Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Melview House Nursing Home
Centre ID:	0250
Centre address:	Prior Park Clonmel Co Tipperary
Telephone number:	052-6121716
Email address:	melviewcareltd@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Melview Care Ltd
Person in charge:	Helen Wheeler
Dates of inspection:	29 May 2012 and 30 May 2012 1 June 2012 and 5 June 2012
Time inspection took place:	**Start-Day 1:** 11:00hrs **Completion:** 20:35hrs **Start-Day 2:** 09:30hrs **Completion:** 20:15hrs **Start-Day 3:** 10:30hrs **Completion:** 17:00hrs **Start-Day 4:** 10:30hrs **Completion:** 19:15hrs
Lead inspector:	Mary Moore
Support inspector:	Catherine O'Keeffe
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 ☒ Follow-up inspection

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 matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, 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
- to randomly "spot check" the service.

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

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

About the centre

Description of services and premises

Melview House Nursing Home was originally a 57-bed facility established in 1970 and now owned and managed by Melview Care Ltd. Long-term, convalescence and respite care are provided. Though originally registered for 57 beds, the centre is now operating as, and has applied to be registered as, a 50-bedded facility due to some operational reorganisation of accommodation.

On the day of inspection, there were 42 residents living in the centre, 41 of whom were in receipt of long-term care.

Melview House is almost 200 years old; it was originally built as a private dwelling and in later years was used as a convent and medical facility by a religious order, the Medical Missionaries of Mary. It has operated as a nursing home in private ownership since about 1985. Melview House is an architecturally significant listed building. It is a three-storey over-basement structure; resident accommodation is provided on the ground, first and second floors. The basement area primarily accommodates service areas, staff facilities and administration offices. The following description of the premises reflects the alterations that have been made by the provider in response to previous inspection findings and fire safety requirements.

The main entrance provides access to the ground floor of the main building; the entrance retains the original three limestone steps. A ramp is provided, leading to a small lobby area or porch and the main reception area.

The ground floor accommodation consists of a sitting room and dining room for residents, and four bedrooms providing accommodation in total for eight residents in four two-bedded rooms. Two of these bedrooms are en suite with toilet, wash-hand basin and assisted shower. There is a bathroom with toilet, wash-hand basin and low-level bath with electric seated insert, and a further single toilet provided for residents' use. A sluice room, staff toilet and changing facilities and the laundry are also accommodated on the ground floor. The oratory has been relocated from its original location on the first floor to the ground floor. From the ground floor, there is access to adjoined buildings originally used as stables that now accommodate administration offices, a meeting room, a smoking area for staff and boiler rooms.

The basement is accessed from the ground floor by means of a restricted stairwell and accommodates the main kitchen and ancillary stores, offices for the person in charge, and changing and toilet facilities for catering staff.

The first floor is accessed by means of a stairwell from the ground floor that leads directly to the nurses' station; a further stairwell leads to a large central landing area, residents bedrooms, and the lift and lobby area. There are four bedrooms providing accommodation for twelve residents, two two-bedded rooms and two four-bedded rooms, none of which are en suite. One of the two-bedded rooms is newly acquired and replaces the original residents' communal/dining area; it is currently without en suite facilities. There is a bathroom with toilet, wash-hand basin and assisted shower

and a second separate toilet and wash-hand basin provided for residents. A further stairwell leads up to the second (top) floor; again there is a main central landing with a residents' sitting/dining room and three bedrooms providing accommodation for ten residents, one twin bedroom and two four-bedded rooms. These bedrooms are not en suite; a bathroom with a toilet, wash-hand basin and assisted shower and a separate toilet and wash-hand basin are again provided.

Further resident accommodation is provided in what is referred to as the "back block" or the "back wing". This is a later construction circa 1950's accessed from the first floor and currently provides accommodation for twenty residents. There are 13 single rooms, two twin-bedded rooms, and one three-bedded room; one of the twin-bedded rooms is en suite with toilet, wash-hand basin and non-assisted shower. There are two bathrooms with toilet, wash-hand basin and assisted showers, a bathroom with toilet, wash-hand basin and floor level bath, and one further single toilet available for residents' use. This 'back wing" originally provided for only one sitting room/dining room and a separate dining room has been provided in the area that originally served as the chapel.

A passenger lift is in place but only serves the central block of the premises from basement to top floor level; it does not facilitate access to the back wing or the nurses station which are accessed only by means of stairwells.

Outside there is some seating to the front of the building, an area of decking to the rear of the building and a large green area to the rear of the premises, which were originally tennis courts. There is ample car parking to the front of the building.

Location

Melview House is situated in a cul-de-sac on a mature site, in a residential area slightly removed from the town centre of Clonmel.

Date centre was first established:	1970
Number of residents on the date of inspection:	42
Number of vacancies on the date of inspection:	8

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	16	3	10	13

Management structure

Melview House Nursing Home has been owned by Melview Care Ltd since 2005. Mr Dermot Dougan, a director of Melview Care Ltd, is the nominated Registered Provider. Mrs Helen Wheeler is the Person in Charge. Claire O'Sullivan was recruited

and appointed as the key senior manager (KSM) in August 2011. There are approximately 50 staff employed comprising nursing staff, care assistants, household staff, catering staff, and administration and maintenance staff. All staff report to the Person in Charge.

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	2	8*	4	4**	1	2***

* 8 care staff to 13:30hrs; 5 care staff from 13:30hrs to 22:00hrs
** 4 staff until 13:00hrs; one laundry person until 17:00hrs
*** The activities coordinator and the maintenance person

Background

This inspection was the sixth inspection of Melview House Nursing Home by the Authority.

The first inspection was a one-day scheduled unannounced monitoring inspection on 21 September 2010. That inspection focused on the key regulatory areas of governance, resident care and the physical environment and assessed compliance in these areas with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The inspector found that elements of the premises including the absence of a functioning passenger lift, and operational practices implemented by staff in an attempt to militate against those elements were hazardous and posed risks to the health and safety of residents and staff as well as compromising the independence, choice, dignity and social dimension of residents' lives. The inspection findings resulted in an emergency Action Plan from the Authority to the registered provider.

This plan dealt with:

- confirmation of the function and safety of the existing goods lift
- provision of a passenger lift
- the safety and suitability of existing fire evacuation ramps
- written confirmation that the premises complied with all the requirements of the statutory fire authority
- the provision of personal emergency evacuation plans for residents
- the provision of timely and appropriate medical care for all residents
- care planning and the re-evaluation of care plans.

The registered provider responded positively to the emergency Action Plan and indicated his commitment to remedial action and improvement.

The second inspection was an announced two-day registration inspection on 2 February 2011 and 3 February 2011. On that occasion, inspectors also took into consideration a concern received by the Authority prior to the inspection from a relative of a resident in relation to the quality of care and services received by their family member, specifically staff communication skills and practices. Inspectors found that the provider acknowledged the limitations of the existing service and the extent of the remedial works required. He demonstrated commitment to investing the environment and the general operation of the centre to comply with the regulations and the standards, and improve upon the quality and safety of the service.

The inspectors found evidence of some improvements made since the first inspection and evidence of proposed further improvements. A programme of staff education and training had commenced, a KSM had been appointed, and a fire safety consultant had undertaken a fire safety survey of the premises. However, without significant investment, including the completion of extensive fire safety upgrading works, the premises were not suitable or safe for, or appropriate to the needs of the residents. The quality and safety of resident care was still significantly compromised by ongoing environmental difficulties including the ongoing lack of a passenger lift, absence of confirmation of fire protection status, poor communication practices and inadequate centre-specific risk assessment and management. Inspectors were satisfied that the daily care received by residents was in general of a good standard.

The person in charge demonstrated in attitude and in action a commitment to the service and care of the residents. However, a significant number of substantial improvements were required to comply with the requirements of 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*. These required actions were dealt with in detail in the action plan at the end of the registration inspection report. A total of 22 actions emanated from the findings of the inspection, but fifteen separate improvements were required alone in relation to the physical environment and seven in relation to staff recruitment. In total the provider and the person in charge had 65 required improvements to implement.

The improvements included:

- confirmation from a competent person that all of the requirements of the statutory fire authority have been substantially complied with
- provision of a passenger lift
- ongoing and relevant centre-specific risk assessment
- personal emergency evacuation plans for residents
- issues pertaining to the upkeep, safety and suitability of the physical environment including fire detection systems
- recruitment practices
- supervision of staff
- communication practices and standards
- care planning
- the prevention and management of falls
- the provision of meaningful and therapeutic activities

- review and ongoing quality improvement
- complaints management.

The provider again responded positively and in a timely manner to the action plan.

The third inspection was an unannounced one-day follow-up inspection on 24 May 2011 to assess the extent to which the provider had implemented the actions of the registration inspection.

Overall, inspectors again found willingness on behalf of the provider and the person in charge to exercise their legislative duties and responsibilities. Inspectors were satisfied that the provider had addressed, or was in the process of addressing, core actions relating to the health and safety of residents, staff and visitors. A passenger lift had been installed and was fully operational. Risk assessments had been completed and there was evidence of the implementation of some, but not all of the required risk management controls. There was evidence that the provider had responded positively in relation to the required fire safety upgrading works. A full fire safety survey had been undertaken by a fire safety consultant and submitted to South Tipperary Fire Authority. The fire detection system had been extended and upgraded to an addressable L1 system and on the day of inspection, work was underway on the upgrade of the emergency lighting.

However, the required works were slow and significant. Clarity was still required in relation to proposed completion dates and the availability of written confirmation that the premises complied with all the requirements of the statutory fire authority. Notwithstanding the objective of the provider to bring about change, inspectors however found the governance of the service to be in a state of disarray and were not satisfied that the change management process had or would achieve the desired objective. Despite the willingness and apparent capacity of the provider and the person in charge to progress the implementation of the required actions progress overall was not satisfactory. The inspectors found that three of the required actions had been satisfactorily completed and further minor improvement was required to fully complete two further actions related to administrative functions; 19 actions remained outstanding. Inspectors also established evidence supporting the lack of suitable and sufficient care to some residents with subsequent negative health, safety and welfare outcomes with little evidence of learning and remedial action to prevent reoccurrence.

The provider was issued with a further 20 action plans, 18 of which were reissued from the previous inspections and two new required improvements. The new improvements pertained to the arrangements for satisfactory replacement of the person in charge on a routine or unexpected basis, and the provision of adequate numbers and skill mix of staff.

These required actions were dealt with in detail in the Action Plan at the end of the inspection report and included:

- written confirmation that the premises complies with all the requirements of the statutory fire authority
- the provision of personal emergency evacuation plans for residents

- staff training in fire safety and evacuation procedures
- recruitment practices
- issues pertaining to the further upkeep, safety and suitability of the physical environment
- sufficient and appropriate replacement of and support to the person in charge, and appropriate governance of the designated centre
- objective analysis and planning in relation to staffing levels, skill mix and management systems
- having appropriate systems in place for reviewing serious or untoward incidents, accidents or adverse events involving residents
- medication management
- assessment, referral and access to allied health services
- access to meaningful and therapeutic activities and social engagement
- the management of serious accidents and incidents
- robust recruitment practices.

Inspectors visited the centre on 22 July 2011; the primary purpose of the visit was to take photographs of the environment to support and inform the documentary evidence gathered on the three inspections to date. The person in charge also provided the inspector with an update on the progress made in the implementation on some of the required actions from the unannounced follow-up inspection of 24 May 2011. Overall, there was evidence that the registered provider had progressed the implementation of the Action Plan. An extensive fire training programme for staff had commenced with an external facilitator; an external facilitator had been sourced to provide education and training for staff on the prevention, detection and management of alleged or suspected elder abuse and an external facilitator had been engaged to provide falls prevention and management training to staff. There was evidence of enhanced access to allied health services for residents, and follow-up of a serious omission in care by a member of the care staff that had resulted in a resident sustaining a serious injury as identified by the inspectors on the last inspection. The person in charge told the inspector that the original governance structure had been restored and was working well. The inspector saw evidence of ongoing environmental remedial works.

The Authority held a meeting with the nominated registered provider and the person in charge on 25 August 2011, at which the Authority outlined its ongoing concerns in relation to the substantial improvements that were still required to achieve satisfactory compliance with the legislation. The Authority acknowledged the cooperation of the provider, the investment made and works initiated and completed, but reiterated and reinforced the requirement to achieve further compliance in a timely manner.

The fifth inspection was an announced two-day follow-up inspection on 7 February 2012 and 8 February 2012. There was evidence of improvement, but the progress made and the level of compliance achieved was not satisfactory. Of the 20 actions followed up on by the inspectors, four were met, five were partially progressed but further improvement was required, and 11 were not met. While the provider had taken action such as providing education and training to staff, sourcing the assistance of external facilitators, improving access to allied health professionals and

installing a computerised care planning system, unfortunately this did not ensure enhanced clinical, safety and quality of life outcomes for all residents. The provider and person in charge were issued with a further 19 actions further to the inspection findings; 16 actions were reissued and three new actions were issued.

Inspectors had serious concerns in relation to the protection of residents from risk of injury, harm or abuse and the provision of suitable and sufficient care to all residents in line with their assessed needs and dependency levels. The inspectors were satisfied that these negative findings and risks in relation to resident health, safety and welfare resulted from inadequate governance structures, including the inadequate supervision of staff, inadequate management of breaches of duty and care by staff, the non-implementation of an effective system for reviewing and continually improving upon the quality and safety of care and services provided to residents and the lack of clinical competency in planning, implementing and evaluating the provision of suitable and sufficient care to residents. It was also of concern to the inspectors that outstanding fire safety upgrading works had not commenced and there was no agreed start date for them.

Based on the risks identified, the provider at verbal feedback was requested by inspectors to take immediate action on three areas within agreed timeframes:

- the protection of each resident from being harmed or being placed at risk of harm or abuse
- the facilitation of all recommended or prescribed treatments to ensure that each resident receives suitable and sufficient care, and is supported to achieve the best possible health
- confirmation that all outstanding fire safety works would be undertaken and confirmation of the timeframe for the completion of the works.

The required actions were again set out in detail in the Action Plan at the end of that report and included in addition to the above:

- adequate and appropriate supervision of staff
- the provision of food and nutrition to residents that was adequate and appropriate to their individualised specific needs and preferences
- the implementation of an effective and robust system for reviewing and monitoring the care and services provided to residents
- the management of complaints
- care planning that ensured the provision of suitable and sufficient care to each resident
- equitable access to meaningful and therapeutic activities and social engagement
- ongoing issues with the premises.

Based on the failures to meet regulatory requirements as identified during all of these inspections, the Chief Inspector on 13 April 2012 issued notices of proposal to cancel and refuse the registration of Melview House Nursing Home. On 11 May 2012, the provider, in accordance with section 54 of the Health Act 2007 submitted to the Chief Inspector written representation in response to these notices of proposal.

Summary of findings from this inspection

This inspection, the sixth inspection of the centre, was an unannounced follow-up inspection.

The inspectors followed up on:

- the 19 actions that emanated from the inspection of February 2012
- the remedial actions identified by the provider as necessary in his response to the Action Plan
- the grounds for cancellation and refusal of application for registration as outlined in the respective notices
- the written representation received from the provider.

Where the inspectors addressed new areas of regulatory non-compliance this aspect of the inspection is reported on in the section of the inspection report titled “issues covered on inspection”. The follow-up aspect of the inspection is reported on in the section titled “actions reviewed on inspection” and outlines the extent to which the provider had implemented the actions.

There was evidence of improvement and the nominated registered provider again repeated his willingness to comply with 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*. To this effect, the outstanding fire safety upgrading works, though not on schedule or complete, had recommenced, and the nominated provider had engaged the services of another service provider in an advisory capacity to assist in the implementation of some of the required improvements. Overall, however, the level of improvement made was not satisfactory and of the 19 actions followed up on by the inspectors three were met, three were partially progressed but further improvement was required, and 13 were not met. Four of the unmet actions were directly related to the provision of a safe and suitable physical environment. The remaining nine unmet actions, however, and four further areas of best practice and regulatory non-compliance identified by the inspectors were directly related to the operational and clinical management of the centre on a daily basis. Based on the findings of five full inspections, the inspectors were satisfied that the failure to achieve satisfactory regulatory compliance and ensure the consistent provision of safe quality care and services to residents was directly co-related to the inadequate governance of the service and the absence of strong clinical leadership.

The inspection findings indicate that the governance of the service did not support and promote effective, transparent management systems and the delivery of high quality, safe care and services. There was evidence of poor communication between management and between management and staff with resultant uncertainty and lack

of clarity in relation to the change management process. The inspection findings also indicate that the provision of care and services was not at all times driven by a person-centred model of care where the rights and holistic needs of the resident took precedence over entrenched attitudes and work practices so as to achieve positive clinical and quality of life outcomes for residents. This was particularly evident in relation to the management of complaints and negative feedback from residents or relatives, the delivery of meaningful and stimulating social activity and the provision of end-of-life care. There was a distinct lack of evidence to support a transparent and robust system for reviewing, and thereby continuously improving upon the quality and safety of care and services provided to residents.

As at the time of the third inspection on 24 May 2011, the inspectors again found the centre to be somewhat in a state of disarray. In addition to the change management processs, the inspectors also found the centre to be busy and challenging for staff. Extensive refurbishment/fire safety works were underway in the basement with significant disruption to the catering service. There had been a significant turnover of staff and an increase in absenteeism since the last inspection; further staff were due to cease employment shortly. There was a high level of short-term resident admissions and discharges to and from the centre. The inspectors saw that despite these challenges staff were attentive to and worked hard to meet the immediate needs of the residents. Given the concerns that the inspectors had in relation to the cumulative negative impact of all of these factors, the provider was requested to review admission procedures. He agreed to cease all further admissions to the centre until all environmental works had been completed.

The provider was issued with a further 20 actions, 16 of which were repeat actions from previous inspection findings.

The required actions are set out in detail in the Action Plan at the end of this report and include:

- confirmation that all outstanding fire safety works would be undertaken, and confirmation of the timeframe for the completion of the works
- the design and layout of the premises
- the implementation of an effective and robust system for reviewing and monitoring the care and services provided to residents
- equitable access to timely and appropriate medical review and care
- practices and facilities to support end-of-life care
- medication management practices
- care planning that ensured the provision of suitable and sufficient care to each resident
- equitable access to meaningful and therapeutic activities and social engagement
- the management of complaints
- health and safety including food safety
- risk management
- adequate and appropriate supervision of staff
- the submission of adequate and accurate notifications to the Authority.

Issues covered on inspection

1. End of Life Care

The inspection findings indicate that the centre did not have the appropriate facilities, protocols and practices in place to appropriately support end-of-life care. Best practice and regulatory requirements state that the wishes and choices of the end-of-life resident and their family are implemented insofar as is reasonably practicable and whenever possible. However, based on documentation reviewed and staff spoken with, the inspectors were satisfied that end-of-life care was not at all times provided in a manner that did not infringe upon the choices, rights, privacy and dignity of other residents, particularly those in shared accommodation.

2. Admission Procedures/Statement of Purpose

Inspectors found that it was difficult to establish precise information in relation to resident activity in the centre, but noted from the directory of residents a high number of residents transiently admitted since the last inspection. Staff subsequently established for the inspectors that approximately 15 residents had been admitted from the local acute facility since December 2011, the average length of stay was 4.5 days and this arrangement was classified by staff as a “clinical winter initiative”. The provider told inspectors that he was unaware of this arrangement and the person in charge told the inspectors that the arrangement assisted the local acute facility in the management of their resources where patients were discharged by them but were not “ready” to go home. Staff spoken with told inspectors that these admissions kept staff “very busy” and they were not satisfied that the needs of all patients admitted were adequately met in the centre as they were not well enough or “stable” enough when discharged from the acute sector.

The inspection findings indicate that this category of care was facilitated without:

- an appropriate risk assessment of the impact of this initiative on an already burdened service given its significant level of non-compliance with the regulations and Standards, staff turnover and absenteeism as reported to the inspectors and the ongoing physical environment remedial works and the extra demands that these were seen by inspectors to place on staff
- clear policy and procedure on the admission, care and discharge of these residents to the centre to ensure that they were admitted and discharged in a planned and safe manner. Staff spoken with confirmed that no pre-admission assessment was undertaken of these residents and a sample of ten clinical records reviewed by the inspector confirmed that eight residents were admitted to and discharged from the centre without medical review once discharged by the acute services. Nursing plans of care reviewed by the inspector specified that the residents’ general practitioner (GP) was to be informed of the admission, visit the centre, review the resident and sign the medication prescription record

- this category of care was not explicitly identified on the most recent statement of purpose submitted to the Authority in February 2012.

Following discussion with the provider and the concerns raised by the inspectors the provider gave a commitment to the Authority to accept no further admissions to the centre until at least 29 June 2012.

3. Health and Safety

Based on the inspection findings, the inspectors were not satisfied that all operational policies and procedures and best practice relating to food safety were in place. On the first day of inspection the inspectors noted that structural fire safety upgrading works were being undertaken in the basement. The person in charge told inspectors that this had necessitated the closure of the main kitchen on 28 May 2012, and the temporary relocation of catering facilities into adjacent areas including rooms that had functioned as staff facilities and the office of the person in charge. The person in charge confirmed for the inspectors that the relevant environmental health officer (EHO) had not been informed of the alternative arrangements in place. The person in charge subsequently contacted the relevant EHO who inspected and monitored the premises and requested the provider to source alternative external arrangements for the provision of cooked meals for residents for the duration of the remedial works.

4. Medication Management

The inspectors were not satisfied that all medication management practices were in line with regulatory and legislative requirements, regulatory body guidelines or the centre-specific medication management policy.

The inspectors found that:

- nursing staff transcribed medication prescription records, and while the records reviewed were signed by the transcribing and checking nurse they were not dated
- a number of transcribed medication prescription records seen by the inspectors to be in daily use, were transcribed records not signed or dated by the relevant GP/prescriber within a designated timeframe
- staff spoken with had identified a requirement for improvement and confirmed that the method of recording each drug and medicine administered, was not conducive to maintaining and retrieving a clear and accurate record of each drug or medicine administered or omitted to each resident in line with their changing needs. Though identified by staff no remedial action had been taken to improve upon the safety and quality of medication prescribing and administration recording practices.

Actions and Grounds reviewed on inspection:

Ground Number 3 for Refusal of Application to Register

Failure of the Registered Provider to satisfy the Chief Inspector that the application for registration, will comply with, or, if for renewal, is in compliance with standards set by the Authority under section 8(1)(b), and regulations under section 101.

1. Regulation 6 General Welfare and Protection: 6 (3) (a) of the 2009 Regulations / Standard 8 Protection

Action required from previous inspection:

Take appropriate action where a resident is harmed or suffers abuse. Put in place all reasonable measures to protect each resident from all forms of abuse.

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.

Agree and implement policy and procedures for the prevention, detection and response to abuse.

This action was partially implemented.

The provider confirmed that further to an allegation of abuse made by a resident against a staff member, and the inspection findings of February 2012, necessary arrangements and appropriate action to protect and prevent each resident from being placed at further risk of harm and/or all forms of abuse had been taken.

However, further protective measures identified as necessary by the provider in his response to the Action Plan had not been implemented. While the elder abuse policy had been agreed and implemented and was signed by staff as read and understood, it had not been reviewed in line with the recommendations of the last inspection. Staff spoken with confirmed that the recent turnover of staff and increased absenteeism had prevented the implementation of management supervision of shifts on a twenty four-hour basis.

Regulation 6: General Welfare and Protection: 6 (3) (b) of the 2009 Regulations / Standards 18 & 20.

Action required from previous inspection:

Accurate documentation shall be maintained of assessment, consent, the nature of the restraint, review, removal of the restraint and opportunity for motion and exercise and all other matters as prescribed so as to comply with best practice,

policy and regulatory requirements in relation to restraint.

Where there is an objective clear clinical rationale for the use of restraint this is clearly documented in the resident's care plan and communicated to all staff. Chosen interventions promote positive outcomes for the resident.

This action was met.

The inspector was satisfied that staff demonstrated an evidence-based approach to the use of restraint. Staff spoken with confirmed that practice was guided by best practice nationally agreed guidelines on the use of restraint. The inspectors saw that minimal physical restraint was used and staff were seen to be patient and attentive and employed non-pharmacological strategies with residents demonstrating challenging behaviours. A restraint register was maintained for the use of bedrails, records of restraint monitoring and removal were in place and there was evidence to support the exploration of alternatives such as low-low beds, movement alarms and impact-reducing falls mats. Nursing decisions to implement or remove bedrails were augmented by an assessment tool, which while described as not being a prescriptive scoring tool, supported clinical judgement when assessing the risks of applying bedrails. There was evidence of discussion with the resident or their representative as appropriate.

3. Regulation 6: General Welfare and Protection: 6 (3) (d) of the 2009 Regulations/Standards 18 & 20

Action required from previous inspection:

Each resident regardless of location, diagnosis and physical and/or cognitive ability is given opportunities for participation in meaningful and purposeful activity and occupation that suits his/her needs preferences and capacities, previous routines, social and recreational interests. Staff are encouraged to view activities as an opportunity to enhance physical, cognitive and social wellbeing and an opportunity to interact and engage with residents.

This action was partially implemented. There was evidence of improved practice but much work still to be done. The provider had continued to engage the services of a recognised company specialising in the provision of meaningful recreation in residential care services, to work with the activities coordinator and formulate and monitor the implementation of a structured activities programme. Documentation was in place for recording and evaluating the delivery of activities. Assessments titled "a key to me" had been completed with approximately 60 percent of the residents. The inspectors saw that more independent and mobile residents enjoyed ready access to the local town and came and went to and from the centre on a daily basis.

Incrementally over the course of the inspections, there have been improvements. However, the inspectors were not satisfied that opportunities for participation in meaningful and purposeful activity and occupation, and the exercise of their religious

rights were fully inclusive of all residents. The inspection findings support that the delivery of the activities programme was still not at all times prioritised by management, and while there was a dedicated activities coordinator the inspectors saw and staff reported that this staff member was frequently allocated other duties. This was compounded by the layout of the building and entrenched work practices. For example, the inspectors saw that while there was enhanced input and activity on the back wing, dependent residents in other areas of the building spent prolonged periods of time in their room with little to stimulate or engage them. Staff, when asked by the inspector how these residents spent their day, told the inspector that these residents declined to participate in activities; other staff said that the residents remained in their room because they required transfer with a lifting hoist. One resident spoken with told the inspector of his enjoyment of company, sports and music and said that he would love to go to the music sessions on the ground floor, but staff never told him when they were on. The person in charge told the inspectors that this was probably correct.

Customer satisfaction surveys undertaken by the person in charge and reviewed by the inspector, while generally satisfactory, indicated that the delivery and scope of the activity programme was one area identified by residents as requiring improvement, as was attendance to their religious needs. Staff spoken with confirmed that mass was said once a week, but was always said in the oratory on the ground floor. Therefore it was either inaccessible or accessible only with staff assistance to many residents with high physical dependency needs, or those mobile only with the assistance of specialised seating.

The activities coordinator had not completed the Sonas programme, (a therapeutic communication activity that utilises cognitive, sensory and social stimulation) as outlined in the provider's response to the Action Plan.

4. Regulation 19: Premises: 19 (a), (e), (f), (g), (i), (l), (n) of the 2009 Regulations / Standard 25 Physical Environment

Action required from previous inspection:

Ensure that residents have access to a safe, secure outdoor space with seating, accessible to all residents, including residents with mobility impairments and those using wheelchairs. The grounds are kept safe, tidy and attractive.

Address the security of the overall campus. There is a secure perimeter.

Review the suitability and safety of the existing smoking room in line with any recommendations made by the fire authority or fire safety consultant.
Provide appropriate, safe and accessible storage facilities for equipment.

Provide a suitable private area where residents can meet visitors in private.

Provide sluicing facilities, including bedpan washers, that are appropriate to the size of the building and easily accessible from all areas of the building. All replacement sinks are stainless steel.

Provide appropriate cleaning room(s) for cleaning staff. The cleaning room is ventilated and contains a sluice sink, wash-hand basin and lockable safe storage for chemicals. All new/replacement sinks are stainless steel.

Provide to the Chief Inspector explicit plans to address the limitations of the premises so as to provide premises that are suitable for the purpose of achieving the stated purpose and function of the premises.

This action was not met.

Incremental progress has been made since the first inspection in September 2010, and while there was again evidence of further remedial works, the overall design and layout of the premises is not suitable for its stated purpose. It does not meet residents' individual and collective needs in a manner that at all times maximises their independence, privacy, dignity and inclusion in the socio-cultural environment of the centre.

The inspector saw and staff confirmed that the original designated smoking room in the back wing was no longer in use as recommended in December 2010 by the fire safety consultant.

Though not fully compliant with the criteria laid down in the *National Quality Standards for Residential Care Settings for Older People in Ireland* a cleaning room had been provided in the back wing as it had extra storage.

The triple bedroom on the ground floor had been reduced to accommodate two residents only.

However, the additional sitting room with scenic views for residents in the back wing as identified in the provider's response to the Action Plan was seen by the inspector to be an area of the original oratory (now a dining room) on the first floor. Access to the dining room is not possible for more dependent and vulnerable residents given that three steps adjacent to an open stairwell govern access to it. No work was seen to have commenced on modification of the windows of the main back wing communal room so as to allow residents to see out when seated. The security of the overall campus had not been addressed. There was no secure perimeter and the inspectors again saw that there was regular unauthorised pedestrian traffic in the grounds that effectively was used as a thoroughfare.

The "back wing" is not serviced by the passenger lift. Dependent residents cannot access the other floors and facilities and spend their entire day in the communal room or in their rooms in the "back wing". The inspectors saw that residents requiring wheelchairs or other specialised seating entered and left the building via a rear fire exit door. However, at the time of this inspection, the back wing was fully occupied and there were eight vacant beds in the main building. When asked for a rationale, the person in charge told the inspectors that this had evolved due to requests from residents and their families for single private accommodation. The

universally accessible available communal space in the back wing is 44m² and almost 24m² short of the space recommended by the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Ten single bedrooms provide less than the required 9.3m² of usable floor space, five of them only providing 7m². The size, design and layout of these rooms are not adequate to meet the needs of more dependent residents. This environment is too compact and too physically segregated from the main building and hub of activity to provide a safe, therapeutic, quality care environment. Conversely, there was evidence to support that the design and layout of the main building also does not meet the needs of each resident. The person in charge confirmed that the passenger lift cannot accommodate specialised seating, and this has influenced her decision making in relation to accommodating residents with high dependency needs in the back wing rather than in the main building.

Given the design and layout of the building the necessary sluicing facilities are not provided.

A suitable universally accessible private space for residents to meet visitors in private is not available.

As previously stated in the report, adequate and appropriate facilities are not available to support end-of-life care.

All meals, snacks and refreshments are brought manually by staff to the back wing. There was a lack of clarity on this inspection as to the safety of using the passenger lift. There was no evidence of constructive, positive reflection to identify interventions to modify the inherent challenges posed by the design and layout of the building so as to enhance the safety and quality of care and services provided to residents.

The provider advised the inspector that he has drawings and plans for the replacement of the “back wing” with a new build; the realisation of this new build is complex.

5. Regulation 31 Risk Management: 31 (2) (d) of the 2009 Regulations / Standard 26 Health and Safety

Action required from previous inspection:

Review the findings of the risk assessments and the controls identified to reduce, control or eliminate the risks to residents, staff and visitors. Identify and implement the remaining controls and review the adequacy of all controls, specifically in relation to the external grounds.

The risk assessments are reviewed on an ongoing basis and updated as required.

This action was not met.

Staff spoken with told the inspector that an external consultant had conducted a review of the findings of the risk assessments and the adequacy of the identified controls. However, the reviewed risk assessments were not in place or implemented within the timeframe identified by the provider in his response to the Action Plan. The inspector saw that restrictors were in place on the remaining chapel windows and work was underway on the erection of a more robust protective barrier around the basement ditch (moat) that surrounds the premises.

There was no apparent alteration to the safety and general security of the external grounds.

The inspection findings indicated that on a daily basis staff had a poor understanding of risk management and the implementation of reasonable measures to prevent accidents. Electronically secured stair-gates erected on open stairwells and designed to control unauthorised access and thereby reduce the risk to vulnerable residents were repeatedly seen by inspectors to be left open by staff; a call-bell string in a toilet had been extended by attaching four plastic bags to it; and on the final day of inspection there was a lack of clarity as to the operating status of the passenger lift. Staff on the final day of inspection requested that the inspector not use the lift for her own personal safety as there was "a strange noise" coming from it; yet there was no notice on it advising residents, visitors or others not to use the lift.

6. Regulation 31 Risk Management: **31 (3) of the 2009 Regulations / Standard 26 Health and Safety**

Action required from previous inspection:

Put in place and implement a comprehensive emergency plan and adequate arrangements that clearly outline for staff the contingencies in place for responding to a loss of power and the actions to be taken while awaiting the restoration of services so as to protect resident safety, comfort and wellbeing and any prescribed treatments.

This action was not met.

Staff spoken with told the inspector that an external consultant had drafted a policy and procedure outlining the response to and the contingencies in place for responding to loss of power. However, staff told the inspector that it was not available as the consultant wished to undertake staff training including a practical exercise with staff prior to implementing the policy.

The inspector saw that rechargeable and working torches were strategically located on each floor.

7. Regulation 32 Fire Precautions and Records: 32 (1) (f) of the 2009 Regulations / Standard 26 Health and Safety

Action required from previous inspection:

Provide from a competent person details outlining the status of the required fire upgrading works identifying start dates and completion dates.

The date by which there is a reasonable expectation that written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with will be available to the Chief Inspector.

This action was not met.

While completion dates have been supplied over the course of repeated inspections these have varied, have been extended and have invariably not been met. In his most recently submitted Action Plan response, the provider stated that these works would be complete by 25 May 2012; the provider confirmed that the work was not complete. The inspectors saw that fire upgrading works were taking place but outstanding works in the back wing had not yet commenced. This was again discussed at length with the provider by the inspectors who reinforced and reiterated for the provider his legislative responsibility to provide to the Chief Inspector with the application for registration, written confirmation from a competent person that all of the requirements of the statutory fire authority have been substantially complied with. The provider again committed to completing the required works including the works in the back wing, and the expected completion date was estimated to be 29 June 2012.

8. Regulation 35 Review of Quality and Safety of Care and Quality of Life: 35 (1) (a) & (b) of the 2009 Regulations / Standard 30 Quality Assurance and Continual Improvement

Action required from previous inspection:

Establish and maintain an effective system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

This action was not met.

There was no evidence of a robust, effective system for reviewing, and thereby, continuously improving upon the quality and safety of care and services provided to residents. There was very little evidence to indicate an understanding of how

incidents, complaints or feedback from residents, relatives or staff contributed to and augmented a system of review and quality assurance.

The KSM confirmed for the inspector that no further audits had been completed since the last inspection.

There was no evidence of learning from previous omissions or deficits in care. While no omissions were detected by inspectors, staff spoken with told the inspector that there was no system of audit in place to ensure that all referrals and prescribed treatments were facilitated.

Minutes were available for three "quality meetings" convened since the last inspection. The minutes reflected the presentation of statistical details on the occurrence of issues such as falls, pressure sores, complaints and the use of psychotropic medication as outlined in Standard 30 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*. The inspector again found that the quality review process did not identify omissions in care and practice, and, therefore, did not ensure that corrective action plans were identified and implemented to ensure that each resident was at all times provided with suitable and sufficient care to enable them to achieve the best possible clinical, safety and quality of life outcomes.

The evidence to support this conclusion is discussed throughout the report specifically in relation to:

- the prevention and management of falls
- the provision of end-of-life care
- adequate and appropriate care planning
- equitable access to timely and appropriate medical review and treatment
- complaints management
- medication management.

The inspector saw that collectively the monthly residents' committee meetings, the advocacy service and completed customer satisfaction surveys provided an invaluable forum for residents and constructive feedback both positive and negative. The residents clearly identified areas they believed required review to improve their quality of life within the centre, such as access to mass, the variety and frequency of the activities provided including a request for outings and shopping trips, a private visitors' room, access to money to enhance their independence and financial autonomy, the variety and quality of meals and mealtimes, and the impact of end-of-life care provision in shared accommodation. While there was one record available for inspection to indicate that the matters raised were acknowledged by the person in charge, it was not clear that action was at all times taken or that the action taken in response to the issues raised actually effected change and improvement on all matters significant to and affecting the quality of life of the resident. For example, while residents had requested social outings and shopping trips and the person in charge had recorded that outings would take place, residents and staff spoken with told the inspector that no outings were planned or had taken place.

9. Regulation 39 Complaints Procedures: 39 of the 2009 Regulations / Standard 6 Complaints

Action required from previous inspection:

Ensure that there is one written policy and procedure in place for staff in relation to the logging of complaints and all staff are familiar with it.

The person in charge will ensure that all complaints and comments are fully recorded, investigated and explored with staff for feedback and future learning. Measures required for improvement that are in line with best practice and are evidence-based are identified, implemented and evaluated and there is clear evidence of this.

This action was not met.

The inspectors again noted ongoing inconsistencies in policy, procedure and practice. It was not clear as to how comments or complaints were assessed, logged, reviewed, shared and explored with staff for feedback, learning and to prevent recurrence.

The complaints management policy and procedure had been revised since the last inspection. Staff spoken with confirmed that complaints were no longer logged on the computerised care planning system, and a hard copy complaints register was in place.

However, the revised policy, while largely compliant with legislative requirements, was not agreed and implemented in practice and:

- made reference to three separate complaints logs, while the inspector saw that there were only two logs in practice
- the operation of the independent appeals process was unclear
- conflicting timeframes for the frequency of complaint audits were included.

The complaints log reviewed by the inspector, both computerised and hard copy, indicated that there were no complaints logged since the last inspection, and staff spoken with confirmed that the “kitchen errors record” as evidenced on the last inspection was no longer maintained. However, staff spoken with told the inspector that all complaints made verbally were not all recorded. Other documentation reviewed by the inspector confirmed that complaints had been made predominantly by residents since the last inspection, some of which were significant in relation to their quality of life in the centre. Based on the documentation reviewed, inspectors were not satisfied that complaints were accurately and adequately recorded or adequately explored and investigated. There was no evidence to support that complainant satisfaction was established or that complaints were welcomed and viewed as a valuable source of reflection, learning and continuous improvement. It was of concern to inspectors that statements made by the person in charge indicated a problem-based, subjective approach to some residents with reported behaviours of a challenging type. The person in charge described one resident who had made

complaints as “always complaining” and another resident who had been physically assaulted by a visitor to the centre as “very annoying”.

Ground Number 4 for Refusal of Application to Register

Failure of each other person who will participate in the management of the centre to satisfy the Chief Inspector that the application for registration, will comply with, or, if for renewal, is in compliance with— standards set by the Authority under section 8(1)(b), and, regulations under section 101.

10. Regulation 8: Assessment and Care Plan: 8 (2) (b) of the 2009 Regulations / Standard 11 The Residents’ Care Plan

Action required from previous inspection:

The person in charge will ensure that the care plan reflects the assessment findings, the residents’ actual needs, and sets out in detail the action to be taken by staff for each individual resident thereby ensuring the provision of suitable and sufficient care.

The person in charge shall ensure that interventions are specific to each resident and identified by nursing staff as appropriate to each individual resident’s assessed needs. Identified interventions are available and implemented.

The care plan is re-evaluated and updated in a timely and safe manner as indicated by the residents’ changing needs and significant events. All elements of the care plan, assessment, problem identification and communication record demonstrate an integrated, consistent plan of care.

This action was not met.

Care plans reviewed by the inspector were not current, were not at all times an accurate reflection of the residents’ needs, and had not been updated in line with the residents’ changing needs or at a minimum three-monthly basis as prescribed by regulatory requirements. This included nutritional care plans and falls-prevention care plans which, given the findings of previous inspections, was of concern to the inspectors. No further audits had been undertaken of care plans. Assessments other than falls-risk assessments were generally updated but some seen by the inspector were incorrectly completed, were not an accurate reflection of the residents’ needs and were not computed to give a correct risk rating. There was evidence to support that these recurring findings and lack of significant improvement were influenced by a transition process in the system of care planning.

Nursing staff spoken with told inspectors that they were currently in the process of piloting a hard copy rather than computerised system of care planning for both nursing and care staff. Nursing staff accepted that this pilot process had impacted on the updating and maintenance of the computerised care plans. Staff spoken with

articulated confusion and a lack of clarity in relation to the care planning process and this was reflected in the inspection findings. Notwithstanding the transition process, it was not acceptable that care plans in use were not updated or that there was no clear process of ensuring that planned care was implemented and evaluated to ensure suitable and sufficient care and a high standard of evidence-based nursing practice to maintain the welfare and wellbeing of the resident, having regard to the residents' dependency and needs.

This was particularly evident in relation to falls, nutrition and wound management. The incidence of wounds was low and there was evidence of good practice; wound assessments and wound care plans were in place and documentation reviewed indicated that wounds resolved. However, staff spoken with told the inspector that there was no evidence-based wound prevention and management policy in place. One resident assessed as at very high risk and with a history of wound development, was seen by the inspector not to have in place the pressure-relieving equipment specified as necessary for her wellbeing in her care plan. Two nurses spoken with were not aware that it was not in place, but confirmed for the inspector that it should have been.

There was evidence to support that care plans were discussed with the resident or their representative as appropriate. Six nursing staff had recently attended a workshop on care planning delivered by an external facilitator.

11. Regulation 8: Assessment and Care Plan: 8 (2) (b) of the 2009 Regulations / Standard 11 The Residents' Care Plan

Action required from previous inspection:

The person in charge will ensure that all staff are familiar with, adhere to and implement the centre-specific, evidence-based falls prevention and management programme.

Put in place appropriate and effective arrangements for reviewing serious or untoward accidents, incidents or adverse events involving residents including falls. The review identifies patterns and trends, required improvements and informs care and practice to avoid repeat occurrences.

Put in place appropriate systems/interventions and plans of care aimed at preventing residents being harmed or sustaining injury or being placed at unnecessary risk of accident and injury.

This action was not met.

The inspector again found that the approach to falls prevention and management was not consistent. A combination of factors such as non-adherence to policy, inadequate assessment and care planning, lack of clarity and subjective nursing opinion as to the level of assistance and supervision required by residents and an

absence of any robust transparent system of review resulted in an ongoing risk of falls and injury for residents.

There was evidence in practice of the implementation of falls prevention strategies such as discreet falls-risk alert stickers, the use of low-low beds and impact-reducing floor mats, hip protectors and movement alarm sensors. There was evidence to support that interventions were less generic and the number of care plans in place had been refined and reduced. However:

- interventions in practice were not at all times integrated into the residents' plan of care
- where generic interventions were appropriate such as falls risk alert stickers, and the completion of a falls risk assessment there was a lack of consistency in their integration into care and the care plan
- the falls risk assessment was not re-evaluated after each fall as stipulated in the falls policy
- where despite their implementation, the resident continued to fall and sustain injuries that required medical/hospital treatment. There was no reference to these interventions in the accident records, care plan or the daily nursing record, nor evidence to support a review of the consistency of their implementation in practice or an evaluation of their efficiency and effectiveness as a falls prevention strategy.

Falls prevention assessment and care planning was inconsistent and inadequate to ensure that suitable and sufficient care and all reasonable measures were in place to reduce the risk of falls and injury. The accuracy and frequency of the completion of the validated falls risk assessment by nursing staff was inconsistent as was the formulation of falls prevention care plans. The resident's fall risk and care plan was not re-assessed following a fall as outlined in the policy. This was compounded by differing subjective nursing opinion and did little to ensure enhanced clinical and safety outcomes for residents in relation to their falls risk. These are repeat findings over the course of the inspection process that have contributed to falls and serious injuries sustained by residents.

Inspectors again saw that call-bells were not at all times readily accessible to dependent residents.

Previously the inspectors found that accidents and incidents had been reviewed, omissions and required improvements identified but not always acted upon; on this occasion with the exception of one fall there was no evidence of the review of falls, accidents and incidents. New recording hard copy documentation had been introduced as outlined in the provider's response to the Action Plan. Records reviewed were comprehensive and indicated that staff reacted appropriately. However the vital missing element was the review individually and collectively of all accidents and incidents to inform risk management strategies, prevent in so far as was reasonably possible a reoccurrence and ensure that every effort was made to protect all residents from falling and prevent avoidable injury to residents.

No further falls prevention and management education and training had been provided to staff. The health and safety statement had not been revised and updated as outlined in the provider's response to the Action Plan; the statement presented for inspection purposes was dated December 2010.

12. Regulation 9: Healthcare: 9 (2) (b) of the 2009 Regulations / Standard 13 Healthcare

Action required from previous inspection:

The person in charge shall conduct a review of all residents' medical and nursing records. Where referral and review to another healthcare professional has occurred the person in charge shall ensure that all recommended treatments and interventions are prescribed and facilitated.

The provider shall ensure that accurate records of all health care referrals and follow-up appointments are maintained.

This action was partially met.

The inspectors reviewed a cross-sample of residents' medical and nursing notes. There was evidence to support enhanced access as appropriate to the residents' assessed needs to services such as physiotherapy, speech and language therapy and dietetic services. There was no evidence found by inspectors to indicate that recommended treatments and interventions were not prescribed and facilitated. However, the inspection findings indicated that there was a lack of congruence between prescribed and recommended treatments and nursing care plans that had not been updated which created an ongoing risk for future error. This is addressed in the actions pertaining to care planning and quality assurance.

During the course of the inspection, inspectors saw that nursing staff were attentive to the residents' changing needs, assessed and evaluated those needs, sought and pursued medical review and treatment in response to those needs as appropriate. The inspectors saw two GPs, a consultant psychiatrist and a physiotherapist visit and review residents during the course of the inspection. However, based on documentation reviewed and staff spoken with, the inspectors were satisfied that all residents did not have equitable access to timely and adequate medical review and care to support them to achieve and maintain the best possible health. Medical care and review was at times reactive in response to acute incidents or deteriorating health rather than proactive and health promoting.

13. Regulation 9: Healthcare: 9 (2) (b) of the 2009 Regulations / Standard 13 Healthcare

Action required from previous inspection:

Put in place suitable and sufficient care and all appropriate healthcare to maintain each resident's welfare and wellbeing, having regard to the nature and extent of

each resident's dependency and needs (nutrition).

Ensure that there is provided to each resident at all times, a high standard of evidence-based nursing practice.

This action was met.

Inspectors saw that residents' weights and nutritional screening were monitored monthly, deficiencies noted and acted upon by nursing staff. A review of residents' weights by the inspector indicated that residents' weights in general were stable and more vulnerable residents had gained weight. Residents had good access to speech and language and dietetic services, and a wide variety of nutritional supplements were in use. Staff with specific responsibility for nutrition had been identified but not fully implemented, and some staff had received further nutritional training.

This action pertained specifically to serious deficits in care identified on the last inspection. While inspectors were satisfied that these inspection findings were satisfactory in this regard, care planning inconsistencies, the requirement for a robust monitoring system for monitoring dietary and fluid intake and the variety and nutritional value of all meals and snacks provided are an ongoing concern in relation to ensuring that each resident receives suitable and sufficient care. These concerns are dealt with in the respective section of the Action Plan.

14. Regulation 9: Healthcare: 9 (2) (b) of the 2009 Regulations / Standard 13 Healthcare

Action required from previous inspection:

Provide each resident with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements, and is consistent with each resident's individual needs.

This action was substantially implemented.

There was evidence to support that action had been taken to identify and rectify the underlying issues contributing to the poor quality and unsafe service provided to residents in relation to meals and mealtimes as evidenced in the inspection findings of February 2012. The inspector reviewed minutes of a meeting held with catering staff on the 05 May 2012, at which an extensive number of required improvements and action plans had been identified and agreed including: staffing and governance, training, equipment and the implementation of hazard analysis and critical control points (HACCP) systems. There was evidence of the implementation of some but not all of the required improvements. Posts of responsibility had been identified and allocated. Catering and nursing staff spoken with confirmed that catering staff had attended training on dysphagia and the preparation of modified diets on 8 May 2012. A new menu was in place and while not complete, there was evidence of enhanced

documentation for catering staff as to each resident's likes, dislikes and specific dietary requirements. These require further review and refinement, however, to ensure accuracy and consistency and had not yet been implemented for all residents. Catering staff spoken with articulated a commitment to the change management process and the provision of quality catering services to residents.

Again, a deficit noted by inspectors was the absence of a system for monitoring and reviewing the implementation and impact of the identified required improvements. Documentation reviewed by the inspector indicated that some residents continued to express some dissatisfaction with the variety and quality of meals and mealtimes, yet staff spoken with confirmed that the "kitchen errors record" for recording complaints/errors/expressions of dissatisfaction in relation to residents' meals was no longer maintained.

Inspectors were not satisfied as to the variety and nutritional value of snacks in stock, seen to be offered to residents, or the variety of products available to residents with diabetes. Some residents would have benefited from the provision of modified delph and cutlery to enhance the quality and independence of mealtimes.

Based on documentation reviewed and staff spoken with, inspectors were not satisfied as to the systems in place for accurately computing and monitoring the daily fluid intake of residents to ensure that this was adequate and appropriate to their needs. Samples of fluid intake records computed by the inspectors were below the recommended daily intake as specified in the residents' care plan.

The scope of responsibility and level of autonomy afforded to senior catering staff to implement the required changes was unclear to them.

As the actions as identified by the provider had been substantially implemented, the required further improvements as identified by the inspectors are again linked to review and quality assurance. They are therefore dealt with in that action in the action plan at the end of this report.

15. Regulation 17 Training and Staff Development: 17 (2) of the 2009 Regulations/ Standard 24 Training and Supervision

Action required from previous inspection:

The person in charge will ensure that management systems are in place that ensures that all staff are appropriately supervised on a regular basis.

The person in charge will ensure that at all times care is supervised and monitored by a competent registered nurse to ensure that care and services are delivered in accordance with best practice, and the needs of the resident as set out in their plan of care.

Develop and implement a robust staff appraisal system that is appropriate to the specific needs of the centre and addresses issues raised in care and practice. Each staff member is informed of their progress, and has an opportunity to rectify

limitations and develop capabilities and strengths.

This action was not met.

There were systems in place for the allocation of staff to respective floors and the allocation of specific tasks and duties to staff. Inspectors saw that there was increased visibility of nursing staff, and that a staff presence was maintained at all times on all floors. However, the inspection findings again indicated that governance was not robust and while systems of allocation were in place and staff were clear on their reporting relationships, monitoring systems were poor and did not ensure appropriate supervision of staff or sufficient monitoring of and accountability for practice and the care and services provided to the residents.

Inspectors found that:

- while the person in charge told inspectors that the disciplinary procedure had not been invoked since the last inspection, staff spoken with told the inspectors that two staff had formally met with the person in charge as a grievance had been expressed in relation to their respective roles and responsibilities. There was no record of these meetings or the issues discussed; inspectors had been told by staff that the grievance related to the supervision of carers and their work
- while systems were in place to allow for the recording and monitoring of care delivered, the process of review was ad hoc and staff spoken with told the inspector that there was no formal procedure for the review of care inputted and recorded by care staff
- two nurses spoken with by the inspector did not know that one resident did not have in place the pressure-relieving equipment specified as required to meet her needs
- the KSM was due to leave the service by mid June 2012, and there were no arrangements in place for her replacement
- given the recent turnover of staff and increased absenteeism, staff reported that the priority had been to cover all staff shifts and it had not been possible to implement management coverage of out-of-office hours as outlined in the provider's Action Plan
- based on documentation reviewed there was evidence to support that all staff either did not have the required English speaking proficiency to communicate effectively with residents and relatives, or did not adhere to local policy and continued to speak to each other in their first language when in the presence of residents. One resident spoken with by the inspector, while speaking well of staff told the inspector that he found this "very disconcerting"
- an effective staff appraisal system had not been implemented. Staff spoken with confirmed that they had not had their skills, competencies and application to their work and duties formally appraised; others told the inspector that they had been given an appraisal form to complete ten months ago but had not yet done so
- the inspector was provided with the minutes of two staff meetings to review. The minutes, while indicating that issues such as supervision and the required

standards of care and practice had been discussed, did not demonstrate how these were to be achieved and monitored, or how ongoing breaches were to be addressed.

16. Regulation 17 Training and Staff Development: 17 (2) of the 2009 Regulations/ Standard 24 Training and Supervision

Action required from previous inspection:

The person in charge will ensure that all staff receive induction training specific to the needs of the centre, and there is clear evidence of this.

The provider will ensure that each staff member's file shall include and confirm the terms and conditions of their employment including: the date on which they commence and shall cease employment, the position they hold, the work that they perform, the number of hours for which they are employed each week and any other records in relation to their employment.

This action was not met.

There was evidence of poor recruitment, staff training and development practices. The process of induction was inconsistent. One staff member spoken with told the inspector that they had undertaken a period of induction on commencement of employment that was formally assessed. However, other staff spoken with and staff files reviewed by the inspector indicated that a formal process for evaluating successful completion of the induction process to ensure that staff had the required knowledge, skills and competencies to perform their role to the required standard was not in place for all staff employed.

Staff spoken with told the inspector that they did not have contracts of employment, while other staff had contracts that were not an accurate description of the position that they held and the duties that they performed in the centre. A sample of staff files reviewed by the inspector did not all contain contracts of employment.

The inspector saw that the provider continued to facilitate English language classes for staff, and staff willingness to attend was good. However, at times it was not facilitated due to staff shortages and service demands. Despite the provision of the classes, there was repeated evidence to support that residents and relatives continued to experience communication difficulties with staff as discussed earlier in relation to staff supervision.

17. Regulation 17 Training and Staff Development: 17 (3) of the 2009 Regulations/ Standard 24 Training and Supervision

Action required from previous inspection:

The provider shall ensure that all the written operational policies and procedures of the designated centre are reviewed in line with any recommendation made by the

Chief Inspector. Ensure that all policies have a current evidence base, are centre-specific, have a clear implementation date and clearly set out for staff centre-specific roles, responsibilities, procedures and reporting mechanisms.

The person in charge will ensure that staff are familiar with and implement all policies and procedures in practice, to guide and inform a high standard of evidence-based nursing practice. There is clear evidence of this.

This action was not met.

The KSM told and showed the inspector that she had reviewed two policies since the last inspection: the admissions policy and the complaints policy. The KSM confirmed, however, that neither policy had been agreed or implemented. The inspector again found the approach to policy review and implementation to be fragmented, and staff spoken with described an ad hoc system of communicating policy and practice reviews and amendments to staff. For example, the amended complaints policy was not implemented, but the procedure for managing complaints in practice had altered with ongoing inconsistencies found by inspectors. The procedure for recording accidents and incidents had also altered with no evidence of formal discussion or communication with staff. There were further findings to support that policy was not congruent with practice as identified in the prevention and management of falls, admission procedures, end-of-life care and medication management.

18. Regulation 36 Notification of Incidents: 36 (2) (d) of the 2009 Regulations/ Standard 26 Health and Safety

Action required from previous inspection:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

This action was not met. The inspector was satisfied that the person in charge had failed to notify the Chief Inspector of all notifiable events occurring in the centre.

The inspector on reviewing accident and incident records and the directory of residents noted that:

- notification had been submitted of eight accidents to residents occurring in the centre in the first quarter of 2012. However, the centre's accident and incident records contained records of seven falls sustained by one resident in this period that had not been included in the returns
- the Authority had not been notified of the death and the circumstances of the death of a resident under the age of 70
- the Authority had not been notified of a physical assault on a resident.

There was no evidence to support that there had been any further occurrences in the centre of any unexplained absence of a resident.

19. Regulation 28 Contract for the Provision of Services 28 (1) of the 2009 Regulations/ Standard 7 Contract/Statement of Terms and Conditions

Action required from previous inspection:

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

This action was not met.

A sample of contracts reviewed by the inspector indicated that a contract for the provision of services had not been agreed with each resident within one month of their admission to the designated centre.

Report compiled by:

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

14 June 2012

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
21 September 2010	☐ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Regulatory Monitoring ☐ Announced ☒ Unannounced
2 February 2011	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
24 May 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
22 July 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
7 February 2012 and 8 February 2012	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☒ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre:	Melview House Nursing Home
Centre ID:	0250
Dates of inspection:	29 May 2012 and 30 May 2012; 1 June 2012 and 5 June 2012
Date of response:	7 July 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:

Protective measures identified by the provider in his response to the Action Plan as necessary to protect each resident from all forms of abuse had not been implemented.

Action required:

The provider shall ensure that all reasonable measures are taken to protect each resident from all forms of abuse regardless of the residents' capacity or manifested behaviours.

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

Action required:

Make all necessary arrangements, by training staff *or by other measures*, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Action required:

Review, amend, agree and implement a policy and procedures for the prevention, detection and response to abuse.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 17: Training and Staff Development
Standard 8: Protection
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A new policy will be in place before 1 August 2012. Further training will be provided for staff.	1 August 2012

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

Opportunities for participation in meaningful, purposeful activity and occupation, and the exercise of their religious rights was not fully inclusive of all residents.

Action required:

Each resident, regardless of location, diagnosis and physical and/or cognitive ability, is given opportunities for participation in meaningful and purposeful activity and occupation that suits his/her needs, preferences and capacities, previous routines, social and recreational interests. Staff are encouraged to view activities as an opportunity to enhance physical, cognitive and social wellbeing and an opportunity to interact and engage with residents.

Action required:

Put in place arrangements to facilitate each resident in the exercise of their religious rights.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 10: Residents' Rights, Dignity and Consultation Standard 18: Routines and Expectations Standard 20: Social Contacts	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Meaningful and purposeful activity that suits resident needs will be put in place before 1 September 2012. Each resident is facilitated to exercise their religious rights.	1 September 2012

3. The provider has failed to comply with a regulatory requirement in the following respect: The physical design and layout of the building is not suitable for its stated purpose. It does not meet the residents' individual and collective needs.
Action required: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.
Action required: Provide adequate private and communal accommodation for residents.
Action required: Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.
Action required: Maintain the equipment, including passenger lifts for use by residents or people who work at the designated centre in good working order.
Action required: Ensure that residents have access to a safe, secure outdoor space with seating, accessible to all residents, including residents with mobility impairments and those using wheelchairs. The grounds are kept safe, tidy and attractive.

Action required:

Address the security of the overall campus. There will be a secure perimeter.

Action required:

Provide a suitable private area where residents can meet visitors in private.

Action required:

Provide sluicing facilities, including bedpan washers, that are appropriate to the size of the building and easily accessible from all areas of the building. All replacement sinks are stainless steel.

Action required:

Provide to the Chief Inspector explicit plans with costing to address the limitations of the premises so as to provide premises that are suitable for the purpose of achieving the stated purpose and function of the premises.

Reference:

Health Act, 2007
Regulation 19: Premises
Regulation 31: Risk Management Procedures
Standard 25: Physical Environment
Standard 26: Health and Safety
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All of the above will be completed before 1 September 2012. No new resident admitted and some rooms redesignated for alternative use.	1 September 2012

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

Reviewed risk assessments were not in place or implemented.

Staff had a poor understanding of risk management and the implementation of reasonable measures to prevent accidents.

Action required:

Review the findings of the risk assessments and the controls identified to reduce, control or eliminate the risks to residents, staff and visitors. Identify and implement the remaining controls and review the adequacy of all controls.

The risk assessments are reviewed on an ongoing basis and updated as required.

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. Ensure that all staff adhere to the implementation of the identified controls.

Action required:

Ensure that all staff at all times 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: New falls and adverse incident policy currently being drafted and will be completed before 1 August 2012. Falls management training for all healthcare staff before 1 September 2012. Risk management policy updated to include the identification and assessment of risks and precautions in place to control risks.	1 September 2012

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

The contingency plan and arrangements in place for the loss of power were inadequate.

Action required:

Put in place and implement a comprehensive emergency plan and adequate arrangements that clearly outline for staff the contingencies in place for responding to a loss of power and the actions to be taken while awaiting the restoration of

services so as to protect resident safety, comfort and wellbeing and any prescribed treatments.

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: A drill for power outage will be completed on 9 July 2012 and a comprehensive emergency plan is now in place.	9 July 2012

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

Written confirmation from a competent person that all the requirements of the statutory fire authority had been complied with was not provided to the Chief Inspector.

Action required:

Provide from a competent person by 7 June 2012:

- details outlining the status of the required fire upgrading works identifying start dates and completion dates
- the date by which there is a reasonable expectation that written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with will be available to the Chief Inspector.

Action required:

Provide to the Chief Inspector written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

Reference:

Health Act, 2007
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Actions above have been completed. A letter from the competent person, the fire engineer, has been forwarded to the Authority.	29 June 2012

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

There was no evidence of a robust, effective system for reviewing and thereby continuously improving upon the quality and safety of care and services provided to residents.

Action required:

Establish and maintain an effective system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Action required:

Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

Action required:

Ensure that there is a quality review process in place for monitoring the quality of residents' meals and mealtimes. The process ensures that each resident is provided with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.

Action required:

The provider shall ensure that issues raised individually by residents or by the residents' representative group are acknowledged, responded to and recorded, including the actions taken in response to issues raised. Action taken in response to the issues raised clearly demonstrates change and improvement on all matters significant to and affecting the quality of life of the resident.

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: Resident survey on all aspects of the services will be completed before 20 August 2012. Monthly resident survey on the quality of the food included on agenda of resident forum meeting and any issues raised brought to team meeting and kitchen meeting. Corrective action taken and used as an opportunity for learning. Comprehensive audit schedule to include all areas of service will be put in place before 1 September 2012.	1 September 2012

8. The provider has failed to comply with a regulatory requirement in the following respect:
Complaints were not accurately and adequately recorded, adequately explored and investigated. There was no evidence to support that complainant satisfaction was established or that complaints were welcomed and viewed as a valuable source of reflection, learning and continuous improvement.
Action required: Ensure that there is one clear written policy and procedure in place for staff in relation to the logging of complaints and all staff are familiar with it.
Action required: The person in charge will ensure that all complaints and comments are fully recorded, investigated and explored with staff for feedback and future learning. Measures required for improvement that are in line with best practice and are evidence-based are identified, implemented and evaluated and there is clear evidence of this.
Action required: Ensure the complaints procedure contains an independent appeals process, the operation of which is clearly outlined in the designated centre's policies and procedures.
Action required: Inform complainants promptly of the outcome of their complaints and details of the appeals process. Maintain a record detailing the investigation and outcome of the complaint and whether or not the complainant was satisfied.

Action required: Ensure that the centre provides an environment that is conducive to residents, staff, family members, advocates and visitors being able to raise issues and complaints verbally and in writing in a spirit of openness and partnership and without fear of adverse consequences.
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: Staff are now conversant with their duties in relation to complaints. An audit of complaints will be carried out monthly and discussed at team meetings, corrective action taken if necessary. Any actions recorded in minutes of meetings are then circulated to staff.	Completed

9. The person in charge has failed to comply with a regulatory requirement in the following respect: Care plans had not been updated and did not demonstrate how they ensured that each resident received suitable and sufficient care to maintain their welfare and wellbeing having regard to the residents' dependency and needs.
Action required: The person in charge will ensure that the care plan reflects the assessment findings, the residents' actual needs and sets out in detail the action to be taken by staff for each individual resident, thereby ensuring the provision of suitable and sufficient care.
Action required: The person in charge shall ensure that interventions are specific to each resident and identified by nursing staff as appropriate to each individual resident's assessed needs. Identified interventions are available, implemented and evaluated in relation to their appropriateness and efficacy.
Action required: The care plan is re-evaluated and updated in a timely and safe manner as indicated by the residents' changing needs and significant events. All elements of the care

plan, assessment, and problem identification and communication record demonstrate an integrated, consistent plan of care.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Regulation 6: General Welfare and Protection Regulation 25: Medical Records Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All nursing staff have completed "care planning" training. All nursing staff are aware of their responsibilities in this area, new system of care planning now in place.	Completed

10. The provider has failed to comply with a regulatory requirement in the following respect: Failing to have necessary arrangements and all reasonable measures in place aimed at preventing residents from being harmed or suffering injury or being placed at risk of harm or injury from falls.
Action required: The person in charge will ensure that all staff are familiar with, adhere to and implement the centre-specific, evidence-based falls prevention and management programme.
Action required: Put in place appropriate and effective arrangements for reviewing serious or untoward accidents, incidents or adverse events involving residents including falls. The review identifies patterns and trends, required improvements and informs care and practice to avoid repeat occurrences.
Action required: Put in place appropriate systems/interventions and plans of care aimed at preventing residents being harmed or sustaining injury or being placed at unnecessary risk of accident and injury.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 35: Review of Quality and Safety of Care and Quality of Life Regulation 31: Risk Management Procedures Standard 26: Health and Safety 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: All residents who have been assessed as being in danger of falling have a specific falls care plan which complies with best practice. Falls audited on a monthly basis, discussed at team meetings, corrective action taken if necessary and results circulated to staff to give them opportunities for learning. New falls policy currently being drafted. Completed before 1 September 2012.	Completed New policy in place before 1 September 2012

11. The provider has failed to comply with a regulatory requirement in the following respect: All residents did not have access to equitable, timely and adequate medical review and care to support them to achieve and maintain the best possible health.
Action required: The provider shall ensure that equitable access to timely and appropriate medical care by a medical practitioner is facilitated for each resident.
Action required: The registered provider shall ensure that accurate chronological records are maintained of all medical reviews, referrals and appointments.
Reference: Health Act, 2007 Regulation 9: Health Care Regulation 6: General Welfare and Protection Standard 8: Protection Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Accurate chronological records are now maintained of all medical reviews, referrals and appointments. Each resident will have a review by GP three-monthly or more frequently depending on needs of resident.	Completed and ongoing

12. The person in charge has failed to comply with a regulatory requirement in the following respect:

The governance of the centre was not robust and did not ensure adequate and appropriate supervision of staff, or sufficient monitoring of and accountability for practice and the care and services provided to the residents.

Action required:

The person in charge will ensure that management systems are in place which ensure that all staff are appropriately supervised on a regular basis.

Action required:

The person in charge will ensure that at all times there are formal systems in place to ensure that care is supervised and monitored by a competent registered nurse so that care and services are delivered in accordance with best practice and the needs of the resident as set out in their plan of care.

Action required:

Develop and implement a robust staff appraisal system that is appropriate to the specific needs of the centre and addresses issues raised in care and practice. Each staff member is informed of their progress and has an opportunity to rectify limitations and develop capabilities and strengths.

Reference:

Health Act, 2007
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Standard 23: Staffing Levels and Qualifications
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Two staff nurses are on duty on a 24-hour basis. Each nurse is allocated a group of residents. Nurses will work directly with the health care assistants (HCA) and supervise the care they give. Each HCA will complete a written record of the care they give to the resident which will be countersigned by a nurse. New staff appraisal system will be in place before 1 September 2012.	Completed and ongoing

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

There was evidence of poor recruitment, staff training and development practices:

- the process of induction was inconsistent
- all staff did not have contracts of employment.

Action required:

The person in charge will ensure that all staff receive induction training specific to the needs of the centre, and there is clear evidence of the satisfactory completion of induction.

Action required:

The provider will ensure that each staff member's file shall include and confirm the terms and conditions of their employment including:

- the date on which they commence and shall cease employment
- the position they hold, the work that they perform, the number of hours for which they are employed each week and any other records in relation to their employment.

Reference:

Health Act, 2007
Regulation 18: Recruitment
Standard 22: Recruitment
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Staff files updated to include the actions above. Four staff will be appointed as mentors and will get specific training. New induction format to be introduced.	1 September 2012

14. The provider has failed to comply with a regulatory requirement in the following respect: The approach to policy review and implementation was fragmented and did not achieve the desired outcomes.
Action required: The provider shall ensure that all the written operational policies and procedures of the designated centre are reviewed in line with best practice, regulatory and legislative changes and any recommendation made by the Chief Inspector. Ensure that all policies have a current evidence base, are centre-specific, have a clear implementation date and clearly set out for staff centre-specific roles, responsibilities, procedures and reporting mechanisms.
Action required: The person in charge will ensure that staff are familiar with and implement all policies and procedures in practice to guide and inform a high standard of evidence-based nursing practice. There is clear evidence of this.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 17: Training and Staff Development 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: A review of all policies will be completed before 1 October and training of policy implementation and method of revision will be provided to all staff.	1 October 2012

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

The person in charge had failed to notify the Chief Inspector of all notifiable events occurring in the centre.

Action required:

Provide a written report to the Chief Inspector at the end of each quarter of the occurrence in the designated centre of any accident.

Action required:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any of the events outlined in Article 36(2).

Reference:

Health Act, 2007
Regulation 36: Notification of incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Notifiable incidents as outlined in Article 36 (2) will be reported.	 Ongoing

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

A contract for the provision of services had not been agreed with each resident within one month of their admission to the designated centre.

Action required:

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

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All residents now have a contract.	 Completed

17. The provider has failed to comply with a regulatory requirement in the following respect: Medication management practices were not in line with regulatory and legislative requirements and regulatory body guidelines.
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, transcribing, storing and administration of medicines to residents and ensure that staff are familiar with and implement such policies and procedures.
Action required: The provider shall ensure that an accurate record is maintained in a safe and accessible place, of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Regulation 25: Medical Records Standard 13: Healthcare Standard 14: Medication Management Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Medication policy will be updated in line with ABA guidelines and all regulation and standards as outlined above. Staff will be provided with medication management training. The method of	 1 September 2012

recording administration of medication and the prescription sheet format will be changed; GP will sign all prescription sheets.	

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

Clear policy and procedure was not in place for the admission, care and discharge of all residents to the centre, to ensure that they were admitted and discharged in a planned and safe manner.

Action required:

The person in charge shall ensure that each resident is admitted to the centre following a comprehensive assessment of their holistic needs including a general risk assessment to ensure that the centre has the capacity to provide suitable and sufficient care to the resident in line with their assessed needs and dependency levels.

Action required:

Ensure that there are adequate and appropriate agreed policies, protocols and procedures in place for the admission and discharge of residents to and from the designated centre to ensure appropriate continuity of care and that residents are admitted and discharged in a planned and safe manner.

Action required:

Ensure that there is a written statement of purpose that accurately describes the service that is provided in the centre. Keep the statement of purpose under review and notify the Chief Inspector in writing before changes are made to the statement of purpose which affect the purpose and function of the centre.

Action required:

The provider shall ensure that there are effective management systems in place that support and promote a transparent and inclusive care environment and the delivery of safe quality care and services.

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose
Regulation 29: Temporary Absence and Discharge of Residents
Regulation 31: Risk management Procedures
Regulation 6: General Welfare and Protection
Standard 10: Assessment
Standard 26: Health and Safety
Standard 29: Management systems
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Comprehensive risk assessment now completed on all residents. Statement of purpose currently being updated. New admission and discharge policy currently being compiled. Policies and procedures currently being reviewed and staff will receive training in their implementation. New management structure put in place with clear lines of responsibility.	1 October 2012

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

The centre did not have the appropriate facilities, protocols and practices in place to appropriately support end-of-life care.

Action required:

Put in place written operational policies and protocols for end-of-life care that outline adequate arrangements for the provision of end-of-life care so that it does not unreasonably infringe upon the wishes, rights, privacy and dignity of other residents.

Action required:

The person in charge shall ensure that, where there is no option but to provide end-of-life care in shared accommodation, the physical, emotional and psychological needs of all residents and where appropriate their representatives are respected and adequately responded to.

Reference:

Health Act, 2007
Regulation 14: End of Life Care
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 16: End of Life Care
Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: New end-of-life policy at present being drafted; completed 1 August 2011. Single room will be offered to resident, if available. If single room unavailable the needs of residents and representatives will be adequately responded to. All healthcare workers will receive training in end-of-life care.	1 September 2012

20. The provider has failed to comply with a regulatory requirement in the following respect: All operational policies and procedures and best practice relating to food safety were not in place.	
Action required: Put in place and implement at all times written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.	
Action required: The person in charge shall ensure compliance at all times with relevant food safety legislation and that staff receive training in relation to it.	
Reference: Health Act, 2007 Regulation 30: Health and Safety Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Kitchen renovation completed and all requirements of food legislation are complied with and policies and procedures are in place.	29 June 2012

Any comments the provider may wish to make:

Provider's response:

I would like to thank the inspectors for their frank and fair assessment.

Provider's name: Dermot Dougan

Date: 9 July 2012