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:	St. Clair's Nursing Home
Centre ID:	0099
Centre address:	Ballinderry Mullingar County Westmeath
Telephone number:	044-9385300
Email address:	mgordon@stfrancishealthvillage.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	VFM Healthcare (Ireland) Ltd
Person authorised to act on behalf of the provider:	Mark Gordon
Person in charge:	Paula Gavagan
Date of inspection:	29 June and 3 July 2012
Time inspection took place:	Day 1 **Start:** 11:50 hrs **Completion:** 17:30 hrs Day 2 **Start:** 09:00 hrs **Completion:** 19:15 hrs
Lead inspector:	Catherine Connolly Gargan
Support inspector:	N/A
Type of inspection	**Day 1** ☒ **unannounced** **Day 2** ☒ **announced**
Date of last inspection:	13 September 2011

About inspection

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

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under 18 outcome statements. The outcomes set out what is expected in designated centres.

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.*
Outcome 2 *The quality of care and experience of the residents are monitored and developed on an ongoing basis.*
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*
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.*
Outcome 5 *The health and safety of residents, visitors and staff is promoted and protected.*
Outcome 6 *Each resident is protected by the designated centre's policies and procedures for medication management.*
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.*
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.*
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 discreet and sensitive manner.*
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.*

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

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

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

About the centre

Location of centre and description of services and premises

St. Clair's Nursing Home is located on a large site in Ballinderry via an avenue in from the road. Ballinderry is a mainly residential area on the periphery of Mullingar town, Co Westmeath. St Clair's nursing home is located within St Francis's Private Hospital complex, a three-storey facility in which St Clairs Nursing Home occupies a part of the ground floor.

The centre is accessible from the lobby of Saint Francis Private Hospital. St Clairs Nursing Home shares a number of other services with St Francis Private Hospital including catering from the main kitchen, the maintenance department, peripathic services and chaplaincy provision.

St Clair's Nursing Home has accommodation for up to 37 residents. There are 25 bedrooms, one single room has an en suite toilet and wash-hand basin and the three-bedded room has en suite toilet, shower and hand-washing facilities. There are two bathrooms and a shower (the shower and one of the bathrooms are wheelchair accessible). There are twelve toilets available for residents' use of which three are wheelchair accessible. Toilet facilities are located throughout the centre and within close proximity of communal areas.

There is an enclosed garden accessible from the centre. The enclosed garden known as "the peace garden" has some seating provided. A landscaped garden and designated pedestrian walkways surrounds the exterior of the building.

The centre has two sitting rooms, one of which is designated as suitable for residents to meet their visitors' in private. A seated area is also available in the lobby area of the centre. Residents have access to a dining room linked to one of the sitting rooms.

The centre is adjacent to a large church and coffee shop, accessible through the door of the centre and facilitates access directly into and from the lobby area of St Francis' Private Hospital.

Date centre was first established:	June 1968
Date of registration:	1 January 2012
Number of registered places:	37
Number of residents on the date of inspection:	33

Dependency level of current residents as provided by the centre:	Max	High	Medium	Low
Number of residents	14	6	6	7

Gender of residents	Male (✓)	Female (✓)
	✓	✓

Management structure

St Clairs Nursing Home is owned by VFM Healthcare (Ireland) Ltd. The nominated Provider on behalf of the company is Mr Mark Gordon who is also the company CEO. VFM Healthcare (Ireland) Ltd took over as providers of the centre in December 2010. The Person in Charge is Paula Gavagan who reports directly to the provider. The Person in Charge is supported by staff nurses, carers, catering, admin and cleaning staff. St Clairs Nursing Home receives catering facilities, maintenance, administrative, chaplaincy and allied health professional services from St Francis Private Hospital. The centre occupies part of the St Francis's Private Hospital building. The Provider has financial, risk advisory and human resource services on site which the Person in Charge can also access to support her work.

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	1	5	1*	1*	1	*

* The centre is serviced by maintenance, catering, peripathic services, pastoral and chaplaincy services as part of the overall Saint Francis Private Hospital Complex.

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

This report set out the findings of an inspection which took place over two days. The first day was unannounced and the second day was announced. As part of the inspection inspectors met with residents, relatives, and staff members. Inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

This inspection was the third inspection of this centre since the VFM Healthcare (Ireland) took over the centre in December 2010. As part of this inspection, the inspector reviewed the provider's progress with meeting compliance in the actions documented in the action plan developed from findings at inspection of the 13 January 2912. There were five actions in the action plan. Two of the five actions were completed fully. Areas still not completed and restated again in the action plan with this report included, inadequate documentation referencing fees on contracts, restraint management and provision of additional communal space and refurbishment of toilets and showers.

Residents and relatives spoken with complimented the staff and the care they received in the centre. Many told the inspector that they were satisfied and 'contented'.

While there was progress being made in a number of areas such as monitoring of clinical care, care documentation, meals and staff education, there was little progress in relation to improving the environment and providing residents with a better quality of life since the last inspection.

The inspector met with the provider on the second day to discuss the significant ongoing risks posed by failure to progress the following:

- relocate a medical gas supply room located in the centre as recommended by a fire engineer and agreed by the provider with the Authority
- a fire exit was ajar on both days of the inspection which would not impede evacuation but did not protect residents who were at risk of leaving the centre unaccompanied
- residents were not adequately protected from all forms of harm and abuse as doors to the centre were either ajar or accessible by unauthorised members of the public
- refurbishment of an independent entrance was not completed
- relocation of a smoker's room to a more suitable location was not done
- refurbishment of the internal enclosed peace garden and completion of window replacement project. The peace garden was not accessible without the assistance of a staff member as the door was locked. The garden had a variety of surfaces and levels which posed trip risk and there was running water which posed a slip risk.

The provider addressed the uncontrolled access to the centre immediately and undertook to address all the other areas as a matter of priority.

Staffing levels required review to ensure all residents' needs were met in a safe and informed way. The provider had rostered an additional carer on night duty which positively impacted on the residents experience.

The three incomplete actions from the action plan of the inspection done on 13 September 2011 has been restated along with new actions identified from findings of this inspection and are documented in the Action Plan at the end of this report. This action plan identifies areas where mandatory improvements are required to address deficits in the service and to comply 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*

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 inspector reviewed the statement of purpose and function copy given by hand to the inspector on the days of inspection and reviewed in January 2012. The provider undertook to amend this statement to take account of the registration number and inclusion of conditions of registration and to forward a copy to the Chief Inspector. Review of the complaints process was also required as were details of other persons who participate in the management of the centre such as the person in charge's deputy. Other areas requiring some revision to bring the document into full compliance with the requirements of the legislation were also been addressed.

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

The quality and safety of many aspects of clinical care was monitored and reviewed. The person in charge described a number of reviews undertaken and planned. The inspector noted that a number of audits had been completed and there was also some evidence of continuous quality improvement in some areas based on outcomes collated data. However, there was a lack of documented analysis and action plans developed to drive improvement. The person in charge described how she reviewed a number of key clinical parameters for each resident on a monthly basis. The inspector noted that these areas included restraint use, medication, weights, skincare, end of life care, care planning and attendance at appointments. Each

month individual monthly resident reviews were totalled. Although these audits were not formally analysed and action plans developed, the person in charge was making decisions on areas to improve without clear documentation making re-auditing difficult.

Review of quality of life parameters also required more attention to enable the person in charge and the provider to make an informed judgement whether measures taken to date had the desired impact on residents' quality of life in the centre. Quality of life in the centre was mainly ascertained from comment and feedback cards completed in the centre. A more in-depth audit of the various aspects of life in the centre was required.

While a number of audits were carried out and documented; an established system was not maintained to include for example, a list of all of the audits and evaluations undertaken, the scheduled date for the next audits, key findings and actions taken to demonstrate systematic continuous quality improvement.

Some audit reports were produced however; these had not been made available to residents. The provider and person in charge told inspectors that they planned to make reports available to residents on findings of audits on the quality of life for residents in the centre.

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 procedure in place which was displayed and was supported by a policy document. A complaints log was also maintained. The provider told the inspector that he welcomed feedback on the service whether positive or negative. Copies of positive feedback were also maintained. While complimentary of the service provided, residents told the inspectors they could complain if they wished.

There was evidence that complaints were investigated and remedial actions completed. However, there was improvement required in relation to appropriately capturing verbal complaints to ensure they were processed within the boundaries of the complaints procedure. The inspector viewed the complaints log which did not include documentation of any verbal complaints. However, there were complaints documented in the minutes from the residents meetings which had fixed agenda items and as a result invited feedback in a number of areas such as catering, environment etc. Complaints logged were fully addressed. Some confusion was noted in the persons nominated in the legislation to deal with complaints in the centre, this was actioned on the days of inspection and corrected.

The provider also stated that they would always seek level of satisfaction with the outcome of investigations; however this was not documented in all cases which impacted on the appeals procedure The investigation process and timelines also required some attention to ensue they were clearly documented in all cases.

An abbreviated version of the complaints process was included in the statement of purpose and residents guide.

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

Residents spoken with told the inspector that they felt safe in the centre. However protective arrangements were not of an adequate standard to ensure residents were safe at all times. Access to the centre by unauthorised members of the public was possible through either the open fire exit or the door to the centre accessible from St Francis Private Hospital. Vulnerable residents assessed as at risk of leaving the centre unaccompanied could potentially egress through the open fire exit. These arrangements did not adequately protect residents from abuse or harm. The fire exit was noted to be ajar on a number of occasions throughout the days of the inspection. The inspector met with the provider on the second day of inspection and highlighted the significant risk to residents posed by unprotected doors in the centre. He told the Authority in May 2011 that he was in the process of refurbishing the fire exit as a new independent entrance to the centre, distinctive from the main hospital, however this was not completed. In response to the inspector highlighting the risks posed by the open fire exit he immediately addressed it, by closing the door, placing signage on it that it was a fire escape only and advising all persons using the centre to enter and egress through the door from the centre to Saint Francis Private Hospital lobby. He also undertook to place a key-code lock on the door to control entry to the centre from the hospital lobby.

While the reception in the lobby of St Francis Hospital was staffed each weekday during office hours, a log of visitors was maintained. However this was not done outside of these hours.

All staff had attended on elder abuse recognition and prevention. Staff spoken with displayed sufficient knowledge regarding the different forms of elder abuse and each was clear on reporting procedures. However the elder abuse management policy reviewed required some revision to inform staff of the specific care and procedures

that was most appropiate to take for each type of abuse. Response to take in the event of an abuse allegation against a senior member of staff also required clarity. A whistleblowers policy was not in place in the centre documenting protective procedures for disclosures from staff, residents or relatives.

There was a policy document available to inform staff on procedures to follow in relation to managing residents belongings. Some residents' finances were kept in safekeeping by the provider. A hand written log was maintained detailing all activity with the account. Each resident had a separate page detailing their account transactions. The inspector viewed the process followed and found it to be transparent and accurate. A statement of account was available for those who wish to review their accounts.

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

The Inspectors viewed operational policies and procedures relating to the health and safety of residents, staff and visitors. An emergency plan was in place with an area of safe refuge identified including transportation arrangements in the event of having to evacuate the centre in an emergency. The person in charge had attended a training course in Health and Safety and was the safety representative for St Clair's Nursing Home.

A safety statement was in place dated January 2012. However a comprehensive risk register in respect of all potential hazards was not in place to minimise risk in those areas ensuring the safe operation of the centre in all respects. For example the hazards associated with the internal garden which has a number of surface levels and types were not documented with appropiate controls identified. This document was not centre-specific as the open fire door was not addressed or the risk of unauthorised persons entering the centre through either door.

Fire safety training was of a good standard, there were regular drills and all staff had training. Fire management for the complex was managed by an on-site designated fire officer. The fire officer conducted unannounced drills at various times of the day and night. On completion of each drill, she wrote a report and made recommendations for future practice if necessary. Signage had been renewed throughout the centre and was in large print informing practice if a fire was discovered. All residents had a risk assessment completed to ensure their evacuation needs were met. Fire equipment checking and servicing requirements were all

addressed. The fire exit door did not impede evacuation but placed vulnerable residents who were at risk of leaving the centre unaccompanied. A plant room housing an oxygen feed system to the operating theatres in Saint Francis Private hospital was still insitu. The fire officer recommended that this be considered for relocation to the external of the building to comply with HTM 02-01 (14.10) in a letter to the General Manager dated 26 October 2010. The risk category that this hazard was allotted in the risk register was 'catastrophic'. The provider undertook to relocate this room by mid – February 2012 but this action was not taken. The inspector also discussed this finding with the provider on the second day of the inspection and he undertook to prioritise this move.

The risk management policy dated 23rd February 2010 did not contain adequate information to inform staff to inform practice in relation to assault, or self-harm. The person in charge had attended training in risk management. The provider employs a risk manager for the complex. All accidents and incidents and near misses that occurred in St Clairs Nursing Home were addressed by the person in charge locally and then fed into a multidepartment risk management committee meeting. The minutes of these meetings were available and referenced satisfactory address of a number of risk issues from a site perspective including traffic management.
The person in charge told the inspector that she was planning to set up a local committee in the centre.

The centre was located on an open site and arrangements were in place if residents left the centre unaccompanied, individual risk assessments were completed and missing person drills were frequent, unannounced and of a good standard. The fire officer co-ordinated these drills, recorded and analysed responses, wrote up a report and made recommendations for improvement if necessary.

Fixed rails and lever rails were not in place on both sides of toilets at recommended locations to assist residents' safety and independence. Work had been done with falls management however low-low beds or alarm mats had not been introduced as fall preventative tools. The inspector noted that each resident had a moving and handling assessment done to ensure their safe mobilisation. Residents who fell were referred to the physiotherapist.

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

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

Inspection findings
There was a comprehensive recently reviewed medication policy that referenced all aspects of medication management including the procedures for prescribing, administering, recording and storing of medication. Nurses did not transcribe medications. Medications were stored and dispensed from a locked press in their

bedrooms. The staff nurses spoken with told the inspector that this arrangement promoted very safe practices.

The centre has a designated pharmacy service; the pharmacist visited the centre on the day of inspection in relation to residents' medications. A monthly audit of medications was done by the pharmacist and the person in charge. Unused or out of date medications were returned to the pharmacy.

Medication management procedures required improvement in relation to documentation of prescriptions and administration records. The Drug Prescription and Administration record was completed by the pharmacist who transcribed the GPs prescription. This documentation comprised of separate loose pages which posed a potential risk of administration error or loss of documentation. Medication administration sheets did not have photographic identification to fulfil professionally recommended checking procedures. Not all information requested on the prescription page was completed such as allergies.

Maximum dose over a twenty four period was not consistently documented for PRN (as required) medications by the GP. Medications were not all signed for by the GP Procedures were in place to record and respond to medication errors.

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

Residents had timely and consistent access to physiotherapy services in particular. Many residents were receiving daily physiotherapy treatments. There was also evidence that residents with acute conditions received physiotherapy treatments to relieve their symptoms. There was also adequate access for residents to occupational therapy services speech and language and dietetics. Choice was available to residents regarding their optician in the centre or attend one of their outside of the centre. A reduction in chiropody fees were negotiated on the residents behalf.

Recognised assessment tools were used to promote health and address health issues. These included assessments of each resident's risk of developing pressure ulcers, malnutrition, and falls risk. The arrangements in place to meet residents' assessed needs which were set out in individual care plans did not address all needs. Some care plans did not adequately reflect or were informed by assessment of need. For example residents with pain and on pain management therapies did not have an assessment tool completed with a corresponding care plan in place to comprehensively describe meeting their needs and to inform effective management of their pain if necessary.

While resident's files contained key records as required, inspectors also found that assessments were not integrated into care plans in all cases making documentation difficult to follow. For example a resident who developed shortness of breath and a cough on the 27 June 2012 did not have a care plan in place referencing how this resident's care should be carried out to meet her needs and prevent deterioration.

Not all assessments following GP review were documented in the residents' medical file. This practice posed a risk of loss of treatment instructions and information. It also did not promote multidisciplinary communication.

There was inconsistent documented evidence of involvement of residents and/or family members in each of the care plans reviewed.

A weekly restraint log was maintained. The person in charge was an accredited train the trainer in this area. All staff nurses and two carers were trained in restraint management.

There was evidence of assessment of need, consent and monitoring of restraints used. The inspector was told that the use of restraint was reduced since training in this area was provided for staff. However, there was a lack of strong evidence that this training was been applied to all areas of restraint practice. The inspector noted that approximately 54% of residents still used bedrails and lapbelts. The inspector noted that bedrails were fully engaged while the resident was in bed. Although bedrails were used by residents to assist them with changing position independently, they could not get out of bed without staff assistance to disengage the bedrail. I was therefore unclear what they were enabling. It was also not clearly documented whether an assessment had been completed to ensure that the restraint used was the one that posed the minimum restriction necessary.

A programme of activities was documented as being in place. The weekly programme was displayed for residents' information. An activity coordinator was

employed full-time by the centre but was not on-duty on the days of inspection. Arrangements were not in place where another staff member replaced her and carried out the activity programme as planned and displayed. Alternative activities were provided where there was less interaction required. The provider and person in charge discussed their intentions to address these deficits. Residents were also waiting for an information session from the pharmacist on one of the days of the inspection which was postponed.

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

Community Palliative care services were well established and when there was a resident in receipt of palliative care, they would visit the centre regularly the inspector was told.

There was a large Church located off the lobby of St Francis Hospital and this church was available for removals and funerals of residents if they wished. A pastoral care team were available. The team had an office in St Francis Hospital. They facilitated bereavement counselling and were also available to meet residents on a one to one basis if necessary.

The inspector viewed a suite of policies referencing various aspects of end of life care. Residents end of life wishes were ascertained where possible and were followed at the time of death but were not documented in care documentation as a routine. Relatives are facilitated to stay overnight if they wish with residents receiving end of life care.

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 discreet and sensitive manner.

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

Inspection findings

Residents spoken with complimented the standard of food and told inspectors they were happy with food on offer. A Bain Marie was introduced with the desired result

for the teatime meal as well as lunchtime in response to residents' issues with the tea-time meal. The chef attended a residents meeting to receive residents feedback regarding their food. There was a pleasant food aroma around the centre during mealtimes and a wide variety of menu which gave good choice of main course for lunch and tea each day. This choice was also displayed on a menu board in the dining room. The food was noted to be wholesome, varied and freshly cooked. A catering supervisor attended the centre for meal-times while a member of catering staff served residents meals from a Bain Marie brought to the dining room from the kitchen. Residents were noted to view the food on offer before they made their choice. Mealtimes were noted to be a social occasion where some residents chatted over their meal.

The inspector was also told how the use of medicinal laxatives had been reduced by introducing natural laxatives such as linseed and prune juice into meals. Residents requested more fish on the menu and the chef provides this option three to four times each week. Options of minced chicken and minced ham are also offered as an alternative to minced beef for residents on modified texture meals.
The catering staff and staff on duty were aware of special diets required for individual residents. A dietician had reviewed the menu and recommendations made were taken on board by the chef.

Residents with new or existing swallowing difficulties were seen by the Speech and Language therapist who prescribed modified fluids and diets following assessment. Modified fluids and diets were grades as per the National Irish Consistency Descriptors for Modified Fluids and Food. Fluids were graded 1 to 4 while food was described in terms of texture A to D supported by pictorial representations. Staff had also received training on these descriptors and can refer residents directly for assessment.

There were adequate drinks and snacks available to residents throughout the day. A water dispenser was located outside the dining room. Residents were provided with new jugs which kept their drinks cool and covered. An additional drink round was in place in the afternoon with a choice of soup or cold drink as desired in response to feedback at a residents' meeting.

The inspector noted that improvement was required during mealtimes to ensure residents who could not eat or drink unaided received adequate assistance and did not have to wait on their meals. There was not enough staff to assist residents and there was an over reliance on three students on work experience. There was not adequate supervision of these students who were each linked to a carer. Staff nurses were noted not to attend the dining room during mealtimes.

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

The inspector viewed a sample of residents' contracts of care. Not all contracts were signed; the inspector was told that this was being followed up. On admission each new resident received a copy of their contract with other admission documentation. Each resident's contract described their terms and conditions. Although the total fees chargeable each week were documented, each resident's individual contribution to the total fee was not clearly stated in each case.

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

The Inspector found that residents received dignified and respectful care. Their capacity to exercise personal choice and autonomy was encouraged and their views were sought and listened to. Residents stated that they felt that they were able to talk to staff at any time. Relatives spoken to were satisfied with information provided by staff about residents' healthcare and general wellbeing.

Residents meetings were held approximately every month and provided residents with an opportunity to voice their views and participate in the running of the centre. Minutes from these meetings were viewed by the inspector and showed that the May meeting was attended by approximately 25% of the residents. Some relatives also attended to be with residents who wished to have them there. The issues discussed were meaningful and changes were made as a result. While some items on the agenda were fixed from month to month, other issues discussed included the ea-time experience for residents; this was resolved by introducing the use of a Bain Maire with positive results. There were a number of trials in progress in response to

residents' feedback at meetings including a larger tea-cup trial and a trial of new chairs in bedrooms. The meetings were planned for the year and dates were displayed on the noticeboard. Following feedback from the meetings the time for meetings changed to 18:00 hrs to suit residents and relatives who wished to be there.

Inspector observed staff knocking before entering residents' bedrooms, waiting for permission before entering, closing doors and curtains in semi-private rooms to ensure that privacy and dignity was maintained.

Residents were encouraged to personalise their rooms and some rooms were noted to be highly personalised.

There was an open visiting policy and inspectors met visitors at different times over the two days. Most residents could meet with their visitors in the privacy of their own rooms or in the visitors' room and in communal areas.

While the communication policy did not inform on all aspects of communication in the centre, practice in this area had addressed a number of areas to improve the quality of life for residents in the centre. Some residents with communication difficulties had assistive devices such as hearing aids and those who were partially blind were registered with the Irish Association who provided talking books and other items to support the residents' quality of life.

There were large colourful notice boards located at various points around the centre for residents' information. A residents' folder was located in the centre's lobby which contained useful and relevant information including a copy of the residents' guide which was also given to each resident. The folder also contained the most recent published inspection carried out by the Authority.

Residents were able to attend Mass on a daily basis in the Church located off the lobby of Saint Francis Private Hospital. If not able to attend, there was a video-link in place which enables residents to view the services in the Church on the television sets in their rooms. Mass was also celebrated in the centre on a monthly basis. Other religious denominations were visited by their ministers, as required.

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

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

Inspection findings

There was a laundry system in place; residents' laundry was washed and ironed off site. Residents who wished to do their own laundry were provided with washing machine and dryer facilities. As these machines were located at the bottom of a stairway, a hazard risk analysis had been developed and controls put in place to mitigate risk of wet floors or fire. This laundry area was clean and tidy. The sink was easily accessed.

Inspectors viewed written operational policies and procedures relating to residents' personal property and possessions. There was adequate space provided for a reasonable number of personal possessions and residents could request a lockable drawer in their room. The Person in Charge confirmed that each resident retained control over their personal possessions. Records were signed by the resident or their relative. While all residents' personal property and possessions was fully documented on admission, not all residents had this list updated at regular intervals to maintain records of changes as required.

New pedal-operated, lidded laundry trolleys were purchased for the centre to transport used linen.

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 full-time as confirmed by the duty roster. Two weeks of the duty roster was reviewed 02 July to 07 July and 09 to 15 July 2012. The inspector noted that the person in charge was the second staff nurse on duty and worked in a supernummary basis on one day only which was while the inspector was on-site. This arrangement was discussed with the provider as it did not allow the person in charge to carry out the requirements of her role as identified in the action plan at the end of this report. While the person in charge is on leave, a deputy is nominated on the same working terms.

The person in charge demonstrated willingness to meet the regulatory requirements in line with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) or the *National Quality Standards for Residential Care Settings for Older People in Ireland*. There was some evidence of on-going improvements being made to improve the quality of life for residents in the centre.

The person in charge has on-going support in her role by the provider. She had engaged in further education having completed a course in risk assessment, a diploma in gerontology and dementia training.

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

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

Inspection findings

There was evidence of a comprehensive staff training programme on many aspects of resident care plus mandatory training. Documented records were maintained in relation to each topic of training completed by each staff member in the centre. The inspector was told that staffing levels and skill mix were subject to on-going review in response to residents changing dependency needs.

There were three staff on work experience in the centre; they were each linked to a carer. They each had task books which were signed off by the staff nurse. They had garda clearance and mandatory training completed. A policy on managing volunteers was available but required review. Staff rotated from night to day duty which facilitated the person in charge to supervise their practice and assess their competencies.

Two carers and a staff nurse were on duty through the night. The person in charge told the inspector that feedback on this was positive as residents told her they could choose what time they went to bed.

The inspector was not satisfied that there was adequate staff on duty on the days of inspection to supervise residents and Volunteers. There were twenty residents with max and high dependency needs. Vulnerable residents were not adequately supervised. The inspector noted that at 11:15 hrs and again at 14:00 hrs on the second day of the inspection, up to nine vulnerable residents were unsupervised by staff for prolonged periods in the sitting room. Two were in assisted chairs, one of which was tilted and three others were in wheelchairs.

As the person in charge is not supernummary for any period during her working week, she may not have an opportunity to complete the administrative and governance aspects of her role as evidenced by the requirements of the action plan at the end of this report.

Carers and staff on work experience assisted residents with eating. There was no staff nurse supervising the dining room for the period of the mealtime to ensure residents' needs were fully met. One resident vomited her meal and required assistance back to her room. The activity co-ordinator was not on duty on the day of inspection and residents were not facilitated to participate in the scheduled activities.

The inspectors reviewed staff files and found that the documents required by the legislation were in place in the sample of files reviewed.

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

In general the centre was kept clean and free from any offensive odours. It was well lit and ventilated. While the design and layout of some parts were suitable, such as some bedrooms, the communal and dining areas, there were some significant limitations and challenges arising out of the fact that the centre's entrance is from the lobby of Saint Francis Private Hospital. This has some impact on efforts to create a homely atmosphere. However, the provider and person in charge were working towards addressing some of these challenges which included refurbishment of an independent entrance, relocation of a medical gas supply room located in the centre, relocation of smoker's room to a more suitable location, refurbishment of the internal enclosed peace garden and completion of window replacement project. The peace garden was not accessible without the assistance of a staff member as the door was locked. The garden had a variety of surfaces and levels which posed trip risk and there was running water which posed a slip risk.

There was appropriate assistive equipment available such as hoists, pressure relieving mattresses, wheelchairs and walking frames. However, storage areas for equipment required review as residents' equipment was located in the bathrooms.

There was a sufficient number of toilet and washing facilities with wash-hand basins in each bedroom and communal toilets located in close proximity to the communal

dining and seating areas. However, the inspector noted that there were two toilets with no hand-washing facilities in them requiring the user to use a sink located outside of them. Hot water temperatures in this sink were greater than 43°C. In order to prevent risk from scalding, preset valves of a type unaffected by changes in water pressure and which have fail safe devices needed to be fitted locally to provide water to a maximum temperature of 43°C.

On the inspection of the 13 September 2011, the smokers room was relocated and the room was in the process of been converted into a cleaners' room. This project was not completed and the room reverted to its original function as a smoker's room. The door to this room was held open and smoke permeated into the area immediately outside the door. This room is documented in the centre's risk register as being in a 'severe' risk category. The cleaners' trolley was stored in another location in the centre which did not comply with the National Standards.

Installation of a conservatory was planned for the enclosed garden; this project was also not completed. The provider told the inspector that it would be in place by mid August 2012.

Inspectors noted that there were measures in place to control and prevent infection, including arrangements for the segregation and disposal of waste, including clinical waste. Staff had received education and training on the risks of infection, commensurate with their work activities and responsibilities and their role in preventing and managing infection. Staff had access to supplies of latex gloves and disposable aprons. Hand gel was located outside each room and in the sluice and communal areas. A weekly hygiene audit is completed by the domestic supervisor but it is not analysed and an action plan developed to promote quality improvement in this area.

There was a television replacement programme underway. Many residents had been provided with new large flat screen televisions. The inspector noted that some residents still had televisions located in their wardrobes which did not enhance their viewing experience. Some televisions were located on tables and one was on a dressing table. Risk hazards associated with this were documented with controls documented including securing the televisions with a strap or both. However, this was not done.

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:
Part 6: The records to be kept in a designated centre
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

The directory of residents was reviewed and cause of death was not documented in two of the logs reviewed. All other information was complete in that it contained all information required by the legislation.

Some of the operating policies and procedures required by schedule 5 of the legislation were available but were not adequate in that they did not contain sufficient detail to inform staff of evidence-based procedures to take in relation to the various practices in the centre. The inspector noted that the following policies needed redrafting communication, recruitment, selection and vetting of staff, provision of information to residents, monitoring and documentation of nutritional intake and the creation of, access to, retention of and destruction of records. Other policies required review included the volunteer policy the elder abuse recognition and prevention policy and the risk management policy. Staff confirmed that they had read and understood the policies and procedures by signing their names on an accompanying sheet.

Some residents' medical records were incomplete as they did not contain details of all GP visits where investigations were made, diagnosis and treatments given.

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

A record of all incidents and accidents was maintained in the centre. Notifications forwarded by the person in charge were reviewed and were accompanied by good supplementary information and follow-up. Returns had been made in respect of quarterly notifications for April 30 2012.

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

Not applicable on this inspection. The person in charge has not taken leave in excess of twenty eight days

Closing the visit

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

Acknowledgements

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

Report compiled by:

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

3 July 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	St. Clair's Nursing Home
Centre ID:	0099
Date of inspection:	29 June and 3 July 2012
Date of response:	22 August 2012

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: Not all matters listed in Schedule 1 of the Regulations.
Action required: Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.
Action required: Make a copy of the Statement of purpose available to the Chief Inspector.
Reference: Health Act, 2007 Regulation 5: Statement of Purpose

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

Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Provider will amend and update the statement of purpose regarding matters listed in Schedule 1 of the Regulations and make the Statement of Purpose available to the Chief Inspector.	21 September 2012

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: An established system was not maintained for quality and safety reviews to include for example, a list of all of the audits and evaluations undertaken, the scheduled date for the next audit, key findings and action taken to inform and demonstrate systematic continuous quality improvement. Audit reports were produced however; these had not been made available to residents.	
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.	
Action required: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents.	
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: A new computerised template of all quality and safety reviews /quality improvement will be implemented and a report in respect of any review conducted by the PIC for the purpose of regulation 35(1) will be made available to the residents.	30 September 2012

Outcome 3: Complaints procedures

3. The provider is failing to comply with a regulatory requirement in the following respect: The designated complaints officer in the centre was not clearly identified. A named independent appeals person independent of the designated person who receives and investigates complaints was missing. The name of the nominated person required by Article 39(10) of the legislation was not documented. Satisfaction with the outcome of the investigation was always sought; this was not documented and therefore did not inform the appeals procedure. Verbal complaints were not addressed as part of the complaints procedure.
Action required: Make available a nominated person in the designated centre to deal with all complaints.
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: 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: 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: The Provider will review the entire complaints procedures - which we are generally content are currently delivering a satisfactory	30 September 2012

output for residents - to inculcate: 1. A new designated person for dealing with complaints. 2. A full outputs-driven complaints register, including close-offs. 3. Include a new independent appeals process. 4. Appointment of a document guardian for all complaints. We have commenced this process-change at the time of writing (14 August 2012).	

Outcome 4: Safeguarding and safety

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

Protective arrangements were not of an adequate standard to ensure residents were safe at all times. Access to the centre by unauthorised members of the public was possible through either the open fire exit or the door to the centre accessible from St Francis Private Hospital. Vulnerable residents assessed as at risk of leaving the centre unaccompanied could potentially egress through the open fire exit.

A visitors' log was not maintained at all times.

The elder abuse management policy reviewed required some revision to inform staff of the specific care and procedures that was most appropiate to take for each type of abuse. Response to take in the event of an abuse allegation against a senior member of staff also required clarity.

A high standard of evidence-based nursing practice was not in place in all aspects of restraint management in the centre.

Residents did not have an opportunity to participate in recreational activities scheduled for them because the activity coordinator was not on duty.

Action required:

Take all reasonable measures to protect each resident from all forms of from harm or abuse.

Action required:

Put a policy in place on and procedures in place for the prevention, detection and response to abuse.

Action required:

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

Action required: Provide a high standard of evidence-based nursing practice in relation to restraint management, Falls and pain assessment.	
Action required: Maintain a record of all visitors to the centre, including the names of visitors.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: At the time of inspection, the correcting of the installation of the new Front Door for St Claris had been ordered and chased up for a long period of time; a spare part being the problem. The door was locked internally in the interim, however was unlocked periodically for use by staff at certain times. This practice was stopped. However I, as the Provider, am satisfied that it was not possible at any time for an intruder to gain access, nor for a resident to egress through these means, unless accompanied by a member of staff. At present, the door has been finished, and is now available for use. It is currently locked until a new CCTV camera is added to the front door of St Clairs. Access by unknown persons into St Clairs is impossible due to the fully-manned reception at the current front door to St Clairs via St Francis Private Hospital. This reception is manned permanently between 0700 hrs - 2200 hrs. This area is covered under CCTV. From 2200 hrs -0700 hrs, the only access is via security buzzer and access by a St Clairs Registered Nurse (RN). The front door is completed. A visitors' log will be in place, with a designated custodian in charge. A full review of abuse, security and protection will be undertaken by 12 September 2012, with all recommended measures in place by 30 September 2012.	July 2012 31 August 2012 30 September 2012

We will review activities. However, it should be noted that the inspector's timing coincided with the death of a close family member of the activities Coordinator who was not at work for that reason. Activities continued, but not to the same extent as normal for very obvious reasons. It should be noted that this Ccntre has invested significantly - and takes very seriously - its responsibilities with regards to activities. Our residents are routinely able to choose to participate in a very large amount of activities, from visits for tea to Belvedere, and other places of interest, to being able to go to chapel, visit the restaurant for lunch, etc. as well as being taken into Mullingar to go to the bank/post office/local shops. We have purchased extra-sized screens for cinema nights, enabled singing sessions with local entertainers etc.	30 September 2012
Notwithstanding the above, we will review activities at the centre, and ensure that all potential options are offered to our residents. We will review all areas of evidence-based nursing regarding restraint management.	30 September 2012

Outcome 5: Health and safety and risk management

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

Plant room housing oxygen feed system to the operating theatres in Saint Francis Private hospital was still insitu. The fire officer recommended that this be considered for relocation to the external of the building to comply with HTM 02-01 (14.10) in a letter to the General Manager dated 26 October 2010.

A comprehensive risk register in respect of all potential hazards was not in place to minimise risk in those areas ensuring the safe operation of the centre in all respects.

An open fire exit door did not impede evacuation but placed vulnerable residents who were at risk of leaving the centre unaccompanied.

The risk management policy did not contain adequate information to inform practice in relation to assault, or self-harm.

Fixed rails and lever rails were not in place on both sides of toilets at recommended locations to assist residents' safety and independence.

Some televisions were located on tables and one was on a dressing table. Risk hazards associated with this were documented with controls documented including securing the televisions with a strap or both, this was not done.

Action required: Provide to the Chief Inspector with written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.	
Action required: Ensure that the risk management policy covers the precautions in place to control the following specified risks: assault and self-harm.	
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.	
Action required: Provide grab-rails in bath, shower and toilet areas.	
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 Provider will provide the Chief Inspector with a letter from a competent person regarding compliance with all aspects of fire safety. We are currently assessing the best location for placing the medical gas unit, which does not contradict the placement of the new St Clairs Nursing Home. The initial plan was to move the medical gas unit into a location that will now be in the middle of the planned St Clairs centre's western edge. We are therefore planning to place medical gases to the north of	30 September 2012

the St Clair's unit, including taking down the current trees and bushes that will also create more light into the dining rooms and new front entrance. A review will be carried out of the risk management policy to include self-harm and assault. The risk management policy will incorporate a new risk register to ensure all potential risks to Residents are mitigated or removed. All appropriate measures such as grab-rails in toilets areas will be in place where required.	30 September 2012 30 September 2012 30 September 2012

Outcome 6: Medication management

6. The provider is failing to comply with a regulatory requirement in the following respect: Medication records comprised of separate loose pages which posed a potential risk of administration error or loss of documentation. Medication administration sheets did not have photographic identification to fulfil professionally recommended checking procedures. Not all information requested on the prescription page was completed such as allergies. Maximum dose over a twenty four period was not consistently documented for PRN (as required) medications by the GP. Medications were not all signed for by the GP	
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 Standard 15: Medication Monitoring and Review	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Provider and the Pic will discuss /review and amend as	30 September

appropriate all aspects in relation to residents' medications with the pharmacist. The PIC and pharmacist meet on a monthly basis and all medication data sheet now have a picture of the resident to ensure photographic identification at all times. All drug presses have individual photographic identification in place. The Provider and the PIC will address issues in relation to GP prescribing and chart documentation, and will ensure that all staff are appropriately briefed and tested in relation to all aspects regarding medication management.	2012 30 September 2012

Outcome 7: Health and social care needs

7. The person in charge is failing to comply with a regulatory requirement in the following respect: The arrangements in place to meet residents' assessed needs which were set out in individual care plans did not address all needs. Inspector also found that assessments were not integrated into care plans in all cases making documentation difficult to follow. There was inconsistent documented evidence of involvement of residents and/or family members in each of the care plans reviewed.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.
Action required: Revise each resident's care plan, after consultation with him/her.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Provider was surprised by this aspect of the report, however accepts that the documentation can be improved to be more clear. The Provider will review each individual resident's care plan, and	 30 September 2012 30 September

communication regarding them. The PIC will consequently review and amend the residents care plans. The monthly review of all residents physical, social, psychological, and medical needs will be reflected in the care plans. These will include the views of family members where appropriate, and where wished for by the resident.	2012

Outcome 9: Food and nutrition

8. The person in charge is failing to comply with a regulatory requirement in the following respect: The inspector noted that improvement was required during mealtimes to ensure residents who could not eat or drink unaided received adequate assistance and did not have to wait on their meals. The policy and guidelines for the monitoring and documentation of residents' nutritional intake required review.	
Action required: Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.	
Action required: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.	
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Provider will review and implement recommendations from that review to ensure that no residents wait for meals, and are provided with assistance where required. The PIC monitors all issues in relation to nutrition and will compile a monthly audit for the centre and promote healthy eating in consultation with the residents. The PIC will review the nutritional policy and amend as appropriate in relation to best practice. Staffing levels at mealtimes will be reviewed and assessed according to residents needs.	 30 September 2012 30 September 2012 30 September 2012

Outcome 10: Contract for the provision of services

9. The provider is failing to comply with a regulatory requirement in the following respect: Although the total fees chargeable each week were documented, each resident's individual contribution to the total fee was not clearly stated in each case.
Action required: Ensure each resident's contract deals include details of the fees to be charged.
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The provider will ensure that each individual's contribution to their fee is stated clearly in their documentation.	30 September 2012

Outcome 11: Residents' rights, dignity and consultation

10. The provider is failing to comply with a regulatory requirement in the following respect: The communication policy did not inform on all aspects of communication in the centre.
Action required: Put in place written operational policies and procedures on communication.
Reference: Health Act, 2007 Regulation 11: Communication Standard 1: Information

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Provider will deploy the VFM healthcare communications	30 September

Director to update all aspects of communication in the centre, including the website, intranet, internal communications policies, external communications policies etc.	2012

Outcome 12: Residents' clothing and personal property and possessions

11. The person in charge is failing to comply with a regulatory requirement in the following respect: Not all residents had this list updated at regular intervals to maintain records of changes as required.
Action required: Maintain an up-to-date record of each resident's personal property that is signed by the resident.
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: St. Clair's Nursing Home has a new up to date record of all residents' property. The PIC will review the register and update as required.	04 January 2013

Outcome 14: Suitable staffing

12. The provider/person in charge is failing to comply with a regulatory requirement in the following respect: Vulnerable residents were not adequately supervised. As the person in charge is not supernummary for any period during her working week, she does not have an opportunity to complete the administrative and governance aspects of her role and did not have sufficient time to meet the legislative aspects of the role as evidenced by the actions in this action plan. Carers and staff on work experience assisted residents with eating. There was no staff nurse supervising the dining room for the period of the mealtime to ensure residents' needs were fully met and to respond to emergencies should they occur while residents were eating. The activity coordinator was not on duty on the day of inspection and residents were

not facilitated to participate in the scheduled activities.
Action required: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.
Action required: Supervise all staff members on an appropriate basis pertinent to their role.
Reference: Health Act, 2007 Regulation 16: Staffing Regulation 17: Training and Staff Development Standard 23: Staffing Levels and Qualifications Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Provider will scrutinise all aspects of the comments above. It is not correct that the PIC is not at any time supernumerary and afforded the opportunity to conduct all administrative duties within a managerial context. Therefore, the Provider will review all aspects of staffing and management and if required, following formal review, commence a re-structuring of all aspects of the centre's operational management, including deployment of staff, their training, pay and succession planning. This review will be completed by 30 September 2012. The recommendations will be implemented by 31October 2012 The supervision of all staff will be included within the above review and implantations.	30 September 2012 31 November 2012

Outcome 15: Safe and suitable premises

13. The provider is failing to comply with a regulatory requirement in the following respect: Refurbishment of an independent entrance, relocation of a medical gas supply room located in the centre, relocation of smoker's room to a more suitable location, refurbishment of the internal enclosed peace garden with erection of a conservatory and completion of window replacement project were still to be completed. The peace garden was not accessible without the assistance of a staff member as the door was locked.

Two toilets with no hand-washing facilities in them requiring the user to use a sink located outside of them required review. Hot water temperatures were greater than 43°C at the point of contact.	
Action required: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.	
Action required: Provide sufficient numbers of wash-hand basins fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.	
Action required: Provide and maintain external grounds which are suitable for, and safe for use by residents.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There has been a significant amount of investment in the premises since this provider has purchased the centre: ▪ car parking management plan, tarmacing, external lighting ▪ new windows and new doors throughout the centre ▪ new entertainment systems for residents ▪ commencement of refurbishment of rooms to suit Residents' interests and tastes ▪ creation of new storage and office space ▪ creation of new space for smokers, only for residents to demand reversal to internalised smoke room. The Provider will however conduct a full review of : The construction and state of repair of the facilities, Review and implement recommendations for deployment of sinks	30 September 2012 16 October 2012

and hot and cold water to match all statutory obligations. With regard to general comments above: The peace garden is open daily. The key is visible and available on a key ring beside the entrance. The conservatory and other St. Clair's projects are ongoing. Most residents prefer to go into the hospital's facilities such as the chapel, shop, restaurant or the hospital gardens. A new garden is being created across from the new entrance which will provide more choice to residents. All environmental factors and investment are weighed against the fact that we are about to put designs into planning for the building of a new 120-bed St Clairs Nursing Home 90 metres to the east of the current location.	

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

14. The provider is failing to comply with a regulatory requirement in the following respect: Some residents' medical records were incomplete as they did not contain details of all GP visits where investigations were made, diagnosis and treatments given.	
Action required: Maintain, in a safe and accessible place, a medical record in respect of each resident with details of investigations made, diagnoses and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner.	
Reference: Health Act, 2007 Regulation 25: Medical Records Standard 13: Healthcare 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 Provider and PIC are aware that not all GPs will sign documentation where required when they visit the Centre. We have a process whereby all residents in St. Clair's Nursing Home have a GP visit sheet in their medical chart. All GP visits are documented and all GP are given the opportunity to document in the medical notes either in St. Clair's Nursing Home or in their private practice. The PIC will continue to monitor and ensure continuous improvement regarding same. All GPs who refuse to comply with our process we will notify to the Health Information and Quality Authority.	Immediate

The provider will review the management of all residents' medical records.	30 September 2012

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

Cause of death was not documented in two of the logs reviewed in the directory of residents.

Action required:

Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

Reference:

Health Act, 2007
Regulation 23: Directory of Residents
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The PIC ensures that cause of death is recorded in the register as soon as possible. In the event that a resident dies outside the centre (another facility) the PIC ascertains the information expediently.	30 September 2012
During the time of the inspector's visit, one death occurred in the local public hospital and we were awaiting the documentation; the other Resident's documentation was awaited.	30 September 2012
We will nonetheless review this and update.	30 September 2012
We will be fully compliant with Schedule 3 of the Health Act 2007.	

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

Some of the operating policies and procedures required by schedule 5 of the legislation were available but were not adequate in that they did not contain sufficient detail to inform staff of evidence-based procedures to take in relation to the various practices in the centre.

Action required: Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.	
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Provider/PIC will review and amend operating policies to adequately reflect the detail to inform staff of evidence-based procedures to take in relation to the various practices in the centre as per Schedule 5 of the Regulations.	30 September 2012

Any comments the provider may wish to make:

Provider's response:

None given

Provider's name: Mr. Mark Gordon
Date: 22 August 2012