Health Information and Quality Authority
Social Services Inspectorate

Regulatory Monitoring Visit Report
Designated centres for older people

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

Centre name:	Kinvara House
Centre ID:	0054
Centre address:	3/4 Esplanade Strand Road Bray, Co. Wicklow
Telephone number:	01-2866153
Fax number:	01-2864353
Email address:	kinvarahousebray@eircom.net
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered providers:	Kinvara House Limited
Person in charge:	Mary Mangan
Date of inspection:	6 March 2012
Time inspection took place:	**Start:** 07:00 hrs **Completion:** 18:00 hrs
Lead inspector:	Linda Moore
Support inspector:	Kieran O Connor (observing)
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Regulatory Monitoring Visit Report

About the inspection

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

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

Additional inspections take place under the following circumstances:

- to follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- for centres that have not previously been inspected within a specific timeframe, a one-day regulatory monitoring visit may be carried out to focus on key regulatory requirements.

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

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

About the centre

Description of services and premises

Kinvara House is a four-storey Georgian building which consists of two adjoining houses with an extension to the rear. Accommodation is provided over the four floors for 36 people including some residents with dementia.

The lower ground floor is known as level one consists of two single en suite bedrooms with wash-hand basin, toilet and bath. The residents' dining room, the main kitchen, laundry, hairdressing room and an assisted bathroom with toilet, assisted bath and wash-hand basin are also located on this floor. Other facilities on this floor include the staff cloakroom.

The main entrance is located on the first floor which leads to the lobby. This is known as level two. There is one large sitting area to the right of the main lobby with direct views onto the promenade and the sea. There is a lounge to the left of the lobby which overlooks a secure, well maintained courtyard accessible to residents. There is an oratory and offices for the person in charge and staff. There is an assisted toilet for residents, staff and visitors on this floor. There are five bedrooms, three of which comprise of a bath, toilet and wash-hand basin and two en suite bedrooms with toilet and wash-hand basin.

The third floor known as level three consists of a small reception area and a small seating area with chairs and a table. There are eight en suite bedrooms on this floor. Four of these consist of bath, toilet and wash hand basin and four are en suite with toilet and wash hand basin. There is also a small store room.

The fourth floor known as level four consists of a shower room consisting of a shower, toilet and wash hand basin. There are eight en suite bedrooms, four of these consist of bath, toilet and wash-hand basin and four have toilet and wash-hand basin. There is also a store room and two offices.

The wing which is interconnected to the original building on the ground floor consists of a lounge which overlooks a secure, well maintained courtyard accessible to residents. There is on an assisted bathroom with assisted shower, assisted bath, toilet and wash-hand basin. There are four en suite bedrooms with toilet and wash hand basin on the ground floor of this extension and nine en suites bedrooms with toilet and wash-hand basin on the first floor of this extension. There are a further two offices and a storage room

There are closed-circuit television cameras (CCTV) in place outside the building and a keypad locking system on the front door.

Location

Kinvara House is located on the sea front in Bray, Co. Wicklow. It is a two minute drive from the dart station and close to local churches, shops and amenities. There is pay parking on the street directly outside the centre.

Date centre was first established:	1 September 1990
Number of residents on the date of inspection:	36
Number of vacancies on the date of inspection:	0

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	11	10	11	4

Management structure

Mary Mangan is the nominated person on behalf of the Provider and is also the Person in Charge. She is also a Director of Kinvara House Ltd and her husband, Denis Mangan is the Managing Director and Chief Executive Officer. She will be referred to as the Provider throughout the report. Gillian Mangan is currently Learning and Development Manager and is being mentored by Mary Mangan to take on the role of Provider in the future. The Provider is supported by a full time administrator who reports directly to her. The staff nurses on duty and the household staff all report directly to the Provider and the care staff report to the staff nurse on duty. The catering assistants report to the Chef who in turn reports to the Provider. An assigned staff nurse deputizes for the Provider when required.

Staff designation	**Person in Charge**	**Nurses**	**Care staff**	**Catering staff**	**Cleaning and laundry staff**	**Admin staff**	**Other staff**
Number of staff on duty on day of inspection	1	1	7	2	2	1	*2

* The managing director/chief executive officer and the learning and development manager were in the centre on the day of the inspection.

Summary of findings from this inspection

This was an unannounced follow up inspection which focused on areas identified for improvement at the inspection on 01 November 2011 and to monitor compliance with the the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The inspector met residents, the provider, the learning and development manager, CEO and staff on duty. Records were examined including care plans, medical records, and staff records including staff files and policies.

The inspector found that the healthcare needs of residents were met. Residents and relatives spoke very fondly of the staff and were very happy with the care delivered.

The inspector found that the provider had been proactive in responding to the action plan from the previous inspection. She had actively engaged the services of an external company to assist in the development of a risk management framework and the introduction of a new care planning model.

There were nine actions identified at the previous inspection. Three of these actions were fully addressed. Six actions were partly addressed and were being progressed. One of these actions was still within the timeframe set by the provider.

Improvements made by the provider since the previous inspection included:

- set up and implementation of the new nursing assessments and care plans
- staff files now up to date and meeting the requirements of the Regulations
- the governance arrangements and risk management were strengthened through the clinical governance meetings

Improvements were still required in the development of polices and training of staff. A new, comprehensive care planning process had been developed, which they were in the process of implementing to reflect the current needs of the residents.

Areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Governance

Article 5: Statement of Purpose

The statement of purpose was not in line with the Regulations and Standards. The inspector was satisfied that the statement of purpose accurately described the services that were provided in the centre but did not contain all of the information required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The inspector explained the areas that needed to be addressed with the learning and development manager.

Article 15: Person in Charge

The person in charge, also the provider, was a registered general nurse who worked full-time in the centre. She had more than the required level of experience in nursing for older people. She was on duty on the day of the inspection, demonstrated an adequate knowledge of the responsibilities as outlined in the Regulations and demonstrated good organisational skills.

She was supported in her role by a staff nurse. The inspector found that the person in charge was very knowledgeable about residents' needs and their backgrounds. She was observed engaging well with residents throughout the day of inspection. The inspector noted that as provider, she was extremely passionate about the service that was provided at Kinvara House and was changing the service from a traditional to an evidenced-based, accountable model.

Article 16: Staffing

This action had been progressed but some documents were still outstanding on a number of staff files. The inspector read a number of the staff files and noted that the majority of files held all of the information as required in Schedule 2, Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations (as amended) 2009. The provider and administer now had a good understanding of what was required by the Regulations. The administrator had a system in place to a follow up on outstanding documents. She showed the inspector a list of the outstanding documentation which was required for some staff files. For example two staff members required a third reference. There was evidence that an application for Garda Vetting had been made for a number of staff.

The inspector found that there were good induction arrangements for newly employed staff members and staff appraisals were used to monitor performance and support staff.

The inspector noted that there was appropriate staff numbers and skill mix to meet the needs of residents based on the resident's dependencies and layout of the premises. Staff and residents agreed that there were adequate staff on duty.

Since the previous inspection, the provider had arranged and facilitated staff nurses to attend care planning training with an external company on the 11,18,25 January and 8, 22, 29 February 2012. The staff nurse on duty was clearly able to describe the care planning processes and the changes being introduced based on the training. The learning and development manager said that training was planned for staff nurses on wound care on the 16 April 2012 and that a date was yet to be confirmed for training in falls prevention and behaviours that challenge.

The provider said the nurses had also attended training on manual handling and elder abuse but the records of the training could not be located. The staff said they had attended this training. The learning and development manager showed the inspector the new process for recording information on the training delivered. This had been implemented for one new staff member for training on the protection of vulnerable adults.

Article 23: Directory of Residents

The inspector read the directory of residents and found that it was up to date and included all of the information as required by the Regulations.

Article 31: Risk Management Procedures

The inspector found that in most regards, practice in relation to the health and safety of residents and the management of risk promoted the safety of residents, staff and visitors. The new risk management processes were being embedded and there were some areas for improvement.

There was a visitors' sign-in book located at the entrance to the centre. This allowed the staff to monitor the movement of persons in and out of the building to ensure the safety and security of residents. Inspectors observed visitors' daily signatures in the visitor's book. There was a full-time administration staff member on duty to guide visitors.

Since the previous inspection, the provider had worked with an external company and developed a formal system to review risk management and the quality of care. In January 2012 a system was established to collect and audit clinical data in order to monitor trends and improve the quality of service and safety of residents. The risk management committee had been replaced by a clinical governance committee. The provider, CEO, the learning and development manager and the administrator who formed the clinical governance committee planned to hold monthly meetings to review the quality of care delivered and the management of clinical and non-clinical risk. The minutes of the most recent meeting showed that the action plan from the previous inspection was being progressed by the clinical governance committee.

The system to identify, record, investigate and learn from serious or untoward incidents or adverse events involving residents had improved. The provider had collected and reviewed information on falls in December and was collecting this data monthly since January. The provider reviewed each incident report and the inspector noted that they now included more information on the preventative measures to minimize the risk of reoccurrence. For example, a resident was reviewed by the GP and the physiotherapist following a fall. The provider had provided bed and chair alarms to residents who were at risk of falling. The provider said she was planning to participate in further training on auditing in March so that she could analyse the falls information further.

The inspector read the audit reports for falls and noted a reduction in the number of falls. The provider and staff members explained that more staff were allocated to work in the afternoons in order to increase supervision of residents in the day rooms and this had contributed to a reduction the number of falls and enhance the safety of residents.

Since the previous inspection, the learning and development manager had revised the risk management policy and was in the process of rolling this out. While the policy had been improved, it still did not meet the requirements of the Regulations. The behaviours that challenge policy included the aggression and violence and there was a missing person policy, but there was no policy on self harm or assault as required by the Regulations. The provider said in the previous action plan that this would be completed by 31 January 2012.

The inspector noted that there were some areas of risk that had not been identified by the provider and there were no control measures in place to manage the potential risk. The inspector noted that all levels within the centre were still accessible by stairways of varying height. Many residents were cognitively impaired and these open stairwells posed a risk to their safety. There had been no risk assessments to ensure that adequate control measures were in place to minimise the risk of residents falling down the stairs.

The laundry room was left open when not in use. While a key pad lock was fitted to the store room, this room which was used to store chemicals was observed to be open during the day. The inspector observed chemicals left unattended in the linen press which posed a potential risk to residents. These practices may be hazardous to resident's safety.

The inspector read a sample of the centre's polices that were required by Schedule 5 of the Regulations and that relate to the management of risk. The inspector noted that while work had commenced in this area since the previous inspection, the restraint policy, protection of vulnerable adult's policy and recruitment policy were not sufficiently detailed to guide care.

The provider had said in the previous action plan that all polices would be revised, made centre specific and rolled out by 29 February 2012.

Article 39: Complaints Procedures

The inspector found evidence of good complaints management practices.

The complaints policy was read by the inspector and details of the complaints procedure were posted publicly and described in the residents' guide/statement of purpose. The procedure provided guidelines on how to make a complaint or express a concern, and how these would be addressed. A named complaints officer was identified as the nominated person to respond to complaints. The policy also identified an appeals process in the event that a complainant was not satisfied with the outcome. The independent appeals person would also ensure that complaints were appropriately managed and records maintained.

The provider confirmed that she met with residents and relatives on a daily basis and usually resolved any issues which arose before they became a source of discontent. The learning and development manager told the inspector that there were no written complaints and verbal complaints were not formally documented. There was no formal system to record all complaints and use them for continuous quality improvement purposes.

Article 36: Notification of Incidents

Practice in relation to notifications of incidents was satisfactory.

The provider and learning and development manager were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. Since the inspection, all relevant notifications had been submitted to the Chief Inspector by the provider.

Resident Care

Article 9: Health Care

The inspector found that the residents had diverse needs - some were highly dependant and required full assistance while other residents were quite mobile and independent. The inspector found a good standard of nursing care was provided and residents had access to appropriate medical and allied healthcare.

The inspector found that there was good access to medical practitioners in the local area and there was evidence that residents were regularly reviewed by their general practitioner (GP). Residents also had access to speech and language therapy, dietician, occupational therapy, physiotherapy and chiropody services. Residents' files held documentary evidence of the provision of these services.

Staff promoted the residents' health by encouraging them to stay active. Residents were seen taking exercise during the day and many attended an exercise class.

The inspector saw documentary evidence to demonstrate that residents' weights were recorded each month and the provider had begun to formally monitor any changes such as significant weight loss. Nutritional risk assessments were used to identify residents at risk and there was evidence of resident's meals being fortified and residents were also being prescribed supplements where necessary.

The inspector reviewed the practice in relation to falls prevention and management and noted that this had improved since the previous inspection but further development was required. Since the previous inspection, the staff were more aware of resident at risk of falls and the day and night staff described the care of those at risk very well to the inspector. Care plans for residents at risk of falls were revised and they now guided practice.

The provider said the falls prevention and management policy was being revised with the other policies but this had not been amended since the previous inspection. This was not evidenced based and did not guide staff in the prevention and management of falls. For example, the policy did not indicate what risk assessment tool was to be used to assess residents at risk of falling or how to respond if a resident fell.

While all residents at risk of falls had a falls assessment and care plan, a review of one resident's file showed that there had been no post falls assessment completed following a recent fall and therefore there had been no analysis to determine the root cause and measures to assist in preventing a recurrence.

The inspector reviewed the practice in relation to the use of restraint. From a review of residents' records and talking to staff, it was noted that restraint management had improved but there were still areas for improvement. There were 16 residents requiring bedrails. There were assessment forms for bedrails which included the alternatives tried prior to using bed rails. Residents who had bed rails had a care plan to manage this.

The provider told the inspector that none of the staff had attended training on the management of restraint and she still did not have a copy of this policy for staff to refer to. The inspector noted that monitoring of the use of bed rails at night time was not documented, the provider and night staff said that residents were checked hourly over night but there was no evidence to confirm that this happened.

The inspector found there was significant improvement to the nursing' assessments, risk assessments and care plans since the previous inspection. The nurses were in the process of implementing a new care assessment and care plan for each resident. The inspector noted that the assessments viewed informed the care plans and when introduced fully would be used to guide the care delivered. The provider said this action would be fully addressed 30 April 2012.

There were opportunities for all residents to participate in activities appropriate to his or her interests and capacities. The inspector saw the activity schedule and spoke to the occupational therapist. She said that the provider was reviewing activation provision and aimed to provide more activities for residents with a cognitive impairment. The residents said they enjoyed the exercise classes in the centre and many said they looked forward to day trips shopping. One resident said the staff encouraged her to get involved but they also respected her wishes if she preferred to stay in her room.

Article 33: Ordering, Prescribing, Storing and Administration of Medicines

Since the previous inspection, the provider had reviewed the medication management policy and re written this with the assistance of an external company. This policy was in the process of being provided to the staff for discussion. Not all staff nurses had read this policy. The provider had said in the previous Action Plan that this would be addressed 31 January 2012.

Medications that required special control measures were carefully managed and kept in a secure cabinet in compliance with the Misuse of Drugs (Safe Custody) Regulations, 1984. These medications were counted at the time of administration and at the change of each shift. Nurses kept a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift. The inspector checked a sample of the balances and found them to be correct. The medication management policy stated that controlled medication would be administered and signed by two nurses. This did not reflect the practice if a resident required a controlled medication on night duty when there is only one nurse on duty. The nurse on night duty said she would call the provider during the night if she needed to administer a controlled medication but this arrangement was not included in the medication management policy.

The nurse told the inspector that transcribed medications were counter-signed by a second nurse. The inspector found the transcribing and administration practices had improved since the previous inspection.

The inspector reviewed the residents' medication administration procedure and records for the administration of Warfarin and found evidence that the practice had improved since the previous inspection. The inspector observed that the staff member on duty referred to the prescription when administering Warfarin, which was signed by the GP within 72 hours of the telephone order.

The nurse told the inspector that they used photographs to identify residents when administering medications but the inspector noted that a small number of the residents' photographs were still missing. There were two residents in the centre for up to one month with no identification in place. The staff nurse explained that she always introduced any new staff member to the residents to minimise the risk of a medication error and that they were awaiting the pharmacist to take the photographs. She said they were in the process of obtaining consents for photographs form the residents/relatives. A lack of identification could result in negative outcomes to residents.

Article 6: General Welfare and Protection

Overall, the inspector was satisfied that measures were in place to protect residents from being harmed or suffering abuse, but there were areas for improvement in relation to the policy on the protection of vulnerable adults and the training records.

Although the centre had a policy on safeguarding of residents, this was not sufficiently specific to the centre to guide practice and inform staff. This was identified at the previous inspection and the provider said that this and other policies would be addressed by the 29 February 2012. These were yet to be revised.

The provider said all staff had attended training on identifying and responding to elder abuse. However, the records were still not available for the inspector to confirm that this had happened. The learning and development manager showed the inspector the format now in place to record any training delivered to staff. The staff spoken to displayed sufficient knowledge about different forms of elder abuse and they were clear on reporting procedures. Residents spoken to confirmed to the inspector that they felt safe in the centre. They primarily attributed this to the staff being available to them at all times and the locking system on the entrance doors. The provider was accessible to all residents as she visited residents each time she was in the centre and enquired about their well-being and if they had any concerns or complaints. The inspector saw this happening and residents confirmed that they were visited frequently and could discuss any issues or worries.

Article 20: Food and Nutrition

The inspector was satisfied that residents received a nutritious and varied diet. There was one dining room and residents were seen to enjoy the social dining occasion. Residents confirmed that they enjoyed the food. The inspector noted that meals were hot, well presented and tasty. Many residents who required assistance ate in their bedrooms and the provider said they chose to eat here.

The inspector saw residents being offered drinks throughout the day. Residents told the inspector that they could have tea or coffee and snacks any time they asked for them.

The chef showed the inspector the four-weekly menus. All residents' dietary requirements were documented to ensure that staff provided the necessary dietary requirements.

Environment

Article 19: Premises

The centre met the needs of the residents. It was found to be well maintained, clean and homely throughout. The inspector found that the bedrooms were personalised with adequate space for belongings. There was a secure outdoor area which residents could access unaccompanied. Residents said they liked to sit in the garden when the weather was fine.

Residents could have their laundry processed in the centre. The laundry room was spacious and well equipped. The inspector spoke with the staff member there and she was knowledgeable about infection control and the different processes for different categories of laundry. All residents' clothes were folded and returned to the residents' rooms. Residents told inspectors that they were satisfied with the laundry arrangements.

There was access to a maintenance staff member at all times; the records showed that all maintenance work identified by the staff was addressed. Records viewed confirmed that the CEO completed an environmental check monthly.

There was an additional dedicated wash hand basin for nursing staff to wash their hands prior to a procedure requiring aseptic techniques such as wound dressings. At the previous inspection, the inspector saw that this was blocked by a hoist and a large chair during the morning of the inspection. This was addressed at this inspection. The inspector observed that this hand wash sink was freely accessible to staff and there was signage in place to remind staff not to keep equipment in this area.

There was one assisted bathroom on the ground floor and the call bell could not be accessed by residents due to its location. There was also no grab rail at the toilet should this be required.

Article 32: Fire Precautions and Records

The provider had taken adequate fire precautions. Fire extinguishers and equipment were kept in good working order and were serviced regularly. Records showed they were last serviced in August 2011. Fire notices and the evacuation plans were posted prominently on all corridors. There was a record of fire drills and evacuation training. The most recent evacuation training had been on 05 March 2012 with the night staff. Fire drill took place at least quarterly with staff and staff were fully aware of what to do in the event of a fire. The CEO checked the fire exits weekly and he said that all staff were aware to check exits daily to ensure they were not blocked.

Despite good evidence of servicing of the fire equipment and alarms, there was no evidence that emergency lighting was serviced regularly

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, CEO, learning and development manager and administrator 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:

Linda Moore

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

7 March 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Kinvara House
Centre ID:	0054
Date of inspection:	6 March 2012
Date of response:	4 April 2012

Requirements

These requirements set out what the registered provider must do to meet 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*.

1. The provider has failed to comply with a regulatory requirement in the following respect: The medication management policy was not congruent with the practice for the administration of controlled medications. The medication administration record did not contain a photograph of the resident in line with professional nursing guidelines.
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storaging and Administration of Medicines
Regulation 25: Medical Records
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Medication management policy updated to reflect practice in administration of controlled medication	Completed
The medication administration records all contain photographs in line with professional nursing guidelines	Completed

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

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

Some practices were hazardous to residents' safety. These included:

- there was no risk assessment of the open stairwell which may pose a risk to residents
- the laundry rooms were left open when not in use and there was access to cleaning chemicals when the cleaning trolleys were left unattended and the store room door was left open which posed a potential risk to residents
- there was poor access to the call bell in one of the assisted toilets and there was no grab rail at the toilet in this bathroom should this be required
- there was no record that the emergency lighting was serviced

Action required:

Implement the plans to put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
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:	
Risk management policy updated.	Completed
New locking system on laundry room door and store room door.	Completed
Grab rails in all public bathrooms.	Completed
Call assistance bell moved to allow better access.	Completed
Emergency lighted tested and recorded in fire book.	Completed
Risk management committee to develop risk register and update relevant documentation	30 June 2012

3.The provider has failed to comply with a regulatory requirement in the following respect:

Staff had not been provided with training to enable them to provide evidenced based nursing care in restraint, falls and wound care.

Action required:

Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 17: Training and Staff Development
Standard 13: Healthcare
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Wound management training arranged.	16 April 20112
Falls prevention training arranged.	03 May 2012
Restraint training arranged.	15 May 2012

4. The provider is failing to comply with a regulatory requirement in the following respect: The centres' polices as outlined in Schedule 5 were general guideline documents and not policies as they did not guide practice. This included the medication management, elder abuse policy, restraint policy for example.	
Action required: Put in place all of the written and operational policies listed in Schedule 5.	
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All written and operational policies as listed in Schedule 5 now in place.	Completed

5. The provider is failing to comply with a regulatory requirement in the following respect: The Statement of purpose did not consist 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). The Statement of purpose was not kept under review.	
Action required: Review the Statement of purpose to ensure it 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) and reflects the current registration.	
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: Statement of purpose updated to reflect all matters listed in Schedule 1	Completed

6. The provider is failing to comply with a regulatory requirement in the following respect: Verbal complaints were not being recorded as per the Regulations.	
Action required: Record all complaints and the results of any investigations into the matters complained about.	
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: Complaints log for all verbal complaints in place.	Commenced

Any comments the provider may wish to make:

Provider's response:

None Supplied

Provider's name: Mary Mangan
Date: 4 April 2012