Health Information and Quality Authority
Social Services Inspectorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

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

Centre name:	Ballinamore House Nursing Home
Centre ID:	0317
Centre address:	Kiltimagh Co. Mayo
Telephone number:	094 9381919
Email address:	ballinamorehouse@hotmail.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Raicam Holdings Limited
Person authorised to act on behalf of the provider:	Hugh O'Boyle
Person in charge:	Caroline McGing
Date of inspection:	11 and 12 September 2012
Time inspection took place:	**Day 1 Start:** 10:30 hrs **Completion:** 17:45 hrs **Day 2 Start:** 10:30 hrs **Completion:** 18:50 hrs
Lead inspector:	Marie Matthews
Support inspector:	N/A
Purpose of this inspection visit:	☐ to inform a registration/renewal decision ☒ to monitor ongoing regulatory compliance ☐ following an application to vary conditions ☐ following a notification ☒ following information received
Type of inspection	☐ **announced** ☒ **unannounced**

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, in which 14 of the 18 outcomes were inspected against. The purpose of the inspection was:

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

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

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

This monitoring inspection was unannounced and took place over two days. It was the fifth inspection by the authority. As part of the monitoring inspection the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. The inspector met with the person in charge and the provider Huge O Boyle and his wife Sharon.

The inspector also followed up on the action plan from the previous inspection by the Authority in October 2011. In general a positive attitude to compliance was demonstrated and most of the actions from the previous inspection had been

adequately addressed. A number were partially addressed and work was underway to address these.

The inspector found that residents were comfortable, felt safe and had a good quality of life. Systems were in place to protect residents from suffering harm or abuse. Staff were trained in adult protection and those interviewed were knowledgeable of the procedures to follow in the case of suspected elder abuse.

The person in charge displayed a good knowledge of her responsibilities in accordance with relevant legislation. Operational policies were in place to guide staff however, some of these required revision to reflect evidence-based practice for example, risk management and restraint policies.

The inspector found that the quality of care provided to residents was in the main good and residents' were seen regularly by a GP (general practitioner). There was good input from mental health services and a physiotherapist visited the centre weekly. Access to some support services required improvement for residents unable to leave the centre.

There were systems in place to manage risk and a risk register was kept up to date however, the inspector identified areas for improvement in the centre's policy. Adequate precautions were in place to prevent fire and staff had received up to date training and were suitably knowledgeable of procedures to follow in the event of fire.

The provision of meaningful activity for all residents was an area identified for improvement in the action plan following the previous inspection. The inspector found that although some activity was arranged it was limited. There was a lack of opportunities for residents with cognitive impairment to engage in meaningful activity

Although the age and layout of the building presented significant challenges, the centre provided a warm comfortable environment for residents. There were still aspects of the physical environment which did not meet the Authority's standards. Five bedrooms are in multiple-occupancy. There are a number of stairs provided with chair lifts however there is no passengers lift available. The Authority awaits the provider's plan to address these issues. There was a need for an ongoing programme of maintenance to ensure the premises and furnishings were well maintained. A number of issues were identified in this area which requires action including re-plastering walls where dampness was evident, replacing uneven flooring and ensuring safe surfaces were provided both externally and internally.

The Action Plan at the end of this report identifies actions that are mandatory to meet 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*.

Section 41(1)(c) of the Health Act 2007

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

Theme: Governance, Leadership and Management

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

Outcome 1

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector reviewed the centres statement of purpose which described the required matters outlined in Schedule 1 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

The profile of the residents reflected the information outlined in the statement of purpose. Primarily long-term care is provided to older people who have physical care needs, dementia and mental health problems. A small number of residents have complex conditions related to degenerative neurological disorders and acquired brain injury. Five of the residents are under 65.

Outcome 2

Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:

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

Outstanding action required from previous inspection:

Ensure that each resident's contract details the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

The inspector reviewed a random sample of residents' contracts of care which were signed by the resident or their next of kin. The contracts clearly set out the fees payable and listed the services included in the fee which included laundry services.

Outcome 3
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

No actions were required from the previous inspection.

Inspection findings

The person in charge is a registered general nurse who works full-time at the centre. She had knowledge of each resident and their specific care needs. Throughout the inspection process the person in charge demonstrated competence and a commitment to delivering good care to residents.

The person in charge advised the inspector that she would be going on planned leave of absence in January 2013. She was aware of the requirement to notify the Authority of her absence and advised that she would do this prior to her departure. She had commenced the process of training the key senior manager, Sharon O'Boyle to act in her absence.

Theme: Safe care and support
Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.
In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.
To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Outstanding action required from previous inspection:

Ensure that all staff members participate in training or any other form of learning regarding preventing residents from being harmed or suffering abuse or being placed at risk of harm or abuse.

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

All staff had received training on identifying and responding to elder abuse and staff spoken with were knowledgeable of the different forms of abuse and were clear on their responsibility to report any suspicion of abuse. A policy on the prevention, detection and investigation of alleged abuse was available and was reviewed by the inspector. The policy contained appropriate contact details for the HSE Adult protection Officer and for the local Garda; however, it required further revision to identify the appropriate members of the management team within the centre to whom staff should first report a suspicion of abuse.

Guidance to staff as to the action to take in the event of an allegation of abuse involving either the owners or person in charge was also omitted from the policy.

Residents told the inspector that they felt safe and many said this was due to the staff presence at all times.

The provider stated that he does not manage the finances of any of the residents in the centre and that no monies are kept on residents' behalf.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Outstanding action(s) required from previous inspection:

1. In the absence of a passenger lift (which is a requirement of the legislation as residents are maintained on two floors) have in place a policy and procedure which references when residents' mobility is compromised that a risk assessment will be carried out.
2. Make sure that the lighting is working in signage relating to fire safety for example

the running man sign located on the second floor (top of house).
3. Erect a handrail on the opposite side of the stair banister leading from fire exit door numbered 3
4. Make sure that evacuation maps and signage on display provide accurate information. For example, a map at location 5 provided in accurate information in relation to evacuating the building.
5. Provide an up to date certificate carried out by a competent person confirming following inspection that the centre is compliant or otherwise with all fire safety regulations and Standards.
6. Make sure that all the fire doors are a good fit for example in the corridors on the ground and first floor, at the top of the ramped area, double doors at main stairway and smoking room.

All actions on risk from the previous inspection were satisfactorily implemented.

1. A new policy on residents' mobility was available which referenced the mobility assessments carried out for each resident. Residents were placed in the centre according to their mobility assessment.
2. Lighting in all fire signage was in working order.
3. A handrail had been provided on the opposite side of the stair banister leading from fire exit door numbered 3.
4. Evacuation maps and signage on display had been transferred into frames and now provided accurate information to escape routes.
5. An up to date certificate by a competent person confirming that the centre is compliant or otherwise with all fire safety regulations and Standards was submitted to the authority following the last inspection.
6. All fire doors were noted to be of good fit including those in the corridors on the ground and first floor, at the top of the ramped area, double doors at main stairway and smoking room.

Inspection findings

The inspector found that the health and safety of residents, visitors and staff was generally promoted and protected. The Authority received notification in July of a resident who absconded and died. The provider was requested to submit documentation in relation to this incident. This was reviewed by the Authority prior to the inspection and found to be satisfactory. The inspector reviewed practice in relation to the safeguarding of residents during the inspection.

A biometric fingerprint door entry system is in use throughout the building and a visitors' log was in use to monitor the movement of persons in and out of the building. The centre is located within a 6 acre site and CCTV cameras are provided extensively around the perimeter of the centre and in corridors and communal areas of the building. These are linked to monitors positioned near the nurses' station which was staffed at all times during the inspection. The provider had installed new gates at the rear of the centre to secure this area and advised the inspector that gates have been ordered for the front entrance. The policy on missing persons had

been updated and a missing person folder was available which the inspector observed contained recent photographs of all residents. Residents are accounted for by staff at the beginning of each shift. Two hourly checks are carried out on those residents who have been assessed as 'at risk of absconding' and these checks are recorded. Missing person drills were carried out regularly. The most recent drill took place on 5th September 2012. Residents interviewed told the inspector that they felt safe in the centre.

There was a system in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. The inspector reviewed the incident and accident log which was audited by the person in charge monthly. Accident forms were completed for each incident that occurred and serious accidents had been appropriately notified to the Authority. There was evidence of residents being monitored closely following any accidents.

A comprehensive emergency policy was available which included arrangements to evacuate residents to a nearby hotel in the event of an emergency. The inspector saw that it included specific arrangements for the evacuation of each resident and included their mobility status and the nearest evacuation door to their room.

The centre was noted to be generally clean on the inspection days and there were measures in place to control and prevent infection. Staff had training in infection control and a colour coded cleaning system was in use to prevent cross contamination. Only one wash-hand basin was provided in one four bedded room for use by residents and staff attending to residents person care. Each resident sharing this room had an individual towel provided. However, there was no disposable hand towels provided for care staff to use before attending to a residents personal care which posed an infection control risk. Alcohol rub was not observed in this area.

A policy on infection control was available, however, it did not detail the arrangements in the event of an outbreak of influenza or guide staff to inform the Health Service Executive Health (HSE) surveillance unit or include any contact numbers in the event of a suspected outbreak of an infectious disease. The policy also required further revision to reflect best practice and national policy on infection control.

The inspector reviewed the centre's risk management policy. The policy did not specifically reference all the particular risks associated with this centre. For example, the centre is located on a large site and there is extensive closed circuit television cameras monitoring the site but the policy does not reference this information. There were separate policies on challenging behaviour and on accidental injury to residents but these were not cross referenced from the risk management policy. Staff described clearly to the inspector how they avoid certain known triggers when dealing with residents who have challenging behaviour to avoid an escalation of the behaviour, however, the policy did not reflect the practice observed. The Risk Management policy also omitted reference to the risk of assault or of self harm as prescribed in the regulations. The centre had a health and safety policy however this was not reviewed by the inspector.

Procedures for fire detection and prevention were in place. Smoke detectors were located throughout the centre. Service records showed that the fire alarm system was serviced on a quarterly basis and the emergency lighting and fire equipment on a yearly basis. Training records reviewed confirmed that all staff attended training on 'fire prevention and response and evacuation'. Fire training was scheduled for three different dates during the year to ensure all staff attended. Fire drills were also carried out three times during the year and records verified that all staff had attended both fire training and an evacuation drill. Detailed evacuation plans were available in the event of an evacuation which included the location, mobility and nearest fire exit for each resident.

Records were available to verify that most staff were trained in the safe moving and handling of residents. The inspector observed that two staff who were absent on training dates were scheduled to attend training convened for a later date. Assistive equipment was regularly serviced and a member of staff was employed to ensure that all maintenance work was carried out in a timely manner.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

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

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection

Inspection findings

There was a medication management policy in place which provided guidance to staff. Medication trolleys were appropriately stored in the treatment room which is locked when not in use. The inspector accompanied a nurse during the medication round and observed practice in administration. Prescription and administration sheets were reviewed and they accurately outlined the residents' details and their prescribed medication. Each medication prescribed was individually signed by the GP. The administration sheets reflected the information on the prescription sheet such as type of medication, the dose and the time of administration. A photograph of each resident was provided on their respective medication administration record.

Medication was supplied to the centre in individualised blister packs by a pharmacy company who had provided training to staff on the system. All medication was clearly identified and a picture of each medication was included with the description on the back of each blister pack. The staff described the system positively and said it was easy to use. However, during the evening medication round the inspector observed one residents' blister pot containing her evening medication had become dislodged from the blister pack and was found by the inspector at the side of the medication trolley. The inspector reviewed this resident's medication administration

chart for the previous evening and saw that the nurse had ensured that this resident got her correct medication by administering medication from the following evening's blister pack. This near miss had not been recorded appropriately or the suppliers contacted at the time. When alerted to the near miss it was appropriately reported and documented by the person in charge. The inspector noted that audits of medication management including drug errors or near misses were not routinely carried out. The person in charge advised that further involvement, training and audit from the pharmacist is scheduled and she agreed to advise the Authority when this date is scheduled.

At the time of inspection two residents were on prescribed medications that required strict control measures (MDAs) in accordance with the Misuse of Drugs (Safe Custody) Regulations, 1984. These were safely stored in a double locked cabinet in the treatment room. An MDA register was maintained and the inspector confirmed that the medication stored matched that documented in the register. These medications were not counted by two nurses and recorded on each change of each shift as is required under the Misuse of Drugs (Safe Custody) Regulations, 1984.

Outcome 11

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:

Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Outstanding action(s) required from previous inspection:

1. Develop residents' care plans with residents to include the assessed needs, care interventions introduced by staff to bring about improvements in the residents' condition/circumstances.

2. Keep residents' care plans under formal review by documenting the information in respect of residents' individual assessed needs and changing circumstances.

3. Implement a comprehensive policy/procedure detailing all aspects of restraint management to include:
    - an assessment and documentation of each resident's needs in respect of any restraint measures
    - identify in the assessment any risk factors, consideration of alternative methods, date of commencement, type of the restraint, duration and frequency of use, periods of non-use of the measure, review and termination and written confirmation that any restraint measure used has been discussed and /or agreed with the resident and/or that a consensus including discussion with significant professionals including the general practitioner (GP) has taken place.

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

Actions 1 and 2 were addressed. See commentary below. Actions 3 and 4 were not adequately addressed and are discussed in more detail below.

Inspection findings

The resident profile was made up of a wide range of residents with complex care needs. Thirteen residents had a diagnosis of mental health problems, eleven residents had a diagnosis of dementia and the remaining residents had complex problems related to acquired brain injury, strokes and degenerative neurological disorders. The inspector saw that mental health services provided regular follow up assessment and monitoring of residents with a monthly visit from the community psychiatric nurse which was documented in residents' care plans. A visit from this team was scheduled to take place on the day of inspection but was postponed due to illness.

The age profile of residents included seven residents under 65 years and 26 over 65 years of age. A key worker system was in place with nurses taking responsibility for a number of residents. Key workers interviewed residents and (for those with cognitive impairment / dementia) their family members to obtain their life histories and assess their social needs. These were generally well described in the care plans reviewed.

The person in charge described good access to general practitioner (GP) services and stated that two local GP's attended the centre on a weekly basis and more often if required. There was documentary evidence in medical files to support this.
The inspector saw that residents' weights, blood pressure, temperature and respirations were monitored and recorded monthly.

Each resident's ability to carry out daily activities was assessed on admission to the centre using recognised assessment tools and these assessments informed staff of residents care needs. Where risks were identified, care plans were in place to inform the care to be provided. The inspector reviewed a sample of three care plans and aspects of others and found that in general they contained person-centred

information about residents and the care they were to receive. There was evidence that assessments and care plans were reviewed on a three monthly basis and more frequently where necessary. Although one resident interviewed told the inspector she was consulted and fully involved in her care plan, consultation with residents was not always clearly documented in the care plans reviewed.

Daily notes were recorded twice a day for each resident, however, the inspector observed that these were sometimes less person-centred, did not always relate to the specific problems identified in the care plan and did not give a clear picture of the care delivered over a 24 hour period.

The inspector was told by residents that the provider or his wife who works at the centre as a key senior manager, took them to any outpatient appointments they needed to attend. A physiotherapist is contracted privately and visited the centre weekly. The notes of her consultations were available and were kept in the treatment room. A chiropodist attended the centre on a fortnightly basis.

The person in charge advised that speech and language therapy is provided by the HSE on a referral basis however, there were no arrangements in place for residents who were unable to leave the centre to avail of these services. In one care plan reviewed a resident was identified as having difficulty swallowing however, there was no evidence that he was appropriately referred to a speech and language therapist. Similarly the inspector observed that while some residents had been assessed by an occupational therapist, these assessments had taken place in hospital prior to admission to the centre. The inspector was told that there were no arrangements in place to have residents unable to leave the centre assessed by an occupational therapist.

The inspector was advised that thirteen residents were subject to some form of restraint measure. Most of these were bedrails. Risk assessments were in place for the sample of restraints in use which were reviewed by the inspector. The inspector saw that restraint release charts were maintained for each restraint measure in place and there was evidence that the use of restraint was regularly reviewed. While some residents used restraints as ‘enablers’, there was no clear indication from the documentation what these restraints were enabling. One resident was in a specialised reclining chair which had not been appropriately assessed as a form of restraint and used a lap belt to ensure his safety. The person in charge said that this seat was purchased to encourage the resident to rest comfortably during the day. She also advised that alternative less restricting options had been considered prior to choosing this option however, this was not documented in the residents’ care plan. There was also no evidence of the involvement of either the general practitioner or of an occupational therapist in the choice of seating provided or to agree to the use of these particular restraint measures.

The inspector was informed that the person in charge had attended training on the HSE national policy on restraint however, this training had not yet been cascaded on to all staff and the centre’s policy on the use of restraint had not been reviewed to reflect national policy.

As stated in outcome 7, there were a number of residents who presented behaviour that challenged. All care staff were trained in dealing with challenging behaviour and four staff were registered psychiatric nurses. A policy on behaviours that challenge was in place in the centre however, the policy was not comprehensive and did not reference some of the techniques observed by the inspector which were used by staff to help prevent potential trigger situations from escalating.

Specialist pressure relieving equipment was in use for residents identified as at being risk of developing pressure ulcers. The person in charge advised that none of the residents had any pressure sores or wounds on the day of inspection.

The provider was required in the action plan from the previous inspection to provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities. This action was not adequately addressed. A programme of activities was in place for two hours on three days a week only. On the first day of the inspection some residents were engaged in an exercise based activity and there was music organised on the second day. The post of activities coordinator was advertised and the person in charge described difficulties she was encountering in appointing someone suitable to this post. In the absence of an activities co-ordinator this role was been delivered by two care attendants. Some residents who were mobile and independent told the inspector that they had plenty to occupy their time and described how they enjoyed going for daily walks in the grounds and visiting relatives in the community. However the inspector still found that there was a lack of opportunities for residents with cognitive impairment to engage in meaningful activity.

Outcome 12

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:

Regulation 19: Premises
Standard 25: Physical Environment

Outstanding action(s) required from previous inspection:

1. Replace the missing wall tile(s) in toilet facility on the first floor (top main house).

2. Provide appropriate ventilation in a storeroom on the ground floor (basement) containing products and in the new sluice and cleaners' rooms.

3. Provide lighting following refurbishment work in sluice and cleaners' room

4. Take action to address the outstanding work relating to the external aspects of the premises making the ground level around the manhole cover (in close proximity to the church) which is raised, repairing potholes and uneven surfaces on the driveway to the centre and re-plastering the external wall is where the plaster is crumbling (close proximity to the church).

5. Ensure that the bedpan washer in the sluice room is fully operational.

6. Decorate the designated visitors' room and install a residents' alarm call system in the room.

7. Replace windowpanes throughout the centre which are cracked for example panes of glass in bedroom number 3.

8. Repair areas of dampness throughout the centre for example an area of dampness in the toilet opposite the staff changing room on the ground floor.

9. Replace the floor covering in a bathroom and designated smoking room where it is damaged. Replace worn curtains and curtain linings.

10. Replace shelving where the chipboard is exposed for example in some toilets.

11. Replace worn curtains and curtain linings.

Actions 1, 2, 3, 5, 7 and 9 from the previous inspection were satisfactorily addressed. Action 6 was partially addressed. Actions 4. 8, 9 and 11 were not adequately addressed or were addressed and have reoccurred and are discussed further below.

Inspection findings

This outcome was not fully reviewed. However, actions from the previous inspection were reviewed. The provider had made progress on most of the actions from the previous inspection. Although the age and layout of the building presented significant challenges, it generally provided a warm comfortable environment for residents. New wall and floor surfaces had been provided in the assisted toilet on the first floor of the main house, ventilation had been provided in the store room of the basement, the cleaner's room and in the sluice room. The bed pan washer had been commissioned in the newly located sluice room and lighting provided as required in the action plan. The broken window panes in room 3 had been replaced and the visitors' room had been redecorated. The alarm call bell for this room had been purchased but was not yet installed and the floor in this room and in the designated smoking room had not yet been replaced. The provider said that he was waiting on a contractor who had commenced this work to return to finish this work.

A number of bedrooms were in multiple occupancy. Furniture in these rooms was minimal and bed clothing worn which detracted from their appearance. Few residents in these rooms had any family photographs displayed and there was little by way of personal effects by their beds or space to personalise their accommodation. Curtains for ensuring privacy in multiple occupancy bedrooms were observed to be old stained and ill-fitting.

Residents are maintained on more than one floor and although chair lifts are provided on stairs, there is no passenger lift. Currently only residents who are mobile

are accommodated on the first floor. The provider has informed the Authority that he plans to address this through the provision of an extension to the building however, plans for this development have not yet been submitted to the Authority.

The provider had repaired some areas of dampness. However, the inspector observed that several new areas of dampness were evident and it was clear that an ongoing maintenance programme is necessary to keep on top of this work.

The ground surface to the front of the centre has been levelled and a patio area is located here for residents use however, this area is not enclosed and can also be used by visitors for car parking and so can only be used by residents under supervision. The ground surface to the side of the centre has pot holes and is uneven and unsafe for residents to walk .Additionally the exterior wall of the exterior has not yet been re-plastered.

The following additional environmental risks were observed by the inspector during the inspection:

- the newly installed stairs banister has not yet been painted
- there is a lack of ventilation evident by the build up of condensation on the window and flaking paint on the walls of the blue staircase lobby
- some skirting boards are badly chipped and damaged and need to be replaced
- the electro-magnetic receiver on one of the fire doors on the lower ground floor was defective
- the walls in the back sitting room are damaged and flaking paint was evident
- the floor of the communal lobby area is uneven and is a potential tripping hazard for residents
- some radiators are showing signs of rust damage and need to be repainted
- the surface of the shelf used to serve food from the kitchenette area located off the dining room is chipboard is in poor repair and should be replaced with an appropriate surface which can be easily and effectively cleaned.

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

Outcome 13
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

No actions were required from the previous inspection.

Inspection findings

The person in charge said there were no complaints received during the last year and so there was no complaints log maintained. It was not possible therefore for the inspector to determine if complaints were appropriately responded to in a timely manner or if residents were satisfied with the outcome of the investigation. Those residents interviewed told the inspector that they had no complaints to make and that they were satisfied that any minor issues which occurred were promptly responded to by the staff or the person in charge.

The inspector reviewed the centre's complaints policy which was prominently displayed and found that it required modification to comply with the requirements of the legislation. There was no clear independent appeal arrangements detailed in the policy and the procedure included in the policy incorrectly directed residents to the HSE. The person in charge gave the inspector the name of an independent advocate who attends the centre however; this person's name was not displayed anywhere in the centre or included in the policy.

Outcome 14
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

This outcome was not fully reviewed during this inspection. However, when reviewing heath care the inspector reviewed the care plan of one resident who was receiving palliative care. The person in charge described good links with palliative care services who attended the centre to provide support and advice as required. This resident did not have any family. No end of life wishes were documented in his care plan. The person in charge gave a commitment to collect this information and document this and all residents' end of life wishes appropriately.

Outcome 15
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

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

Outstanding action(s) required from previous inspection:

There were no actions were required from the previous inspection.

Inspection findings

The inspector was satisfied that residents received a balanced nutritious and varied diet. Two separate meal sittings took place, one in the centre's main dining room and one in the rear sitting room accessed by a ramp from the main dining room. Residents who required assistance were accommodated in this room. The inspector observed tea and dinner and observed that dining was a pleasant social occasion. Meals were generally well presented and there was good choice of food offered to residents. Fresh fruit was offered to residents every morning with breakfast along with a choice of cereals. Homemade bread, scones and soup were made daily by the chef which several residents commented favourably on to the inspector. Residents spoken with said they could have their breakfast in their room or in the dining room at a time to suit them. The inspector saw that some residents on pureed diets were not served their meals in individual portions and their meals were mixed together affording them less choice.

Water dispensers were provided throughout the centre. Residents were observed being offered hot drinks and snacks throughout the day.

Residents' weights were being monitored on a monthly basis. Those assessed as at risk of malnutrition were prescribed food supplements by the GP. Staff spoken with were knowledgeable about individual resident's specialised needs such as a pureed or minced diets and individual dietary restrictions. However, there was no ongoing input from a dietician to the centre or specialist advice for residents with special dietary requirements. The inspector was advised following the inspection that a dietician has been sourced privately and a visit is scheduled for the 26 September 2012.

Outcome 16

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

References:

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

Outstanding action(s) required from previous inspection:

1. Ensure that the privacy curtains closes fully around each residents' bed.

2. Make sure that all locks are operational in toilet /bathroom/shower facilities for example the door of the toilet room located on the second floor (top of the house) (right side).

Part one of this action was not adequately addressed. Part two was fully addressed. This is discussed in the commentary below.

Inspection findings

This outcome was partially reviewed in order to review the providers' progress against the action plan. As discussed in outcome 12, the privacy curtains to in one of the multiple occupancy rooms in the upstairs of the main building did not extend fully around the resident's bed thus impacting on this resident's privacy. The person in charge advised that these had been washed and the wrong curtain replaced. This problem had also occurred at the last inspection so it was unclear to the inspector if it had been adequately addressed and had reoccurred or if the curtains had shrunk due to washing and were no longer fit for purpose.

The inspector also observed that instructions to staff describing the type of incontinence pad worn by each resident and other notices about residents personal care were publicly displayed in the communal assisted bathrooms and over residents beds, for example, instructions on residents oral hygiene notices were seen above the bed of a resident sharing a multiple occupancy bedroom which also impacted negatively on residents privacy. The person in charge agreed that these notices would be immediately removed to ensure residents' privacy. The inspector observed that staff were respectful to residents and knocked on doors before entering. Locks were fitted to all toilet and bathroom doors.

A visitors' room was available to residents which had been refurbished since the last inspection and residents said that their relatives were always made welcome when they visited. The provider commented that this room was rarely used by visitors who generally visited relatives in one of the sitting rooms. There were no restrictions on visiting times but relatives were asked to respect residents' privacy during meal times. The inspector observed that many of the residents did not have a chair provided in their bedrooms to allow them to sit by their bedside or for visitors who chose to visit them in their bedrooms.

Telephones at the centre had mobile handsets which allowed residents to make calls in private. Televisions were provided in the main sitting rooms used by residents but few residents had televisions provided in their bedrooms.

Outcome 17
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

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

Outstanding action(s) required from previous inspection:

Provide suitable and appropriate bedroom furniture particularly wardrobes, chest of drawers and lockable facilities for residents. Ensure that all freestanding wardrobes are safe for residents' use.

This action required from the previous inspection was not satisfactorily addressed and is discussed in the commentary below.

Inspection findings

The inspector spoke with residents who said they were happy with the arrangements for laundering their clothing. The inspector visited the laundry areas and reviewed the systems in place to ensure that residents' property was appropriately cared for. There was a system in place to label residents clothes to prevent them from going missing.

The laundry has been divided into distinct areas. All soiled clothing is laundered in a newly provided laundry area with industrial sized machines. A separate area is provided for folding and ironing clean clothes. This system ensured good infection control arrangements. however, the new laundry provided required resurfacing of the floor and walls to enable them to be easily and effectively cleaned.

The inspector visited a small number of residents' bedrooms and found that not all had adequate or sufficient wardrobe space provided to accommodate residents' personal belongings. In one of the multiple occupancy bedrooms, for example, the inspector observed that furniture was generally scantly provided and two of the residents shared a wardrobe which did not have any dividers to separate clothing. The inspector also saw that another resident in a single room did not have sufficient space to store all her clothing.

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

Outcome 18

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

References:

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

Outstanding action required from previous inspection:

Ensure that sufficient staff members are on duty to supervise residents particularly in the back sitting room during the morning and early afternoon.

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

There was an action in relation to staffing levels in the action plan for the previous inspection. On this inspection the inspector found that supervision in the sitting room accessed via the ramp had improved and this area was supervised at all times however, the inspector still had some concerns regarding staffing levels as the post of activities coordinator was still vacant and health care staff were been deployed to deliver a programme of activities for residents (This is discussed under outcome 11). The person in charge described difficulties she was encountering recruiting someone suitable for this the role.

The inspector reviewed rosters for the previous month and the month ahead. In addition to the person in charge there was normally one nurse and three care assistants on duty during the day to care for 33 residents. This reduced to one nurse and two care staff at night. The rota confirmed that these staffing levels were maintained at weekends.

The centre is not compactly arranged and residents are accommodated over different floors. The person in charge told the inspector that she is continuously assessing staffing levels according to the dependency level of the residents and confirmed that she has the autonomy to increase staffing levels as required. She also said that the provider and his wife live nearby and are available in the event of an unexpected problem. Residents told the inspector that staff were always on hand to assist them and those staff interviewed by the inspector confirmed that they had sufficient time to attend to residents care needs.

Most residents were observed to use the sitting room on the ground floor close to the nurses' station during the inspection which the inspector observed was supervised at all times. Another sitting room is located behind the nurses' station and the inspector observed a small number of residents in this area were also supervised.

The provider showed the inspector a training matrix he used to ensure staff had attended all mandatory training. Other courses staff had attended included infection control, food hygiene, challenging behaviour and training on the centres emergency plan. The inspector observed that the matrix only indicated if the staff member had attended training and did not included the date of training which would have been more beneficial to the provider to ensure updates were planned to comply with legislative requirements. Certificates confirming attendance at training were kept on staff member's individual staff files.

A recruitment policy was available to guide the recruitment process. The person in charge told the inspector she was in the process of recruiting new care staff and these positions together with an activity coordinator had been recently advertised. Three staff files belonging to different staff grades were reviewed by the inspector. Garda clearance was available and staff files were well organised and contained all the information identified in Schedule 2 of the regulations. The inspector saw that Garda vetting applications had been applied for new staff recruited.

The person in charge maintained a record of An Bord Altranais professional identification numbers (PIN's) for all registered nurses. This was reviewed by the inspector and seen to be up to date.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Marie Matthews

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

18 September 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre Name:	Ballinamore House Nursing Home
Centre ID:	0317
Date of inspection:	10 and 11 September 2012
Date of response:	15 October 2012

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

Outcome 4*: Operating *Policies and Procedures

The provider has failed to comply with a regulatory requirement in the following respect: A number of policies for example the policies on restraint, infection control and challenging behaviour were not in line with current evidence-based practice.
Action required: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All current policies and procedures will be reviewed and updated as necessary in particular the infection control policy in relation to an outbreak of influenza, challenging behaviour and restraint.	19 November 2012

Outcome 6: Safeguarding and safety

The provider is failing to comply with a regulatory requirement in the following respect: The procedure on Elder Abuse required revision to adequately guide staff as to the appropriate member of the management team to contact in the event of an allegation of abuse and the procedure to follow if the allegation involves either the owners or person in charge.
Action required: Put in place all reasonable measures to protect each resident from all forms of abuse.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The elder abuse policy will be amended to identify the process to undertake if the allegation involves the owners or the person in charge.	22 October 2012

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: The Risk Management policy required review to comply with the requirements of the regulations. It did not specifically reference all the particular risks associated with this centre and omitted reference to the risk of assault or of self harm as prescribed in the regulations.

Action required:

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Action required:

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

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: Within the nursing home there is and has been from previous inspections a risk management policy which covers absence of a resident, assault, aggression and violence and self- harm. The missing persons policy and procedure has recently been updated (a copy of which was sent to the Authority). As stated in Outcome four, a review of all policy within the centre will be completed and a policy relating to accidental injury to resident or staff will be devised. However, as reflected in the inspectors report, there is already in place a system of identification, recording, investigation and learning from incidents and the inspector reviewed the incident and accident log which is audited monthly. The risk management policy will be updated to reference the cctv monitoring and fingerprint access systems.	19 November 2012 31 October 2012

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

There is no passenger lift provided to safely transport residents between existing floors.

The floor of the communal lobby area is uneven and is a potential tripping hazard for residents

Action required:

Provide a lift where residents are maintained on two, or more, floors.

Action required:

Ensure safe floor covering is provided.

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: There are four chairlifts located in the centre and as per our registration conditions residents with reduced mobility are not located on the upper floor. We have made provision for a lift in our plans for an extension. Proposed dates are commence in mid 2013 and completed by mid 2014. The existing timber floor in this area will be removed and new floor covering will be installed. I have examined this area again the timber laminated floor is worn and faded in certain areas and requires replacing. However the boards are not uneven or raised and are not a trip hazard. I have contacted the flooring company who installed the original floor and it will be the end of November before they can remove this floor and install a new one.	Attended to in maintenance schedule from October 2012 to March 2013 Will be completed by the last week of November 2012 or the 1 week of December 2012

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

Only one wash-hand basin was available in multiple occupancy bedrooms for use by four residents and staff and there was no disposable hand towels provided for care staff to use before attending to a residents personal care which posed an infection control risk.

Action required:

In relation to infection control, 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: In relation to infection control, all reasonable measures are taken to prevent cross contamination there are infection control policies within the centre, there is hand gels available throughout the centre and outside multiple occupancy bedrooms. There are also gloves and aprons readily available. There are paper towels available in all bathroom areas and clinical room. There is a ready supply of hand towels which can be used by staff and new ones got from the laundry when required. If a resident is been seen by the general practitioner or other members of the multidisciplinary team they are seen in the clinical room where there is a hand wash basin and hand towels available. Dispensers for paper hand towels and soap dispensers will be installed in multiple occupancy bedrooms. The order for the supply and installation of these units was placed on the 01 November 2012 with a hygiene company.	30 November 2012 Will be completed by 19 November 2012

Outcome 8: Medication management

The Provider and person in charge is failing to comply with a regulatory requirement in the following respect: MDA medications were not counted by two nurses and recorded on each change of each shift as is required under the Misuse of Drugs (Safe Custody) Regulations, 1984.
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.
Action required: The Person in Charge shall ensure that staff are familiar with such policies and procedures.
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of

Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The centre has current and up-to-date policies in relation to ordering, prescribing, storing and administration of medicines to residents. In relation to MDA drugs, as you have highlighted in your report at the time of inspection we had two residents on once weekly transdermal patches. No other controlled drugs were in use. Two registered nurses check and administer these patches on the day they are due and both sign in the controlled drug record book. Since your visit we have commenced a daily checking log for MDA drugs which is checked by two nurses on a daily basis. All nurses are aware of the medication management policies and have signed to state that they have read and understood such policies. While this was done on the introduction of the medication management I have instructed all staff to familiarise themselves with the policies again. Any new nurses will be directed to this policy during their induction to the nursing home.	Log commenced on 12 September 2012 25 October 2012

Theme: Effective care and support

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect: Consultation with residents was not always clearly documented in the care plans reviewed. There was variable linkage between the care plan and the care reported on in the daily notes
Action required: Revise each resident's care plan, after consultation with him/her.
Action required: Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances and no less frequent than at 3-monthly intervals

Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All residents' care plans are formally reviewed at three monthly intervals and some more frequently depending if their needs change. As explained to the inspector during her visit we are currently trailing a different approach to our care plans documentation and evaluation and attempting to incorporate the care plans in the daily evaluations. The process we have been using will be looked at and a decision will be made upon feedback from the nursing team. Where possible residents care plans are discussed with our residents but we endeavour to improve on this.	09 November 2012

The person in charge is failing to comply with a regulatory requirement in the following respect: There was no arrangements in place for residents unable to leave the centre to be assessed by an occupational therapists , Speech and language therapist or a dietician	
Action required: Facilitate each resident's access to physiotherapy, chiropody, occupational therapy, or any other services as required by each resident.	
Reference: Health Act, 2007 Regulation 9: Health Care Standard 13: Healthcare Standard 15: Medication Monitoring and Review Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: As the inspector has highlighted in her report a physiotherapist is contracted privately and visits every week, all residents have access to her. The inspector was informed that an occupational therapist is also contracted privately and she had recently assessed a lady for a new chair. Another resident who required specialised seating was assessed by a HSE occupational therapist who visited her and completed her assessment within the nursing home. Another gentleman's needs had changed and at the time of the inspection had not been referred to the occupational therapist. This gentleman has now been assessed and equipment purchased to meet his requirements, this was relayed to the inspector via telephone on the 04 October 2012. Dietician services are provided by a private company and residents have been seen by a dietician. If the GP wishes to refer one of his residents for an outpatient review, (or they have a follow up appointment post hospital admission), once they receive an appointment the resident is either taken by a family member, the service provider or any resident with limited or restricted mobility are transported to their appointments using suitable mobility transport accompanied by a member of staff. A privately contracted chiropodist also attends the nursing home and provides chiropody care to all residents.	This service is already in place

The provider is failing to comply with a regulatory requirement in the following respect: Care practice in relation to restraint was not evidence-based. For example. Risk assessments did not provide a consensus judgement that the intervention was in the best interests of the resident, was the least restrictive solution and was being put in place as previous less restrictive interventions had failed in all care plans reviewed.
Action required: Provide a high standard of evidence-based nursing practice in relation to restraint.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The HSE guidelines on restraint is been disseminated to all staff within the nursing home.	03 December2012

Outcome 12: Safe and suitable premises

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

The physical environment did not comply with the Authority's Standards.

Areas of dampness were evident throughout the centre.

There is a lack of ventilation evident by the build up of condensation on the window and flaking paint on the walls of the blue staircase lobby.

The newly installed stairs banister has not yet been painted.

Some skirting boards are badly chipped and damaged and need to be replaced.

The electro-magnetic receiver on one of the fire doors on the lower ground floor was defective.

The walls in the back sitting room are damaged and flaking paint was evident.

Some radiators are showing signs of rust damage and need to be repainted.

The surface of the shelf used to serve food from the kitchenette area located off the dining room is chipboard is in poor repair and should be replaced with an appropriate surface which can be easily and effectively cleaned.

The new laundry provided requires resurfacing of the floor and walls to provide enable them to be easily and effectively cleaned.

The surface of the grounds to the left of the centre are damaged and uneven and a tripping hazard for residents.

Action required:

Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.

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: Keep all parts of the designated centre clean and suitably decorated.	
Action required: Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.	
Action required: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The multiple occupancy bedrooms conform to the required sq metre requirements of the regulations which were physically measured and approved during our re-registration. As from July 2014 these bedrooms will become twin rooms as per the new regulations. A new battery was installed in the automatic fire door closer. The new stair banister has been painted. During 2012 we have extensively renovated, painted and refurbished in the building. We have completed the ground floor area of the main house including all communal areas and rooms, bedrooms and toilets, shower and bathroom areas. The same has been completed in all of the corridor areas and 21 single bedrooms. This maintenance schedule is still a work in progress and the items highlighted by the inspector are in areas of the premises i.e. the first floor of the main house and basement area that we have yet to complete. Due to the nature of this work which requires the relocation of residents to other bedrooms on a	13 September 2012 30 September 2012 Maintenance schedule from October 2012 to March 2013

temporary basis and maintenance to certain service areas will have to be attended to at night time, this work will be completed by the end of March 2013 and all of the above actions will have been completed.	

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect: There was no complaints log maintained. There was no clear independent appeal arrangements detailed in the policy and the name of the independent advocate who visits the centre was omitted from the complaints policy.	
Action required: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.	
Action required: Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.	
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: There is a complaints log available within the nursing home but at the time of the inspection there were no complaints logged. A process of documenting such information will be completed for the future. The complaints procedure does contain the name of the independent person but this procedure will be reviewed.	16 October 2012 16 October 2012

Outcome 14: End of life care

The person in charge is failing to comply with a regulatory requirement in the following respect: End of life wishes were not documented in residents' care plans.	
Action required: Identify and facilitate each resident's choice as to the place of death, including the option of a single room or returning home.	
Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The resident highlighted in the report is a gentleman who has a diagnosis of cancer. He has no next of kin and is under the care of the psychiatric services. His condition was reviewed by his general practitioner and a decision was made on his end of life care and has been documented in his notes. Our residents have been with us for a number of years and we are familiar with both their and their families' wishes when it comes to end of life care however, I acknowledge this is not documented in their care plans. I intend to rectify this matter through discussion with the residents and their families and ensure it is documented clearly in their care plans.	Completed 18 September 2012 O3 December 2012

Outcome 16: Residents' rights, dignity and consultation

The provider is failing to comply with a regulatory requirement in the following respect: The curtains to ensure privacy between beds in one of the multiple occupancy rooms in the upstairs of the main building were tested by the inspector and did not extend fully around the resident's bed thus impacting on this resident's privacy. Instructions to staff describing the type of incontinence pad worn by each resident and other notices about residents personal care were publicly displayed in the communal assisted bathrooms and over residents beds, for example, instructions on residents oral hygiene notices were seen above the bed of a resident sharing a multiple occupancy bedroom which also impacted negatively on residents privacy.

Action required: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.	
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 2: Consultation and Participation Standard 4: Privacy and Dignity	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Curtains have been correctly placed around the correct bed areas thus ensuring correct fit. The instructions relating to incontinence wear and denture care have been removed.	 13 September 2012 18 September 2012

Outcome 17: Residents' clothing and personal property and possessions

The provider is failing to comply with a regulatory requirement in the following respect: Each resident did not have had adequate or sufficient wardrobe space provided to accommodate their personal belongings.	
Action required: Provide adequate facilities for each resident to appropriately store, maintain and use his/her own clothes.	
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Either new freestanding wardrobes or purpose built clothes storage units will be constructed in these bedrooms.	 Maintenance schedule from October2012 to March 2013

20 new wardrobes have been purchased. At present four are in position the remaining 16 have to be delivered from a central Dublin depot to their Castlebar store. I have been quoted me 10 days for delivery.	Will be completed by 23 November 2012

Outcome 18: Suitable staffing

The person in charge is failing to comply with a regulatory requirement in the following respect: There was not sufficient staff employed to ensure the provision of meaningful activity to all residents.	
Action required: Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
Reference: Health Act 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There are three day rooms utilised within the nursing home, one of which is continuously supervised by a member of staff. The other two day rooms are in the main area of the nursing home and there are always staffs presents which the inspectors report reflects. There are a number of activities been carried out during the week. We have specific activities three times a week which includes bingo, bowling, reminiscence, art, reading of the newspapers and card games. Mass is provided every week and on Sundays holy communion is provided by the local priest. The Legion of Mary visit every Friday morning to say the rosary with all the residents who wish to participate. We have music sessions every Friday for two hours. In addition to this we provide nail care and hairdressing in the morning time. Any opportunity to chat and interact with the residents is taken. All residents are offered the opportunity to participate in the activities however it is their choice and right to refrain from participation if they wish to. Each resident has a care plan relating to activities, there are	

opportunities for all residents to participate in activities if they wish to. We currently do not have any residents with severe cognitive impairment. Activities are part of each residents care plan and it is documented what they do and don't like to participate in. We have asked the residents their wishes in relation to the time of day we have structured activity sessions and the feedback from the residents is that they prefer it in the afternoon. The skill mix and staffing on current shifts is adequate for our residents current needs as the inspector highlighted in her report We are in the process of recruiting new staff, interviews have taken place and the successful applicants will be taking up their posts in the coming weeks. Care attendant commenced employment on 22 October 2012 and another care attendant commenced employment on 29 October 2012.Both are contracted to work 30 hours per week. This now allows our activity staff member to dedicate more hours to this function.	05 November 2012

The person in charge is failing to comply with a regulatory requirement in the following respect: Practice in relation to restraint was not in line with evidence-based practice	
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The HSE guidelines on restraint policy is been disseminated to all staff. Staff have the opportunity to attend relevant training provided by the college and through on line E-learning facilities. Relevant and mandatory training is provided in-house.	03 December2012

Any comments the provider may wish to make:

Provider's response:

I am pleased that the Authority stated that a positive attitude to compliance was demonstrated I am sure this can be continued by attending to the above requirements during the stated time period. I would like to thank the Inspector for the courtesy extended to everyone at the centre during the Inspection.

Provider's name: Hugh O'Boyle
Date 15 October 2012