Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

Centre name:	Thomond Lodge Nursing Home
Centre ID:	0109
Centre address:	Ballymahon Co. Longford
Telephone number:	0906-438350
Email address:	seankellythomond@gmail.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Thomond Care Services Limited
Person authorised to act on behalf of the provider:	Sean Kelly
Person in charge:	Trish Ennis
Date of inspection:	31 October 2012, 4 November 2012 and 26 and 27 November 2012
Time inspection took place:	**Day-1 Start:** 14:50 hrs **Completion:** 16:55 hrs **Day-2 Start:** 16:00 hrs **Completion:** 21:10 hrs **Day-3 Start:** 09:00 hrs **Completion:** 15:30 hrs **Day-4 Start:** 09:00 hrs **Completion:** 15:15 hrs
Lead inspector:	Florence Farrelly (day 1 and day 2) PJ Wynne (day 3 and day 4)
Support inspector(s):	Sheila McKevitt (day 2)
Type of inspection	☐ **announced** ☒ **unannounced**
Number of vacancies on the date of inspection:	None

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by Regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

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

Regulation has two aspects:

- Registration: under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of their registration.

Monitoring inspections take place to assess continuing compliance with the Regulations and Standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of 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*.

This inspection report sets out the findings of a monitoring inspection, in which 15 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☒ following a notification of a change in person in charge
- ☒ following information received in relation to a concern/complaint

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☒
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☒
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This monitoring inspection was unannounced and took place over four days. This was the eighth inspection carried out by the Health Information and Quality Authority's Social Services Inspectorate (the Authority).

The main purpose of this inspection was to assess progress in relation to previous action plans and to determine the extent that risks identified in previous inspections had been addressed. There has been ongoing weak compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended)in the areas of governance, risk and medication management, staffing levels and obtaining all the documentation required by

Schedule 2 of the Regulations in relation to staff employed. The last inspection was conducted on 4 and 5 July 2012. The person in charge, Mary Mealy, was subsequently interviewed by inspectors on 18 July as part of the fit person assessment for her role. She demonstrated competence for this role but verification that she had the required three years experience in the last six in the care of older people was required. The response to the action plan of the inspection conducted on 4 and 5 July 2012 was reviewed by the inspector. The response did not provide adequate information that indicated that the matters raised would be addressed with appropriate rigour and within reasonable time frames. Inspectors visited the centre on 30 August 2012 to discuss this with the provider. They were told that the person in charge was no longer in her post. The report was re-issued and the subsequent response provided was considered satisfactory. During the inspection the inspector raised concerns that care staff employed by a relative had not provided the required Schedule 2 documents that are necessary for persons working with vulnerable people to the provider. There was also concern that care practice in respect of one resident was not appropriate to his care needs. The provider and person in charge were requested to review both matters. The person in charge instigated a meeting with the multidisciplinary team involved and a care plan to meet the resident's needs was subsequently devised.

There were 18 non-compliances with the requirements of the Regulations outlined in the action plan of the inspection report dated 4 and 5 July 2012. The inspector found that four of these actions had been completed. These included developing a training matrix which allowed the inspector to readily identify that staff had access to ongoing education in addition to the mandatory training and revising the infection control policy to provide appropriate guidance for staff. Fire extinguishers were serviced and missing person profiles were completed for all residents. Eight actions were partially progressed to include aspects of care planning, changes to medication management and improvement to plans of care for end-of-life. There were six actions not completed including aspects of restraint practice and the development of a quality improvement system. The complaints procedures and policies to guide practice in areas of risk management and on recruitment, selection and vetting of staff were inadequate. The actions identified as partially or not completed are reinstated in the action plan of this report.

Information was received in October 2012 relating to care and welfare, lack of staffing and inadequate governance. Consequently a triggered inspection was undertaken by the Authority. Aspects of the concerns brought to the attention of the Authority were substantiated and included inadequate staff levels. The actions outlined in this report require the provider to address those issues as well as others identified during the inspection.

As part of this monitoring inspection inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. The inspector focused on regulatory requirements relating to safeguarding and safety, risk and incident management, resident care, quality of life and staffing levels, management of finances, to assess how care was being delivered and to determine the extent to which these impinged on the delivery of care and provision of positive safe outcomes for residents.

The person in charge had changed since the last inspection in July 2012. Trish Ennis was notified to the Authority as the person in charge from 24 August 2012. In order to assess the suitability of the person in charge, inspectors from the Authority completed a fit person interview on 14 November 2012. The inspectors concluded the person in charge was appropriately qualified and experienced as required by the Regulations to be the person in charge of the designated centre.

The inspectors were satisfied that the residents clinical care needs were being met. Residents had good access to general practitioner (GP) and allied health professionals. The centre was well furnished. Bedrooms were spacious and bathrooms were well equipped to assure the safety and privacy needs of residents. Mealtimes were nutritious and residents could practice their religious beliefs. There was a structured program of activities in place facilitated by an activity coordinator.

The inspectors found aspects of the service that needed improvement and these improvements included:

- the inspector was not satisfied by observing practice, reviewing the rota and taking account of the dependency needs of residents', that a sufficient nursing staff level was available to meet the care needs of all the residents on each Monday when respite residents are discharged and new respite residents are admitted. The inspector further concluded that care assistant staff levels remained inadequate to ensure suitable supervision and to meet the need of residents in a person centred manner in the afternoon and evening time

- en suite bathrooms were not cleaned in a timely manner after morning use. A cleaner was rostered to clean communal areas in the morning and then commenced work in the laundry. A second cleaner commenced duty at 12.30pm and started cleaning the residents' en suite bathrooms at this time. This was not suitable to meet the needs of residents and the delay in ensuring required cleaning was undertaken posed a potential infection hazard

- aspects of restraint practice did not reflect the new national policy on promoting a restraint free environment

- there was limited evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when reviewed or updated in the sample of case files examined

- all the information required by Schedule 2 of the Regulations was not available in each file examined to include three written references and a full employment history, the outcome of Garda Síochána vetting and certification by a medical practitioner of physical and mental fitness for the purpose of the work staff perform

- the inspector identified the need for further improvement in the development of policies to include the risk management policy, the complaints policy, the policy on recruitment, selection and vetting of staff, the adult protection policy and the medication management policy

- the system for quality assurance and monitoring required further expansion to review additional areas which impact on resident's wellbeing and to ensure sufficient systems are provided for to ensure enhanced outcome for residents

- the statement of purpose did not meet all the requirements of Schedule 1 of Regulations.

A number of these factors had been identified for improvement during the inspection conducted during July and it is a concern that these matters are again identified for remedial action. The areas where repeated failures have been identified include staffing levels and deployment of staff, the recruitment arrangements for the vetting of staff who work with vulnerable people and aspects of risk management.

A meeting was held with the provider and person in charge on 20 December 2012 to discuss the governance arrangements and the repeated failings identified during inspections. Minutes of the meetings were furnished to the provider and person in charge following the meeting.

The Action Plan at the end of the report identifies areas where mandatory improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Section 41(1)(c) 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*.

Theme: Governance, Leadership and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1

There is a written statement of purpose that accurately describes the service 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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings
The statement of purpose is kept under review by the provider and had been updated in October 2012. The statement of purpose set out the services and facilities provided in the designated centre. However, the statement of purpose did not meet all the requirements of Schedule 1 of Regulations. The following matters were omitted or lacked sufficient detail to include:

- the conditions of registration attached by the Chief Inspector
- the registration number
- the organisational structure was unclear as the lines of authority and reporting accountability were not clearly identified in the organisational chart
- the professional registration of the key senior manager who deputises in the absence of the person in charge was not indicated
- the number of whole time equivalents for each grade of staff was inaccurate
- a mission statement was outlined. However, the aims and objectives of the centre were not specified
- the range of dependency levels catered for was not outlined.

Outcome 3
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings
There were three changes to the post of person in charge in the past three years. The person in charge had changed since the last inspection in July 2012. Trish Ennis was notified to the Authority as the person in charge from 24 August 2012. She had previously held this role from the time of registration until January 2012. In order to assess the suitability of the person in charge inspectors from the Authority completed a fit person interview on 14 November 2012. The purpose of the interview was to assess the understanding and capacity of the person in charge to comply with the requirements of the Regulations and the Authority's Standards. She was assessed as appropriately qualified and experienced to be the person in charge of the designated centre in accordance with Regulation 15.

All staff the inspectors spoke with during the inspection on 26 and 27 November was aware of who the person in charge was and of her role in the centre. The inspector reviewed the staff roster for a three week period. While the person in charge was involved in the delivery of clinical care, allocated time was denoted on the roster for the person in charge to undertake the management and governance tasks required by her role. This time was identified separately on the roster.

Outcome 4
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:
Regulations 21-25: 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:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

It was required from the inspection in July 2012 to put in place all the operational policies listed in Schedule 5 of the Regulation and to review polices in the timeframe required by the Regulations. The inspector reviewed a sample of polices and identified the need for further improvement in this area to include the risk management policy, the complaints policy, the policy on recruitment, selection and vetting of staff and the adult protection policy. These are discussed in more detail further in this report. Polices did not have an implementation or review date indicated.

Directory of Residents

Substantial compliance ☒ Improvements required * ☐

Staffing Records

Substantial compliance ☐ Improvements required * ☒

This is discussed further under Outcome 18 of this report.

Theme: Safe care and support
Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes

rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6
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

Action(s) required from previous inspection:

1. Make all necessary arrangements, by policy revision and implementation, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

2. 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.

3. Maintain a record of the training completed by staff in a manner that makes it easy to determine that all staff has received the regulatory information or training on elder abuse.

4. Put in place written operational policies and procedures relating to residents' personal property and possessions that fully protect residents. Provide receipts for all money and valuables retained for safe keeping.

Inspection findings
This action plan was partially completed.

1. There was a centre-specific policy in place on the protection of residents from abuse. The policy defined the various types of abuse, outlined the investigation process and procedures to protect the residents. However, the policy did not contain the contact details of the elder abuse officer in the Health Service Executive (HSE) or how to manage an allegation of abuse against a senior member of the management team. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were not documented in the policy. The person with overall responsibility to investigate a reported issue of concern was not clearly identified in the procedures as the policy referenced both the director of care and nurse in charge.

2. A review of training records indicated all staff had been trained in elder abuse and had knowledge of adult protection to ensure the safety of residents. Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified the person in charge as the person to whom they would report a suspected concern or the most senior nurse on duty in the absence of the person in charge.

3. A training matrix was developed which listed all staff employed and allowed the inspector to easily identify staff had received the education or training on adult protection. This was evidenced by a review of staff files where certificates of training were available in each file reviewed. The inspector viewed evidence of a program of ongoing education and further training was planned for December 2012. This was confirmed during conversations with staff that were arranged to attend.

4. The inspector reviewed the procedures for managing residents' finances and spoke to the administrator with responsibility for maintaining residents' finances. The management of residents' finances on a previous inspection was identified as an issue of concern. The inspector reviewed the centre's procedures on managing residents' finances during day three of the inspection.

   A record of the handling of money was maintained for each transaction. Two signatures were recorded in all instances and a receipt provided for each transaction. The ongoing balance was transparently managed and explained to the resident or their representative. A monthly statement of the account was issued to the resident or their representative. Receipts were issued for valuable items handed in for safekeeping and a property log was maintained for residents.

   The inspector reviewed the policy on managing resident's finances. While no significant amounts of money were held on behalf of any resident the policy did not include a procedure to guide staff on the maximum amount they will accept and hold in safe keeping on behalf of residents on admission to the centre.

Residents spoken to stated that they felt safe in the centre. Residents attributed their safety to the "front door being secured" and "having a call bell" to summon assistance and identified staff as being kind and helpful to them. The inspector observed staff throughout the course of the inspection and noted respectful and caring interactions between staff and residents.

Garda Síochána vetting had been applied for all staff members. The provider was awaiting the outcome of Garda Síochána vetting for three members of staff recently recruited. This was evidenced by a review of returned Garda Síochána vetting forms examined by the inspector.

Outcome 7
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

Action(s) required from previous inspection:

1. Ensure measures are in place to prevent accidents to any person in the designated centre and in the grounds and provide a readily accessible profile of residents assessed as being at risk if they leave the centre unaccompanied.

2. Put in place a comprehensive written risk management policy and implement this throughout the designated centre and 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. Ensure the physical design and layout of the premises meets the needs of each resident. The use of the foyer as a sitting area for prolonged use needed review as it presented hazards to residents who used assistive equipment due to the number of residents that used the area.

3. Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre. Ensure that hazardous substances and critical activity areas such as the laundry are appropriately secured when not in use and that hazardous substances are appropriately stored.

4. Have in place arrangement to ensure that critical equipment is appropriately serviced.

5. Amend the infection control policy and procedure to include the maintenance of a record of all residents and staff that receive the influenza vaccine. In this centre this should include the influenza status of residents admitted for respite care. The contact details of the local public health office including out of normal working hours contact details should also be available in the procedure. Have available the latest guidance on infection control and the management of influenza outbreaks including information from the Authority on managing outbreaks of influenza in designated centres.

6. Put in place an emergency plan for responding to emergencies. Outline the system for communication to be followed during an emergency situation.

7. Make adequate arrangements for detecting, containing and extinguishing fires; giving warnings of fires; the evacuation of all people in the designated centre and safe placement of residents; the maintenance of all fire equipment; reviewing fire precautions, and testing fire equipment, at suitable intervals. Ensure that staff have appropriate training and guidance to enable them to identify that all fire fighting equipment is in appropriate working order.

Inspection findings
This action plan was partially completed.

1. The centre had a missing person's procedure to guide staff through the actions to take should a person leave the centre unescorted. A missing person profile was completed for all residents in the centre. This was viewed by the inspector and included colour photographic identification, a physical description of each resident to include height and weight and space to record what the resident was last seen wearing and any distinguishing features. Staff spoken with were familiar with the procedure to follow should they be unable to locate a resident. All windows were fitted with restrictors and exit doors around the building secured. The front entrance was monitored by CCTV (closed circuit television). There were no incidents of residents leaving the centre unescorted reported to the Authority and recorded in the accident/incident near miss register since the inspection in July 2012.

2. The risk management policy was revised during the course of the year. The inspector reviewed the risk management document and found that while it contained a range of information on risk factors relevant to care settings, it required further revision to meet all the requirements of the Regulations. Precautions to control or minimise risk were specified for the communal areas, bedrooms, the kitchen and external grounds. However, a risk assessment to identify potential hazards within bathrooms was not included. A risk assessment of the use of the foyer by residents around the nurses' station was not completed although identified as a potential hazard when the centre was inspected in July 2012. While the communal sitting and dining areas were used throughout the day and comfortably furnished, many residents sat for long periods in the foyer area around the nurses' station. On day three and four of this inspection it was also noted that there was a variety of equipment used by residents in the area which could be trip hazard for others walking through as it was the main route residents and staff had to use to get from bedrooms to the main facilities.

   The risk management policy did not clearly outline the governance arrangements to manage risk situations. The policy reviewed did not specify who had the overall role and responsibility for health and safety procedures and an organisational safety structure was not included in the health and safety procedures. Additionally the risk management policy did not outline the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or near miss events to ensure learning for all staff to minimise the risk of repeat occurrences.

   Procedures to guide staff actions in the event of self-harm and assault was included in the policy. However, they lacked sufficient detail to appropriately guide staff. While there were arrangements outlined in the policy on challenging behaviour to manage violence and aggression and additional literature was included as reference material. However, centre-specific procedures to guide staff actions and interventions were not sufficiently detailed.

3. The inspector visited the laundry area. This was secured with a coded key pad to restrict access in the interest of safety to residents and visitors. A separate area was provided for the storage of cleaning chemicals which was secured.

4. There was a service contract in place for hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. The contract in place covered breakdown and repair for all beds, air mattresses and other equipment, used by residents. The inspector examined the hoists and they were recently serviced. A maintenance person was employed on a part-time basis to undertake minor repairs. On day one of the inspection it was observed foot plates were not provided on all wheelchairs. This was rectified by the provider and reviewed by the inspector on the fourth day of the inspection. It was noted on examination foot plates were in place on all wheelchairs and staff were observed ensuring the foot plates were correctly in position when mobilising residents.

5. The inspector viewed the infection control policy and found it provided appropriate guidance for staff when managing a range of infectious illness including noro virus, clostridium difficile and influenza. The contact details for the local health office, the infection control nurse and the public health doctor to include out of normal working hours contact details were available. A record of all residents and staff that receive the influenza vaccine was maintained and readily accessible for review by the inspector. Records were maintained for all residents admitted for respite care. The infection control policy included the most recent guidance on infection control and the management of influenza outbreaks. Safety alerts issued by the Authority on managing outbreaks of influenza in designated centres was maintained.

6. The inspector reviewed the emergency plan which was updated to include contact details of all staff and a priority contact details for members of the senior management team. However, the emergency plan in place was not comprehensive to guide staff in responding to untoward events. The plan reviewed did not outline clear procedures to follow in the event of emergencies. While relocation arrangements were provided for should it be deemed necessary to evacuate the building, the plan did not indicate how the evacuation would be undertaken. Staff roles and responsibilities were not defined in the emergency plan.

7. The inspector viewed contracts which indicated the fire alarms; smoke and heat detectors were checked and serviced. The fire extinguishers were serviced in July 2012 and a service record was available in documentation examined which included the number and type of all fire fighting equipment maintained on the premises. Recorded checks were undertaken daily to ensure fire exits were clear and unobstructed and the fire panel was functioning correctly.

   The inspector reviewed records of fire drill practices. These records indicated regular drills were completed and staff responses times were monitored. The inspector viewed records of fire safety training. Records indicated staff received training by a competent person in theoretical and practical aspects of fire safety and evacuation techniques. The most recent fire safety training was undertaken with staff on 23 November 2012. Staff spoken with could explain the procedures

to ensure safe placement of residents in the event of a fire and how they would evacuate immobile staff.

The inspector viewed records in staff files which indicated the majority of staff been trained in the safe moving and handling of residents. This was evidenced by a review of staff files. A certificate of training attendance was provided in files examined. However, the inspector identified six members of staff as requiring training in the safe moving and handling of residents.

Outcome 8
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

Action(s) required from previous inspection:

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 in relation to discontinued medications, maximum dose in 24 hours of PRN medications, nurses signatures on transcribed medications and doctors signatures for all medications prescribed.

Have in place systems for medication management that are in accordance with legislative requirements and An Bord Altranais agus Cnáimhseachais na hÉireann (the Nursing and Midwifery Board of Ireland) guidance.

Inspection findings
This action plan was not completed. This failing was identified in a previous inspection and an action plan was outlined in report of 4 and 5 July 2012.

A medication management policy was in place. The inspector reviewed this and found that procedures did not provide sufficient detail to guide and inform staff in all areas of medication management. The policy did not provide sufficient detail to guide staff on the safe administration of medication, outline the procedure for safe transcribing in accordance in accordance with legislative requirements and An Bord Altranais agus Cnáimhseachais na hÉireann guidance. The policy did not contain a procedure for the safe disposal of unused or out-of-date medication or medication that was discontinued. There was one resident who self administered his eye drop medication and another with percutaneous endoscopic gastronomy (PEG) feeding systems in place. While there was a plan of care in the case file for the resident who self administered some of his medication, there was no procedure to guide staff on self administration or administration via enteral feeding tubes.

The Authority was informed medication errors occurred in August and some residents did not receive their medication as scheduled. New drug charts were put in place for each resident since the inspection in July 2012. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were clear, legible and distinguished between PRN (as needed), short-term and regular medication. The signature of the GP was in place for each drug prescribed in the sample of drug charts examined. The maximum amount for PRN (as needed) medication to be administered within 24 hour period was stated on the sample of drug charts reviewed. The inspector viewed the GP signature in place for medication that was discontinued in the sample of charts reviewed.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes.

The inspector identified three residents whose medication was being crushed prior to administration due to swallowing difficulty by the residents. However, the drugs were not prescribed on the medication charts for administration in a crushed form.

The clinic room was neatly maintained and stocks of drugs were checked routinely. Medications that required special control measures were kept in a double-locked cabinet. A register was maintained which was viewed by the inspector. Medications were counted and recorded on each occasion at the change of each shift by two nurses from opposite shifts. The temperature range of refrigerated medication was being appropriately monitored and recorded.

Outcome 9
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings
Practice in relation to notifications of incidents was satisfactory. The inspector reviewed a record of all incidents/accidents that had occurred in the centre since the previous inspection in July 2012 and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
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

Action(s) required from previous inspection:

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.

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 and to the Chief Inspector on request.

Inspection findings
This action plan was partially completed.

The inspector found that while advances had been made with regard to establishing and maintaining 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, further work was required in this area. Records were maintained of restraint practices and any episodes of pressure sores occurring and accidents/incidents. Data collected from accidents and incidents was reviewed for trends and action put in place to ensure enhanced outcomes for residents. For example, one resident was identified as having fallen repeatedly in a short time frame, had a medication review completed and no falls were since reported.

A process for auditing information on each area in which data is collated was not in place and there was there was no improvement plan developed arising from all audits completed.

Additionally, the system for quality assurance and monitoring required further expansion to review additional areas which impact on resident's wellbeing and to ensure sufficient systems are provided for to ensure enhanced outcome for residents.

Audit findings had not been collated into a report with a copy made available to the residents or their representative.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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

Action(s) required from previous inspection:

1. Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances as and no less frequent than at 3-monthly intervals.

2. Ensure that each residents care needs are set out in an individual care plan.

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

4. Ensure that a high standard of evidence based nursing practice is in place in relation to restraint management.

Inspection findings

1. This action was partially progressed. Each resident had a care plan completed in the sample reviewed. The inspector reviewed three residents' care plans in detail and certain aspects within other plans of care. The arrangements to meet residents' assessed needs were set out in individual care plans.

   The inspector was told by the person in charge that nursing staff were reviewing care plan documentation and in the process of changing from the current

documentation to a new care planning system. There was evidenced by a review of a care plan completed on the new documentation. The person in charge informed the inspector this was a key priority for the immediate future.

2. Care plans examined were noted to be reviewed at the required three-month intervals or in a timely manner in response to a change in a resident's health condition. It was identified on the inspection in July 2012 some reviews were indicated by a date only and it was not clear exactly what aspects of the care plan had been reviewed or who had been involved in the review. This practice was still evident in some of the sample of care plans examined by the inspector. A narrative of the reviews undertaken was not provided on reviewing some of residents' care plans examined to outline how the conclusion or judgment on the care pathway to follow had been determined.

3. There was limited evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when reviewed or updated in the sample of case files examined.

4. Two staff had completed training on the national policy on promoting a restraint free environment. Overall the level of restraint measures in place was low. Restraint practices included the use of bedrails by eight residents and a lap belt by one. The inspector reviewed a sample of assessments that underpinned restraint practice. The risk assessment completed prior to the use of the restraint was not based on the best practice policy and took cognisance only of a limited range of issues. A clear evidence-based rationale outlined in narrative form was not provided in all cases of the need for a restraint measure. While signed consent was obtained and the GP was involved in the decision making process there was limited evidence of trialling alternative options prior to the decision to use bedrails as an enabling factor.

Outcome 12
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings
The building is specifically designed to meet the needs of dependent older people. There was a variety of communal space throughout the building. Visitors usually met with residents in the communal sitting rooms, the foyer or their bedrooms but access

to a private space was available in the library or visitor's room for those who wished to see relatives' and friends privately. Residents had suitable facilitates to store their clothes and personal belongings.

Bedrooms are spacious and suitable to meet the comfort and care needs of the residents. There is a call bell system in place at each resident's bed. There is suitable lighting provided in each bedroom to meet the needs of the residents including a dim light facility. The en suite facilities in each bedroom are suitably adapted to meet the needs of residents. Showers are level with the floor finish providing ease of access.

On day two of the inspection it was noted the day room, dining room, library and front reception areas were not at optimal temperatures of 21 degrees as required by the Authority's Standards. Temperature checks by the inspector indicated a temperature ranging from 12 to 15 degrees. The issue regarding the heating was brought to the attention of the provider who immediately addressed the matter. On the third and fourth day of the inspection the temperature of communal and bedrooms areas were checked and readings of 19 and 22 degrees respectively were recorded at intervals around the building. The provider had implemented a manual procedure independent of the computer based system which regulated the heating controls to check the temperature of the building at intervals.

The communal areas and the bedrooms were maintained in a visually clean condition. However, residents' en suite bathrooms were not cleaned in a timely manner after morning use. A cleaner was rostered to clean communal areas in the morning and then commenced work in the laundry. A second cleaner commenced duty at 12.30pm and started cleaning the residents' en suite bathrooms at this time. This arrangement was not suitable to meet the needs of residents and the delayed time frames in the need for required cleaning also posed a potential infection hazard.

There was suitable staff facilities provided for changing uniforms and for the storage of personal belongings.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
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

Action(s) required from previous inspection:

Maintain a documented record of all complaints detailing the investigation and outcome

of the complaint and whether or not the complainant or resident was satisfied.

Inspection findings
This action was not completed.

The inspector reviewed the complaints log. There were three complaints documented since the last inspection in July 2012. The log contained the facility to record all relevant information about the complaint, investigation made and the outcome. However, clear evidence that the complainant was satisfied with the outcome achieved was not in place. The complainant's signature was not obtained to verify their satisfaction with the outcome of the issued raised by them.

The inspector reviewed the complaints policy and procedure and noted it did not meet all the requirements of the regulations. The nominated person with overall responsibility to investigate a complaint was unclear as the policy stated 'any member of staff informed of a complaint will refer it to the nurse in charge, the director of nursing or the manager'.

A nominated person (separate from the person nominated to investigate all complaints) who would monitor that the complaints process was followed to ensure all complaints are appropriately responded to and the required records are maintained was not identified. An independent appeals process if the complainant was not satisfied with the outcome of their complaint was not ensured. The procedures referred residents to an agency which does not assist to resolve issues of concern on behalf of residents.

There were no timescales stated within the complaints policy or procedure to ensure all complaints are investigated promptly and the complainant is informed of the outcome of their complaint and the appeals process in a timely manner.

The complaints procedure was displayed on the wall inside the main entrance. However, it was not prominently visible as required by the regulations as an ornamental flower display was located in front of the framed complaint procedure.

Outcome 14
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

Action(s) required from previous inspection:

Put in place written operational policies and protocols for end of life care.
Review end of life care wishes as part of care plan reviews to ensure that requests reflect residents or their representatives' current wishes.

Inspection findings
This action plan was partially completed.

The inspector reviewed the care plans for two residents who were receiving end of life care at the time of inspection. The local palliative care team provided support and advice. This was evidenced by a review of the medical notes where instruction was provided for staff. The person in charge confirmed the palliative care team will attend the centre outside of core hours if required.

Plans of care were outlined for end of life in the case files examined. The plans described in good details the goals and interventions for ensuring the residents physical care needs were met. However, the psychosocial aspects in relation to end of life care or spiritual plans of care were not detailed sufficiently in the sample reviewed.

There was a policy in place to provide guidance to staff on managing all aspects of end of life care.

Outcome 15
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings
On the second day of inspection it was noted that the dining experience for residents was not of a high quality. While residents were offered choice of what they wished to eat the inspector noted that there were no condiments' on the table, no milk on the table and there was no choice of cold drinks. The inspectors noted that residents who were being given a soft diet had this food served from a lunch box on a trolley in the dining room. The inspector noted that the outside of the box was tepid to touch. However, the staff member heated the food again prior to giving it to residents in their room.

On the third and fourth day of inspection the inspector observed mealtimes and noted matters identified on the previous occasion were addressed and the meal times were a pleasant experience.

Those that required help were offered assistance sensitively and discreetly. Staff in the dining room were observed encouraging residents to be as independent as possible while eating. Residents had access to drinks during the day.

Outcome 16
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

Action(s) required from previous inspection:

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

2. Put in place written operational policies and procedures on communication and put in place practices that facilitate and encourage each resident to communicate.

Inspection findings
This action was partially completed.

1. A communication policy was in place and outlined procedures to guide staff to assist in communicating with residents. The policy included procedures to guide staff in communicating with residents who have visual or hearing impairment.

2. There was a CCTV (closed circuit television) cameras focused on the dining room and day sitting rooms. The camera had not been removed from these areas since the last inspection in July 2012. There were no notices in place to advice residents or their relative of the continuous monitoring by CCTV. This compromised the privacy of residents to undertake activities in private within a communal space. For example, while having their meals or spending time with their visitors or engaging in activities and relaxing in communal areas.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
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

Action(s) required from previous inspection:

1. 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.

2. Have in place a record of all mandatory training that is readily accessible.

3. The Provider shall ensure that written policies and procedures relating to recruitment, selection and vetting of staff are complied with.

4. Maintain, in a safe and accessible place, a record of the name, date of birth, details of position and dates of employment at the designated centre of each member of the nursing and ancillary staff and all other documentation listed in Schedule 2 of the Regulations.

Inspection findings
This action was not completed.

1. The provider employs 39 staff in total which includes both part-time and full-time posts. There were 12 registered nurses to include the person in charge and 17 care assistants. In addition, there is catering and cleaning staff employed. The staff team were caring for a resident group that had a wide range of care needs, some with complex medical conditions. The majority of the resident group were in advanced old age. There were 48 residents accommodated on the third and fourth day of the inspection with 11 residents rated as maximum dependent and four highly dependent, 16 were assessed as having medium dependency care needs. The inspector viewed the staff duty rota for a three week period. The rota showed the staff complement on duty over each 24-hour period. The staff roster detailed their position and full name. However, the rota was not outlined in the 24 hour clock format and night duty was indicated as 'ND' only.

   On this visit the inspector was not satisfied by observing practice, reviewing the rota and taking account of the dependency needs of residents that a sufficient

nursing staff level was available to meet the care needs of all the residents particularly on each Monday when respite residents are discharged and new respite residents are admitted. The nurses' spoken to explained to the inspector the work involved and the amount of time required to ensure a safe admission and discharge process including completing care plans and reviewing medications. It was established from this that there was only one nurse for a significant part of Monday available to meet the clinical care needs of residents. The demands on a single staff nurse for a significant part of the day had the potential to compromise resident safety in the delivery of clinical care.

There was six care assistants rostered from 8.30 am each day until 2pm when the care assistant level decreased to three. One of these care assistants was in engaged in activity provision for two hours each afternoon leaving two care assistants to meet resident's needs. From 4.30pm until 10pm there was three care assistants rostered. While there was an adjustment to the rostering of care assistant levels after day one of the inspection, 31 October 2012, the inspector concluded that care assistant staff levels remained inadequate to ensure suitable supervision and to meet the needs of residents in a person-centred manner due to the layout of the building and the different communal areas available to residents. The day room was located close to the front door and the nurses' station was located centrally in the building not allowing nursing staff to monitor the movement of visitors to the centre. On occasions residents were assisted from the day room to the seated foyer close to the nurse's station in the evening time to allow for supervision. This arrangement compromised the flexibility of comfortable routines for residents during the evening time. Considering the care needs of residents including those who needed assistance to help them to go bed for the night, the inspector was not satisfied that sufficient care assistant staff were available to meet the needs of all the residents in the evening time. Additionally as discussed under Outcome 12 there was a deficit of cleaning staff available in the morning time to ensure residents' bathrooms were cleaned within an appropriate time frame.

2. There was a training matrix available which allowed the inspector to readily identify that staff had access to ongoing education in addition to the mandatory training required by the regulations. The matrix contained the details of training for all staff and readily identified when training was undertaken.

3. The inspector reviewed the policy on recruitment, selection and vetting of staff as this was identified as an area for improvement on the previous inspection. The policy did not provide sufficient detail to guide actions to ensure robust practices for recruiting and selecting staff. While a contract of employment was signed by staff members in files reviewed the job descriptions outlining the reporting relationships, the purpose of the post and the principal duties and responsibilities were not available. The inspector was told copies of job descriptions are given to staff however a copy was not retained in the staff file.

4. The inspector examined seven staff files to assess compliance with Regulation 18 and Schedule 2 of the Regulations. This was an area repeatedly identified for improvement on previous inspections. All the information required was not available in each file examined to include three written references and a full

employment history. There was not valid photographic identification for each staff member as some photos were not part of an official document and therefore not verifiable evidence of identification. All files examined had a self declaration in relation to certification of physical and mental fitness. None had been certified by a medical practitioner and this was not sufficient evidence of physical and mental fitness.

The provider and person in charge were committed to providing ongoing training to staff. A range of professional development training was undertaken by accredited trainers and an inspector reviewed the certificates issued by trainers in staff files.

There was evidenced by reviewing the attendance records, certificates in staff files and reports from staff. Five staff had recently completed food hygiene training and 26 staff had received training in infection control and hand hygiene on 16 November 2012. Twenty five members of staff were trained in cardio pulmonary resuscitation techniques in January 2012. Staff had also attended training on dementia care, behaviours that challenge and medication management.

All of the care assistants employed had completed Further Education and Training Awards Council (FETAC) Level 5 training. This was evidenced by reviewing the certificates available. A record of An Bord Altranais agus Cnáimhseachais na hÉireann professional identification numbers for all registered nurses was maintained.

Closing the visit

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

P.J Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

1 December 2012

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	Thomond Lodge Nursing Home
Centre ID:	0109
Date of inspection:	31 October 2012, 4 November 2012 and 26 and 27 November 2012
Date of response:	09 January 2013

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*.

Theme: Governance, Leadership and Management

Outcome 1: Statement of purpose and quality management

The provider is failing to comply with a regulatory requirement in the following respect: The statement of purpose did not meet all the requirements of Schedule 1 of Regulations.
Action required: Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).
Action required: Make a copy of the statement of purpose available on request to residents.

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

Action required: Make a copy of the statement of purpose available to the Chief Inspector.
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. Revised copy of statement of purpose now available for all residents, Copies left at main reception and now given to all new admissions. 2. Copy to be sent to Chief Inspector with this report	 04/01/2013 10/01/2013

Outcome 4: Records and documentation to be kept at a designated centre

The provider is failing to comply with a regulatory requirement in the following respect: The inspector identified the need for further improvement in polices governing practices to include the risk management policy, the complaints policy, the policy on recruitment, selection and vetting of staff and the adult protection policy. Polices did not have an implementation or review date indicated.
Action required: Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.
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 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: 1. All policies will be reviewed and updated by the end of March 2013 in line with Schedule 5 Regulations. Those needing immediate attention as outlined in Outcome 18 (Recruitment, selecting and vetting of staff will be reviewed by the end on January 2013. Staffing Records, Risk Management (amended), Adult Protection, Complaints Policy (amended and on display at two points in the building, Main entrance and Main Reception area). The recruitment policy has been amended to include step by step recruitment techniques for advertising, interviewing, selecting of candidate. 2. We shall strive to review and update all of our policies and will ensure all are reviewed at a maximum within a three year period. We shall include date that policy has been reviewed and the next review date on all policies.	30/03/2013 04/1/2013 04/1/2013

Theme: Safe care and support

Outcome 6: Safeguarding and safety

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

The policy did not contain the contact details of the elder abuse officer in the Health Service Executive (HSE) or how to manage an allegation of abuse against a senior member of the management team.

Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were not documented in the policy.

The person with overall responsibility to investigate a reported issue of concern was not clearly identified in the procedures as the policy referenced both the director of care and nurse in charge.

The policy on managing resident's finances did not include a procedure to guide staff on the maximum amount they will accept and hold in safe keeping on behalf of residents on admission to the centre.

Action required:

Revise the elder abuse policy to include procedures to manage an allegation of abuse against a senior member of the management team and to contain the contact details of the elder abuse officer in the HSE.

Action required: Revise the elder abuse policy to clearly identify the person with overall responsibility to investigate a reported issue of concern and outline protected disclosure procedures to guide staff in their reporting of a suspicion of abuse.
Action required: Revise the policy on managing resident's finances to guide staff on the maximum amount they will accept and hold in safe keeping on behalf of residents on admission to the centre.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
1. Elder abuse policy has be amended to include the name and contact number of the elder abuse officer for the Longford Area and also how to manage an allegation of abuse against a senior member of staff and include protected disclosure procedures to guide staff in their reporting of a suspicion of abuse.	04/01/2013
2. The person with overall responsibility for investigation of allegations of elder abuse is now clearly identified as the person in charge, Trish Ennis and in her absence only Sarah Murray CNM	04/01/2013
3. The policy on managing residents finances has been amended to state the maximum amount that will be retained on account for any one resident will be €2,000.00	04/01/2013

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: A risk assessment to identify potential hazards within bathrooms was not available. A risk assessment of the use of the foyer by residents around the nurses' station was not completed. The risk management policy did not clearly outline the governance arrangements to manage risk situations or the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or near miss events to

ensure learning for all staff to minimise the risk of repeat occurrences.

Procedures to guide staff actions in the event of self harm and assault was included in the policy however, they lacked sufficient detail.

Centre-specific procedures to guide staff actions and interventions in on managing violence and aggression were not sufficiently detailed.

The emergency plan in place was not comprehensive to guide staff in responding to untoward events.

Action required:

Put in place a comprehensive written risk management policy and implement this throughout 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:

Ensure that the risk management policy covers the precautions in place to control the following specified risks: aggression and violence; and self-harm.

Action required:

Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Action required:

Put in place an emergency plan for responding to emergencies.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. Risk Management policy shall be reviewed to include risk	 31/01/2013

assessment on bathrooms (amended) and the use of the Foyer area by residents. 2. Procedures have been put in place to commence audits on any risks identified and precautions to control these risks shall be followed through, any new hazards identified will be assessed, controls put in place and communicated to all staff. The risk assessments shall be reviewed every six month or as required to allow for any changes to the environment, residents or equipment. 3. A more detailed guide for staff on how to deal with self harm and assault, aggression and violence are now included in the risk management policy. 4. Written records of all risks identified will be recorded and investigated to enable controls to be put in place to reduce or eliminate the risk of a re-occurrence of a hazard and ensure learning for al staff. 5. Emergency plan has been updated to give a step by step guide for staff dealing with emergencies.	31/01/2013 31/01/2013 31/01/2013 04/01/2013

The provider is failing to comply with a regulatory requirement in the following respect: The inspector identified six members of staff as requiring training in the safe moving and handling of residents.	
Action required: Provide training for staff in the moving and handling of residents.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All staff with the exception of two staff have now received manual handling training. Both of these were away for extended holidays and shall be returning late January at this point both will receive manual handling and patient lifting training.	28/01/2013

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: The medication management policy did not provide sufficient detail to guide and inform staff in all areas of medication management. There was no procedure to guide staff on self administration or administration via enteral feeding tubes. The inspector identified three residents whose medication was being crushed prior to administration due to swallowing difficulty. However, the drugs were not prescribed on the medication charts for administration in a crushed form.
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.
Action required: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.
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: 1. Written operational policies and procedures relating to ordering, prescribing, storing and administrating medicines along with comprehensive guide for all medication policies is now in place along with procedural guide on self administration of medication or via enteral feeding tubes. All nurses have been made aware and are familiar with same. All residents requiring crushed medication shall have each medication requiring crushing prescribed as same by GP. 2. Policy and procedure in place for the disposal of out of date and unused medicines and all staff nurses are aware and familiar with same.	04/01/2013 04/01/2013

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

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

A process for auditing information on each area in which data is collated was not in place and there was there was no improvement plan developed arising from all audits completed.

The system for quality assurance and monitoring required further expansion to review additional areas which impact on resident's wellbeing and to ensure sufficient systems are provided for to ensure enhanced outcome for residents.

Audit findings had not been collated into a report with a copy made available to the residents or their representative.

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 and, if requested, to the Chief Inspector.

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: 1. A system has been put in place to expand the audits we are currently undertaking to include the following; Residents who have had moderate to severe pain within the previous week, Residents who have received psychotropic drugs including sleeping tabs within the last week, residents who spent most of their time in bed or chair in last week. Residents who have experienced significant weight loss over last three months. Unexplained absence of residents, Significant events, or any other events which we feel will improve the quality and well being of our residents. An improvement plan will be developed	30/03/2013

arising from audit findings. We are now including a resident's quality initiative questionnaire to be filled in by all residents along with the quality initiative questionnaire sent to families. 2. Following our audits we shall compile a report from the information gathered, which will be shared with staff, residents and families. A copy of the report will be made available to same and to the Chief Inspector on request.	 31/01/2013 30/01/2013

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect: A narrative was not provided on reviewing some of residents' care plans examined to outline a conclusion or judgment of the care pathway or how care should be continued. There was limited evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when 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 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence

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

Provider's response: 1. On 3 monthly reviews of care plans or before, family and resident will be asked to participate in compilation of same and there agreement will be documented in care plans. 2. Care plans will be revised after consultation with residents.	 30/03/2013 30/03/2013

The person in charge is failing to comply with a regulatory requirement in the following respect: Aspects of restraint practice did not reflect the new national policy on promoting a restraint free environment.
Action required: Put in place appropriate and suitable practices relating to the restraints in accordance with evidence-based practice.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Regulation 6: General Welfare and Protection Standard 11: The Resident's Care plan Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Suitable practices relating to the use of restraints are now in place in accordance with the policy, Towards a Restraint Free Environment in Nursing Homes, Department of Health and in accordance with evidence - based practice.	 04/01/2013

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect: Residents' en suite bathrooms were not cleaned in a timely manner after morning use.
Action required: Keep all parts of the designated centre clean and suitably decorated.

Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Cleaning roster has now been changed so that the cleaning of bathrooms and bedrooms commences earlier so that the rooms are fresh, clean and tidy for all residents, especially those who wish to stay in rooms for extended periods.	04/01/2013

Theme: Person-centred care and support

Outcome 13: Complaints procedures

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

The complaints policy and procedure and noted it did not meet all the requirements of the regulations. The nominated person with overall responsibility to investigate a complaint was unclear.

A nominated person who would monitor that the complaints process was followed to ensure all complaints are appropriately responded to and the required records are maintained was not identified.

An independent appeals process if the complainant was not satisfied with the outcome of their complaint was not ensured.

There were no timescales stated within the complaints policy or procedure.

Clear evidence that the complainant was satisfied with the outcome achieved was not in place.

The complaints procedure displayed on the wall was not prominently visible.

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).

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 available a nominated person in the designated centre to deal with all complaints.	
Action required: Inform complainants promptly of the outcome of their complaints and details of the appeals process.	
Action required: Maintain a record of all complaints and whether or not the resident was satisfied.	
Action required: Display the complaints procedure in a prominent position in the designated centre.	
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: 1. The Person in Charge is the nominated person to deal with all complaints. The nominated independent person to deal with maintenance of records and complaints responded to appropriately is Heather Neary this is reflected in our policy, which is on display in the main reception area and the main entrance. 2. Sean Kelly Provider has been nominated as the independent appeals processor. 3. The Person in Charge is available to deal with all complaints in the designated centre. 4. A time line of a maximum period of 30 working days has been assigned to deal with all complaints and will be forwarded to complainant in writing along with appeals process.	04/01/2013 04/01/2013 04/01/2013 04/01/2013

5. A record of all complaints shall be held on file and shall be signed by all complainants or their representative as to their satisfaction with outcome of complaint. 6. Complaints procedure is displayed at the main entrance right hand side and the main reception desk and is free from any obstructions.	04/01/2013 04/01/2013

Outcome 14: End of life care

The person in charge is failing to comply with a regulatory requirement in the following respect: The psychosocial aspects in relation to end of life care or spiritual plans of care were not detailed sufficiently in the sample reviewed.
Action required: Provide appropriate care and comfort to each resident approaching end of life to address his/her physical, emotional, psychological and spiritual needs.
Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. We shall speak to residents approaching their end stage of life and discuss and document in as far as possible their wishes and choices. This will be documented in their care plans incorporating their religious, spiritual, cultural practices. Information such as which family members they request present, priests, friends etc. In as far as possible we will try to facilitate any requests they may have.	 04/01/2013

Outcome 16: Residents' rights, dignity and consultation

The provider is failing to comply with a regulatory requirement in the following respect: The continuous monitoring by CCTV compromised the privacy of residents to undertake activities in private within a communal space for example while having their meals or spending time with their visitors or engaging in activities and relaxing in communal areas.

Action required: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.	
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 4: Privacy and Dignity	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: CCTV cameras have been disconnected from the dining room, day room and library to allow privacy to the residents and their families in the communal areas in addition to privacy already secure in their bedrooms.	04/01/2013

Theme: Workforce

Outcome 18: Suitable staffing

The person in charge is failing to comply with a regulatory requirement in the following respect: On this visit the inspector was not satisfied by observing practice, reviewing the rota and taking account of the dependency needs of residents' a sufficient nursing staff level was available to meet the care needs of all the residents on each Monday when respite residents are discharged and new respite residents are admitted. The inspector concluded that care assistant staff levels remained inadequate to ensure suitable supervision and to meet the need of residents in person-centred manner in the afternoon and evening time. The rota was not outlined in the 24 hour clock format. Night duty was indicated as 'ND' only, therefore times staff commenced and finished their work shifts were unclear to the inspector.
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: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Reference:

Health Act, 2007
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. The Person in Charge or CNM shall provide a roster in conjunction with the needs of the home using relevant tools. Staff levels have been amended to ensure adequate supervision and to meet the needs of the residents. 2. Rosters planned fortnightly showing every member of staff on duty this includes nurses, carer, kitchen, cleaning, and maintenance and administration staff. This will be laid out in a 24hr format.	04/01/2013 04/01/2013

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

The policy on recruitment, selection and vetting of staff did not provide sufficnet detail to ensure robust practices for recruiting and selecting staff.

All the information required by Schedule 2 of the Regulations was not available in each file examined to include three written references and a full employment history and valid photographic identification.

All files examined had a self declaration in relation to certification of physical and mental fitness. None had been certified by a medical practitioner and this was not sufficient evidence of physical and mental fitness.

The provider was awaiting the outcome of Garda Síochána vetting for three members of staff recently recruited.

Action required:

Put in place written policies and procedures relating to the recruitment, selection and vetting of staff.

Action required:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.

Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.	
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. The policy on recruitment, selecting and vetting of staff shall be revised to ensure a robust step by step guide to include, advertising, interview technique, selection and a comprehensive reference check which will include a signed declaration of fitness by GP and include all other information as per schedule 2. 2. No member of staff shall be allowed commence work until a full packing is in place in line with schedule 2. Proof of ID, Driving Licence/Passport with Photo and Garda Vetting form. Original certificate required for proof of relevant qualification/training. A full employment history and any gaps investigated. 3 written references on headed paper including most recent employer. 3. We have requested that all staff members get a declaration of physical and mental fitness from their GP. All new employees shall not start work unless all documentation is in line with schedule 2 to include GP declaration of fitness to work.	30/01/2013 04/01/2013 04/01/2013

Any comments the provider may wish to make[1]:

Provider's response:

We wish to thank the various inspectors who visited our centre over the past number of months. We respect your input and realise the importance of adhering to all actions outlined in our report.

Provider's name: Sean Kelly
Date: 09/01/2013

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