. Each resident had their own wardrobe and a side table with lockable drawer. A record was maintained of any personal items that residents brought to the centre.

Laundry facilities were provided on the premises and these were adequate. An inspector viewed a sample of the clothing being laundered and each item was marked with the initials of the owner. Residents and relatives who spoke to the inspectors expressed satisfaction with the laundry service.

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 was full time in her post. She was registered with An Bord Altranais and had been in charge of the centre since it opened in 2010. She had previously been the person in charge of another designated centre for older people. She demonstrated that she had the clinical knowledge to ensure the suitability and safety of care to residents. Inspectors observed that she was familiar with the residents, the staff and all aspects of the service.

She told inspectors that she monitored the quality of the service by talking to residents, relatives and staff and by observing the practice of staff. She undertook the pre-admission assessments and was closely involved in the formulation of care plans. Training records showed that she completed a level 6 training course in gerontology in 2011.

The inspectors found that she was centrally involved in the operation and governance of the centre and that she received adequate support from the nominated provider who also worked fulltime in the centre.

When interviewed by inspectors, the person in charge demonstrated her knowledge and understanding of the legislation and her statutory responsibilities and her

commitment to the provision of a person-centred service. She had signed for the implementation of all the policies and procedures and had ensured that notifications were sent to the Chief Inspector as required.

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 staffing levels and skills mix of staff were sufficient to meet the needs of residents on the day of inspection. Residents and relatives commented on the kindness and caring attitude of staff. Staff demonstrated their knowledge of the policies and procedures. However, there was insufficient evidence that all staff had received mandatory training.

There was a policy on the recruitment, selection and vetting of staff in place. The person in charge told inspectors that all but one of the care staff had Further Education and Training Awards Council (FETAC) Level 5 qualifications. An inspector observed that the current registration details were maintained for all nursing staff and viewed a sample of five personnel files. These were well organised and each one contained photographic identification, full employment history, documentary evidence of relevant training and qualifications and evidence of Garda Síochána vetting. However, two of the five files did not contain three written references and one of the files did not contain evidence of physical and mental fitness. There were no volunteers working in the centre.

Inspectors viewed the planned staff rota which showed staff on duty at all times during the day and night and was prepared in advance. A review of the staffing rota indicated that the staffing levels on the day of inspection were according to the usual arrangements.

Inspectors observed appropriate interactions between staff and residents. There was a staff presence throughout the day in communal areas and inspectors observed staff chatting easily with residents. Residents and relatives told inspectors that staff were very kind and that they could talk to them at any time.

Inspectors viewed minutes of staff meetings and saw that issues covered by the legislation and standards were on the agenda. Staff who spoke to inspectors were clear about their roles and responsibilities and to whom they reported.

Staff who were recruited when the centre opened told inspectors that they had received a comprehensive induction and that they received training in elder abuse, fire safety, challenging behaviour and manual handling. There was evidence that training in fire safety and evacuation had been provided by an external company on 15 November 2010 and that training in moving and handling had also been provided by an external company on 8 November 2010. Training in continence promotion and medication management had been provided during 2011 and a senior member of staff attended a Train the Trainer course on restraint in 2011. The person in charge told inspectors that the dietician was scheduled to provide training to staff on the use of the MUST tool on 24 October 2011.

However, an inspector viewed the staff training and education records and there was no overall training matrix in place. There was insufficient evidence that all staff had received mandatory training in fire safety and moving and handling. Two staff who were recruited in 2011 told inspectors that they had not yet received training in elder abuse, moving and handling and fire safety.

Handover reports were given at the end of each nursing shift. These were attended by both nursing and care staff. A number of staff told inspectors that they had an appraisal which was carried out by the person in charge.

General staff facilities comprised a staff dining room and male and female changing rooms, which included lockers, toilets and showers.

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

Inspectors found that the design and layout of the centre was suitable for its stated purpose. Both the residential and communal facilities were comfortable and homely.

All the residents' bedrooms were bright and well ventilated. They had en suite facilities with toilet, wash-hand basin and shower. The bedrooms and en suites had

separate thermostats to control the temperature. The furniture comprised of electric profiling beds, wardrobes and side tables with lockable drawers. Each resident had easy access to a call bell and a reading light. The windows had restrictors fitted.

The communal space was sufficient to accommodate all residents. The main day room had comfortable seating arranged to ensure that approximately 40 people could sit in small or larger groups if they wished. An adjacent indoor sunroom and a separate area near the reception could accommodate approximately 30 people. There were also a number of alcoves throughout the premises with comfortable seating and coffee tables. There was a quiet room which was available for residents to use or for family visits or celebrations. The oratory had video and sound-broadcasting facilities. The activities room was arranged for approximately 16 people. There was a smoking room with adequate ventilation and an extraction system and also a small private room for visitors.

There were four assisted toilets, three for residents and one for visitors, close to the reception and lounge areas. There was also a toilet adjoining the hairdressing salon and the two bathrooms, which contained assisted baths, and toilet facilities.

The corridors, which were wide and had handrails fitted, were bright and art work hung on the walls throughout the premises. The floors had non-slip covering. Under-floor heating was provided throughout the premises using a geo-thermal system. All hot water taps were fitted with anti-scald valves.

The dining room was spacious and well furnished. The kitchen was large and well-equipped and had adequate storage for frozen, chilled and fresh food. A food safety management system was in place. There were appropriate changing facilities for kitchen staff. The laundry and sluice rooms contained all the appropriate equipment. There were adequate storage facilities for cleaning materials and equipment.

There were two nursing stations, a clinic room, a treatment room and offices for administration and management. Adequate secure storage was in place for files and valuables.

A range of appropriate assistive equipment was in place, including two assisted baths, hoists for lifting, sit/stand hoists, a seated weighing scales and overlay mattresses. There was adequate storage for equipment throughout the premises. Arrangements were in place for the regular servicing of equipment.

There were two enclosed gardens, on of which could be accessed by two doors from the main day room and a door from the dining room. These contained lawns, planted areas, circular walkways and garden furniture.

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 Resident's Guide did not include a copy of the most recent inspection report or the telephone number of the Chief Inspector.

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* ☒

The policies on risk management and infection control needed to be updated.

Directory of residents

Substantial compliance ☒ Improvements required* ☐

Staffing records

Substantial compliance ☐ Improvements required* ☒

Two of the files viewed by the inspector did not contain three written references and one did not contain evidence of physical and mental fitness.

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 was satisfactory.

Inspectors viewed the records of all accidents and incidents that had occurred in the designated centre since the previous inspection. All relevant incidents were notified to the Chief Inspector as required.

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 key senior manager to deputise for the person in charge in the event of her absence.
Inspectors were informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider and the person in charge to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

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

11 November 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:	Castle Gardens Nursing Home
Centre ID:	0696
Date of inspection:	11 October 2011
Date of response:	30 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 2: Reviewing and improving the quality and safety of care

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

There were no formal management meetings and there was no overall system in place to ensure that the quality and safety of care and the quality of life of residents was reviewed and monitored at appropriate intervals.

Action required:

Establish and maintain a system for reviewing 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

* 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: A system of formal monthly (or as required) management meetings has been established to review the quality and safety of care and quality of life of residents. Minutes of these meetings are being recorded and filed.	Completed 11 November 2011

Outcome 4: Safeguarding and safety

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

A number of staff had not received training on the protection of residents since they commenced work in the centre.

Records of residents' finances were maintained on loose sheets and not retained as part of the residents' records and transactions were signed for by two members of staff but not by residents or their representatives.

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.

Action required:

Put in place all reasonable measures to protect each resident from all forms of abuse.

Reference:

Health Act 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All members of staff have received training on elder abuse. Residents' financial records and transactions are recorded and stored in a safe with restricted access. Where possible residents or their representatives are requested to co-sign any transactions.	 Completed 29 November 2011 Completed 29 November 2011

Where this is not possible the person in charge and a member of staff both sign and co-sign witnessing the transactions.	

Outcome 5: Health and safety and risk management

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

The policy on risk management did not include the precautions in place to control the risks specified in the regulations nor the arrangements for identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Two staff who were interviewed by an inspector had not received fire training since they took up their posts.

Two hoists were left on the corridor while their batteries were being charged. This could constitute a trip hazard for residents.

Action required:

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm. Ensure that the policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Action required:

Provide suitable training for staff in fire prevention.

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: The risk management policy has been reviewed and updated to ensure it covers the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression, violence and self harm; The revised policy now covers arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. All current staff have now completed fire prevention training. The hoists in question have been relocated off the corridor to where they do not constitute a hazard.	 Completed 28 November 2011 Completed 28 November 2011 Completed 28 November 2011

Outcome 6: Medication management

4. The provider is failing to comply with a regulatory requirement in the following respect: Two keys of the controlled drugs cupboard were in use in contravention of the professional guidelines.
Action required: Put in place appropriate and suitable practices 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: There is only one key to the controlled drugs cupboard in use.	 Completed 10 October 2011

Outcome 7: Health and social care needs

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

A resident whose behaviour was challenging did not have a care plan on this issue. Residents who spoke to inspectors were not aware of their care plans and a number of care plans were not signed by the residents or their representatives.

A falls risk assessment was not signed or dated by the assessing nurse.

There was no evidence that the particular interests of a resident with cognitive impairment had been adequately assessed and that adequate provision had been made for her participation in the activity programme.

Action required:

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

Action required:

Provide a high standard of evidence-based nursing practice.

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
Regulation 8: Assessment and Care Plan
Standard 13: Healthcare
Standard 18: Routines and Expectations
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:	
A care plan for challenging behaviour has been developed for the resident referred to. Individual care plans are developed and agreed with residents who are capable of doing so. Where a resident is incapable to do so, the care plan is agreed with their representative.	Completed 11 November 2011
All individual risk assessments are now signed and dated by the assessing nurses.	Completed 11 November 2011
The resident referred to above has now been assessed for participation in activities and this has been recorded in the relevant documentation.	Completed 11 November 2011

Outcome 10: Contract for the provision of services

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

The policy of the centre was that the contract should be signed within eight weeks of admission and not within one month as required by the regulations.

The contracts did not provide sufficient detail on the care and welfare of the resident in the centre and the details of the services to be provided. It was not clear what services were covered by the fees and what other charges might apply.

Action required:

Agree a contract with each resident within one month of admission to the designated centre.

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:	
Contracts of care have been amended to ensure they are now signed within one month of admission as outlined in the regulations.	Completed 14 November 2011
Contracts now provide sufficient details on the services and care to be provided and state all fees and charges which may apply.	Completed 14 November 2011

Outcome 11: Residents' rights, dignity and consultation

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

None of the residents who spoke to inspectors were aware of the residents/family committee meeting. A dedicated residents committee was required to ensure that the residents were consulted on an ongoing basis regarding the operation of the service.

Action required: Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.
Reference: Health Act 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A designated residents committee has been established in addition to the existing resident/family committee.	 Completed 21 November 2011

Outcome 14: Suitable staffing

8. The provider / person in charge is failing to comply with a regulatory requirement in the following respect: There was no overall training matrix in place. There was insufficient evidence that all staff had received mandatory training in fire safety and moving and handling. Two staff, who were recruited in 2011, told inspectors that they had not yet received training in moving and handling and fire safety. Two of the five files viewed by an inspector did not contain three written references and one of the files did not contain evidence of physical and mental fitness.
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.
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 have been obtained in respect of each person.
Reference: Health Act 2007 Regulation 17: Training and Staff Development Regulation 18: Recruitment Standard 24: Training and Supervision Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A training matrix has been developed for all staff. All staff have now received manual handling and fire training. All staff have access to education and training. Current and future training needs are identified as part of the staff appraisal system currently in place. All staff files have been reviewed and updated where necessary to include all the required documentation. This review will be completed by 10th December 2011. The recruitment policy has been amended to ensure that all staff have the required documentation prior to commencement of employment.	Completed 22 November 2011 10 December 2011

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

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

The Resident's Guide did not include a copy of the most recent inspection report or the telephone number of the Chief Inspector.

The policy on infection control needed to be updated.

Action required:

Produce a Resident's 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:

Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.

Reference:

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

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

Provider's response: A revised Resident's Guide is being produced to include: a summary of statement of purpose; terms and conditions in respect of accommodation; standard form of contract; the most recent Health Information and Quality Authority inspection report; a summary of complaints procedure; and contact details of the Chief Inspector. The policy on infection control is currently being updated and will be completed by 31 December 2011.	12 December 2011 31 December 2011

Any comments the provider may wish to make:

Provider's response:

None received.

Provider's name: John Devoy

Date: 30 November 2011