<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Fearn Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>0338</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Bishops Street</td>
</tr>
<tr>
<td></td>
<td>Elphin</td>
</tr>
<tr>
<td></td>
<td>Co Roscommon</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>071-9535424</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:fearnanh@gmail.com">fearnanh@gmail.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>☑ Private ☐ Voluntary ☐ Public</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Eldabane Holdings Limited</td>
</tr>
<tr>
<td>Person authorised to act on behalf of the provider:</td>
<td>Martin O' Dowd</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Anne Marie O'Brien</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>31 July 2012</td>
</tr>
<tr>
<td>Time inspection took place:</td>
<td><strong>Start</strong>: 09:30 hrs  <strong>Completion</strong>: 19:20 hrs</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary McCann</td>
</tr>
<tr>
<td>Support inspector:</td>
<td>PJ Wynne</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>☑ unannounced  ☐ announced</td>
</tr>
<tr>
<td>Date of last inspection:</td>
<td>13 September 2011</td>
</tr>
</tbody>
</table>
### About inspection

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

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

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 2</td>
<td>The quality of care and experience of the residents are monitored and developed on an ongoing basis.</td>
</tr>
<tr>
<td>Outcome 3</td>
<td>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</td>
</tr>
<tr>
<td>Outcome 4</td>
<td>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.</td>
</tr>
<tr>
<td>Outcome 5</td>
<td>The health and safety of residents, visitors and staff is promoted and protected.</td>
</tr>
<tr>
<td>Outcome 6</td>
<td>Each resident is protected by the designated centre’s policies and procedures for medication management.</td>
</tr>
<tr>
<td>Outcome 7</td>
<td>Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.</td>
</tr>
<tr>
<td>Outcome 8</td>
<td>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.</td>
</tr>
<tr>
<td>Outcome 9</td>
<td>Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.</td>
</tr>
<tr>
<td>Outcome 10</td>
<td>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.</td>
</tr>
</tbody>
</table>
Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

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

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

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

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

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

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

Location of centre and description of services and premises

Fearna nursing home is located on Bishop Street, Elphin, County Roscommon just off the (R368) and a few minutes’ walk from the town of Elphin. The location allows residents access to local shops, the post office, a bank and other local amenities.

The centre is a two-storey building which was built in 1840. It originally operated as a convent school and has been a nursing home for the past 18 years. It is registered by the Health Information and Quality Authority (the Authority) to provide care for up to 34 residents. Many of the original features such as stonework and tiling are still in evidence. It has been converted and modified over the years to improve the facilities available for residents.

Access to the entrance is by code lock. On entry there is a lobby area with seating which is used by residents as a quiet sitting area. To the left lies the nurses’ office. The hallway leads to the ground floor accommodation and service areas.

Accommodation on the ground floor includes the dining room, sitting room, kitchen, laundry, bedroom areas, bathrooms, toilets and visitors’ room. There is a stairs and lift to the first floor. Bedrooms, bathrooms, toilets, a storage area and sitting room are located on the first floor. A stair-lift runs between split floor levels on the first floor. Areas off the corridors on the ground and first floors are ramped. Assisted toilets are provided close to the communal areas on both floors. Accommodation consists of nine single bedrooms and eight twin rooms and one triple room. A local general practitioner (GP) provides medical support and specialist services are accessed through the Heath Service Executive (HSE) or privately as required. There are mature gardens and parking spaces to the front of the building. A smaller secure garden off the dining room provides a safe outdoor space for residents.

Residents are admitted who require respite, convalescence, long term care and dementia care needs. Residents have access to physiotherapy on a weekly basis and occupational therapy on a referral basis.

| Date centre was first established: | 05 September 1994 |
| Date of registration: | 26 March 2011 |
| Number of registered places: | 34 |
| Number of residents on the date of inspection: | 24 |

<p>| Dependency level of current residents as provided by the centre: | Max | High | Medium | Low |
| Number of residents | 10 | 12 | 2 | 0 |</p>
<table>
<thead>
<tr>
<th>Gender of residents</th>
<th>Male (√)</th>
<th>Female (√)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9</td>
<td>15</td>
</tr>
</tbody>
</table>

**Management structure**

The provider is Eldabane Properties Ltd. Martin O’Dowd is the nominated person on behalf of the Provider Company. He is also the nominated provider of two other centre in Roscommon Fearna Manor and Meadowlands. The Person in Charge is Ann Marie O’Brien. She is responsible for the management of the centre. A team of staff nurses, carers, catering and domestic staff report to her. There is an area supervisor, Michelle Horan who provides support to the Persons in Charge of the three centres in the Roscommon area - Fearna Manor, Fearna Elphin and Meadowlands.

<table>
<thead>
<tr>
<th>Staff designation</th>
<th>Person in Charge</th>
<th>Nurses</th>
<th>Care staff</th>
<th>Catering staff</th>
<th>Cleaning and laundry staff</th>
<th>Admin staff</th>
<th>Other staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff on duty on day of inspection</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3**</td>
</tr>
</tbody>
</table>

** activity staff and the area supervisor

**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.**

Fearna Nursing Home was first inspected by the Health Information and Quality Authority (the Authority) in November 2011. A registration inspection was completed in April 2010 and follow up inspections were carried out in September 2010 and September 2011. The findings of previous inspections concluded that some improvements were required to meet all of the requirements in the Regulations. These inspection reports can be found at www.hiqa.ie.

The previous inspection was carried out in September 2011 and that report detailed eight actions that required review in order to comply with current regulations. Inspectors found on this inspection that three actions were completed, four were partially completed and one remained outstanding. The one outstanding was with regard to the premises. The provider has plans in place to build a new centre with a completion date identified as 2014. While work had been undertaken with regard to actions relating to the contract of care, and risk management, inspectors found that these required completion.
This was the fifth inspection carried out by the Authority and it was a monitoring unannounced inspection. The inspectors focussed on regulatory requirements relating to governance, risk and incident management, resident care and the environment to assess the extent to which these impinged on the delivery of care and provision of positive safe outcomes for residents.

The inspectors spoke with residents, the person in charge, the area supervisor and staff. Records were examined including residents’ records, staff rotas and files, register of residents, policies, fire safety records and accident/incident report records. The person in charge informed the inspector about recent developments in the centre. These included the decrease in numbers to 28 residents thereby ensuring that all residents had greater personal space.

The inspector was satisfied that the residents were well cared for and that their nursing and care needs were being met. The inspector found that the staffing levels were adequate to meet current residents’ needs. Staff and residents agreed that there were adequate staff on duty. From review of staff rotas and discussion with the person in charge the inspector confirmed these staffing levels to be the norm. No resident or staff member raised any concerns with regard to staffing levels. Call bells were noted to be responded to in a timely fashion and the inspectors noted that residents were supervised at all times in communal areas. There was a programme of recreational activities in place which included an exercise class, an art session and reading. Areas which required review included:

- further development of risk management
- provision of mandatory staff training in fire safety response and prevention and in safe moving and handling
- review of staff files
- further development of care plans
- review of contacts
- environmental issues.

The action plan at the end of this report identifies areas where improvements must be made 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.

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

#### 1. Statement of purpose and quality management

**Outcome 1**

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

On this inspection it was found that the statement of purpose contained all of the information required by Schedule 1 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The most recent up to date Statement of Purpose was submitted to the Authority in March 2012. While the centre is registered to provide accommodation for 34 residents the provider has stated in the updated Statement of Purpose that the maximum number to be accommodated will be 28.

The person in charge was aware that the current document should be kept under review to ensure that it reflected the service to be provided and to provide a copy to the Authority if changes in the service were made.

Outcome 2

_The quality of care and experience of the residents are monitored and developed on an ongoing basis._

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

Inspectors found that a system had been implemented to ensure the quality of care given to residents was monitored, developed and improved on an ongoing basis. Data was collected and analysed on a number of key quality indicators such as accidents/incidents, medication, pain management, falls, wounds and the use of restraint. An influenza vaccine audit had been completed in October 2011. Areas for improvement were identified and acted upon, for example, an audit of pain management was completed in July 2012 which reviewed the effectiveness of the prescribed analgesia. While there was an analysis of the information collected, a report on the quality and safety and quality of care of residents in accordance with regulation 35 was not available.

A residents’ committee was active within the centre and issues that were raised at these meetings were addressed. Resident questionnaires were completed three monthly and any issues raised were addressed. This is discussed in more detail under Outcome 11. The person in charge voiced a proactive approach to changing and improving practices. She described how she felt things had improved through
analysis of the information gathered and how she discussed the results of the audits immediately on completion of same at the staff handover meetings.

### Outcome 3

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

**References:**
Regulation 39: Complaints Procedures
Standard 6: Complaints

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**Inspection findings**

Written operational policies and procedures were in place for the management of complaints. The complaints process was displayed in a prominent place and residents were aware of it. Residents stated that they would speak to person in charge or any of the nurses if they had a complaint. All residents spoken with confirmed that they were happy with the service provided and had no issues or concerns at the current time. The person in charge was the person nominated to deal with complaints and she maintained a record of the details of the complaint, the investigative process and the actions taken. An inspector reviewed the complaints log and noted that there were no complaints documented since the last inspection. There was an action in the last inspection report that outcomes of the investigation into complaints and whether or not the resident was satisfied had not been documented in the complaints log. As there had not been any recorded complaints since the last inspection the inspector was unable to ascertain whether this action was completed. The person in charge informed the inspector that she would make sure that she checked with the complaint initiator to assess whether she/he were happy with the outcome of the complaint and would ensure she/he were aware of the appeals procedure.

An independent person was available if the complainant wished to appeal the outcome of the complaint.

### 2. Safeguarding and safety

### Outcome 4

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

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

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**Inspection findings**

Inspectors were provided with a copy of the centre’s prevention, detection and response to elder abuse policy. There was evidence that all staff had attended
training on elder abuse detection and prevention. Some staff working in the centre on the day were questioned by an inspector regarding the procedures to be followed in the event of an alleged incident of elder abuse and they were clear how they would report and that the welfare of the residents was their primary responsibility.

Documentary evidence of attendance at elder abuse detection and prevention training was maintained for each staff member in a staff training matrix.

An Garda Síochána vetting was completed for all staff.

The centre was secure. Access to the centre was controlled and the nurses’ office was situated on the right immediately on entry. A receptionist was on-duty two days per week and the nurses’ office was generally manned by a staff member. A visitor’s record was maintained and completion was monitored by staff.

Outcome 5

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

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

Inspection findings

An action with regard to the risk management policy was contained in the previous report. The provider had used the services of an external consultant to assist with risk management procedures. A revised risk management policy had been developed. However, this policy did not comply with current legislation. It failed to adequately guide and inform staff of measures to take in response to a variety of risk situations. For example, it did not include the risks of assault of residents, staff or visitors in the centre or information with regard to dealing with aggression or violence. It also failed to reference other policies that were available in relation to risk to inform staff of the overall risk management procedures in the centre.

The centre’s risk register was reviewed by an inspector. This document detailed that a hazard identification of the kitchen, external grounds and equipment had been completed in March 2012. However, resident areas such as bedrooms corridors or bathrooms, or the height of some bedroom doors had not been reviewed. The door of the sluice room was not secure, consequently, residents could access this area. Not all staff had up to date training in safe moving and handling.

There was a missing person policy in place which included clear procedures to guide staff should a resident be reported missing. Photographic identification was available for each resident in their care records. There were no controls in place to ensure the temperature of hot water was dispensed at a safe temperature.
An inspector monitored the temperature of the hot water in two room sand found that it was 49.5 degrees centigrade where the recommended maximum safe level is 43 degrees centigrade.

There was an adequate system in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. An inspector reviewed the incident and accident log. Incident forms were completed for each incident and there was evidence of residents being monitored closely following an incident. Inspectors found that risk assessments were completed and care plans developed for residents with preventative strategies identified such as environmental precautions, additional aids and extra supervision by staff. The person in charge completed a monthly falls audit to determine the causative factors and to identify and implement preventative measures. The person in charge stated that this was a very positive exercise for staff and residents and by implementing the recommendations of this audit had resulted in less falls particularly for frequent fallers. The physiotherapist reviewed residents that fell and made recommendations on the prevention of further falls.

Hand rails were in place on both sides of the corridor. There was signage in place to alert resident's staff and visitors where there was an incline in the floor level.

The inspectors found that there were some procedures in place to manage infection control. The sluice room had been refurbished. Wall mounted dispensers containing hand sanitising gel were located at the entrance door and throughout the building; however there were inadequate amounts of these. For example, they were not available outside sluice room door.

Procedures for fire detection and prevention were in place. The inspector reviewed service records which showed that the fire alarm system, emergency lighting and fire equipment were checked and serviced regularly. This had last been completed on the 15 May 2012 and was due for a re-check on the 3 August 2012. The inspector read records which showed that regular inspections of fire exits were carried out. The inspector noted on walking around the building that all fire exits were unobstructed. The inspector read the training records and found that not all staff had attended annual training on ‘fire prevention and response and evacuation’. Fire drills to reinforce the theoretical training provided to staff to ensure they are confident of the procedure to be followed in the case of a fire were not carried out, even though the fire policy stated that ‘fire drills would be completed monthly’ biannually. Staff spoken with by inspectors were knowledgeable on the procedures they were required to follow in the event of the alarm sounding and evacuation procedures.

Where falls occurred there was inconsistent evidence available to demonstrate that the resident was assessed for possible head injury. Neurological observations were not recorded routinely to monitor residents to ensure that a head injury had not been sustained and that consciousness had not been affected. Information recorded included factual details of the accident/incident, date and time event occurred, name and contact details of any witnesses and whether the GP and next of kin had been contacted.
A comprehensive emergency plan was in place to guide staff in responding to untoward events. The plan outlined a clear procedure to follow in the event of fire, flooding and loss of utilities. Contingency arrangements were provided should it be necessary to evacuate residents from the building. A visitors’ log was in place to monitor the movement of persons in and out of the building to ensure the safety and security of residents and to inform staff re who was in the premises should evacuation be required.

**Outcome 6**

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**References:**

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

Standard 14: Medication Management

**Inspection findings**

There was a comprehensive medication management policy in place which provided guidance to staff. The inspector accompanied a nurse during the medication round and observed practice in administration. The staff nurse on the medication round was knowledgeable of the medications being administered and ensured that residents took the medication. The nurse told the inspector that they used photographs to identify residents when administering medications. These were available for all residents.

There were close links with the pharmacist who regularly attended the centre and checked on storage procedures. Medicines were being stored securely. The temperature ranges of the medicine refrigerators were monitored daily and a record was kept. Controlled drugs were being stored in controlled in a drug cabinet that conformed to statutory requirements. Medications that required special control measures were kept in a double locked cabinet. A register was maintained and these medications were counted by two nurses and recorded on each change of each shift which was in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Appropriate arrangements were in place for the disposal of medication.

Deficits were noted with the medication administration charts. These did not consistently identify the maximum dose of “as required” medication to be administered in a 24 hour period. On some charts there was no time of administration, for example, an order stating administer three times daily. Additionally, there was no signature of the general practitioner documented where medication was discontinued.

As discussed under Outcome 2 medication audits were being completed.

**3. Health and social care needs**
Outcome 7
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

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

Inspection findings

While staff informed the inspector that the centre had good access to general practitioner (GP) services and this was also confirmed by the residents, the inspector noted that there was poor written evidence available on medical files reviewed of consultations with the GP. For example one resident had only one recording for 2012 and this was review post a fall. One file reviewed had no entry for 2012 to date. The inspector noted that there is a need for a comprehensive medical history to be available for all residents with regular medical reviews. Where this is absent it poses a risk to residents, particularly if an acute medical problem arises out of hours when the regular GP is not available.

The person in charge also stated that reviews of medication were occurring at three monthly intervals. She stated that the medication charts were re-written every three months and this was the process with regard to reviews of the medication. There was no entry by the GP in the medical records reviewed to support that he/she had seen the resident and discussed their medication with them as part of the review.

There was good access to allied healthcare services. A physiotherapist attended the centre twice weekly. While the centre had regular services of an in-house occupational therapist this service is no longer available. The person in charge informed the inspectors that they can access occupational therapy and speech and language therapy by GP referral. Dietetic services were available to the centre and there was evidence on files reviewed of input from dietetic services. Dental services
could be accessed locally. Audiology services were arranged as required via GP referral. Eye checks were also arranged as required.

The inspector found that generally, a good standard of nursing care was provided. A computerised documentation system is in use. The inspector reviewed five residents care files. There were nursing assessments and clinical risk assessments carried out for all residents, for example, a validated pressure ulcer risk assessment, a manual handling assessment, continence assessment and dependency assessment. Additional assessments included for example a nutritional status assessment and a falls risk assessment and a behavioural and mental state checklist. The inspector noted that the assessments were not fully utilised to inform the care plans and the care plans required further input to ensure that they guided the care. There was a daily record of the residents’ health condition and treatment given. However, the nurses’ entries were not timed which is not in line with best practice guidelines from An Bord Altranais.

Staff demonstrated good knowledge and understanding of each resident’s background and informed inspectors that they tried to involve residents and relatives in planning care. There was poor documented evidence of involvement of the residents or their representatives in the development and review of the care plan. An action with regard to review of care plans was contained in the previous action plan. On this occasion inspectors found that care plans were reviewed on a regular basis and specific review documentation was in place to ensure care plans should be reviewed at three monthly intervals.

The inspectors found that there was a wound management policy in place. There was one resident with a leg ulcer wound on the day of inspection. There was an assessment completed for the wound and there were visual aids available to determine the effectiveness of treatment being provided. From speaking with the staff and the resident and on review of the wound documentation, it was clear that this wound was improving. Specialist pressure relieving equipment was in use for residents identified as at risk of developing pressure ulcers and these were checked regularly to ensure they were at the correct setting for the resident.

The person in charge had completed the train the trainer course in restraint management and had trained all staff on good practices in restraint management. Restraints in place related to bedrails. The centres policy on restraint provided guidance to staff on best practice. Inspectors reviewed files for a sample of these residents and found that there was an assessment completed for the use of bedrails with consideration of the risks associated with the use of bedrails and there was evidence of alternatives being tried prior to the use of bedrails.

There were opportunities for residents to participate in activities appropriate to their interests and capacities. Sonas therapy (a group session involving stimulation of all five senses particularly useful for people with cognitive impairment) was a regular session on the activities schedule. A programme of events scheduled for the day was displayed. Social histories were recorded. However, many residents did not have a life story completed which might enhance communication with some residents particularly those who were cognitively impaired.
Activities on offer included bingo painting playing cards. The mobile library attended the centre and some residents commented on how beneficial this was.

### Outcome 8

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

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

#### Inspection findings

There were no residents receiving end-of-life care on the day of inspection. The inspector discussed end-of-life care planning with the staff. Staff confirmed that while they would know the residents’ wishes and would have spoken with the family, they did not document end-of-life care wishes. Individual religious and cultural practices were facilitated and family and friends were facilitated to be with the resident when they were dying. Residents had the option of a single room and access to specialist palliative care services, if appropriate.

A policy document was available to inform staff of procedures to follow in providing end of life care to residents. A pain assessment tool was in use for residents who were prescribed analgesia.

Religious personnel are available and attend the centre regularly and as requested. There is a large oratory in the centre which was accessible and available for use for religious services and quiet reflection.

### Outcome 9

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

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

#### Inspection findings

A recognised nutrition assessment tool was in use and there was regular monitoring of residents’ weights to assess fluctuations. Residents who were being monitored for weight changes and nutritional care plans were in place. Residents told inspectors that the food served was very good and that they had varied meals that offered choice and variety. A menu was displayed on the notice board in the dining room. Inspectors noted that there was adequate staff assisting and serving the meals in the
dining areas and found they were knowledgeable about individual resident’s specialised needs.

A policy entitled ‘nutritional needs’ was in place. However, this policy did not comply with current legislation as it failed to detail aspects of monitoring nutritional intake. Residents had access to fresh drinking and meals and snacks were available at flexible times. Meals times were seen to be unhurried social occasions that provided opportunities for residents to engage communicate and interact with each other and staff. Kitchen staff were informed by the nursing staff of residents’ dietary requirements. A list of special dietary requirements was seen in the kitchen. The kitchen was well stocked and there were satisfactory environmental health officer reports available.

An inspector spoke with the chef who was knowledgeable of residents’ likes dislikes and special diets. All residents’ dietary requirements were documented to ensure that staff provided the necessary dietary requirements. She told the inspector that resident’s meals were fortified and residents were also being prescribed supplements where necessary.

4. Respecting and involving residents

**Outcome 10**

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

**References:**

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

**Inspection findings**

A written contract of care which detailed the terms and conditions of the occupancy including services provided was available for each resident. However, they were not complete in many cases. The provider kept the signed page of the contract and the rest of the contract was given to the resident or relative responsible for paying the fees. Fees to be charged were not clearly documented in each case in relation to funding provided by the Nursing Home Support Scheme and contribution paid by the resident. They also failed to detail fees to be charged or the cost of services not included in the fee such as hair dressing.

**Outcome 11**

*Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.*
Residents were consulted through a residents’ forum and a relatives meeting for their input into the operating of the centre. Residents were also consulted about how the centre was planned and run through one to one contact with the person in charge and other staff. An inspector reviewed minutes of resident meetings. Issues discussed at the last meeting included choice of day trip and a discussion was held with regard to whether resident were happy with how their clothes were managed.

Residents’ religious rights were facilitated through regular visits by the clergy to the centre and the facilitation of services such as mass, rosary and sacrament of the sick.

The person in charge spoke about how the centre was managed in a way that maximised residents’ capacity to exercise personal autonomy. Residents had a choice of when to get up and go to bed, how they spent their day and the foods they ate. Residents spoken with stated that staff respected their wishes and encouraged them to make choices for themselves.

The person in charge displayed an awareness of the importance of privacy and respect for residents. She emphasised how important she felt that residents receive care in a dignified way that respects their privacy. There were no restrictions on visits except when requested by the resident or when the visit or timing of a visit was deemed to pose a risk. Staff were noted to communicate well with residents and displayed a caring attitude towards residents staff told inspectors that they knew many of the residents locally before they moved into the centre. Some residents had their own mobile phone and other residents had access to a telephone if they wished to avail of this.

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

### References:
- Regulation 7: Residents’ Personal Property and Possessions
- Regulation 13: Clothing
- Standard 4: Privacy and Dignity
Inspection findings

A policy on residents’ personal property and possessions was in place. Appropriate record keeping was maintained of residents’ personal property. Residents could retain control over their own possessions through the provision of adequate space for personal possessions.

An individual record of each resident’s personal property was recorded on admission. However, this was not updated to reflect changes throughout the residents stay. While inspectors confirmed with residents that there were no instances of missing items and the complaints log did not contain any complaints re clothes going missing, inspectors noted that many items of clothing were not identifiable by their label.

While there was a transparent system in place in relation to the management of the residents’ finances, this did not comply with best practice. One resident who did not have a personal bank account had money accruing in the business account of the provider. The resident obtained a statement in relation to these monies on a regular basis and transparent documentation with regard to the monies was available. The person in charge and area supervisor explained that this was as a consequence of the resident not having a bank account and that they had tried to open up a personal account for the resident but had been unable to do so. The area supervisor stated that she would discuss this with the provider and the resident and try and ensure that a separate resident account was available for the resident. The area supervisor confirmed post inspection that a personal bank account had been opened for this resident and the provider confirmed post inspection that no monies were held on behalf of any resident in the company account. The person in charge confirmed that a personal bank account had been opened for the resident who had no personal bank account. A small amount of money was managed by the person in charge on behalf of another resident. An accountable and transparent arrangement was in place with regard to this matter.

An inspector met with the laundry staff who explained the systems in place to ensure that residents’ own clothes were returned to them. Residents expressed satisfaction with the laundry management.

5. Suitable staffing

Outcome 13

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

References:
Regulation 15: Person in Charge
Standard 27: Operational Management
**Inspection findings**

The post of person in charge was full time and the person in the post was a nurse with 16 years experience of nursing older persons. She has been employed at the centre since 2003 and has been the person in charge since 2009. She demonstrated good clinical knowledge to ensure safe and suitable care.

The person in charge also demonstrated good knowledge of the legislation and of her statutory responsibilities. She was engaged in the governance, operational management and administration of this centre on a regular and consistent basis. She had attended the HIQA information session in April 2012. Recent courses attended by the person in charge included, ‘best practices in recording clinical care for nurses and midwives’, ‘the role of the occupational therapist and the importance of seating posture and pressure care’ and ‘wound care management’. She completed the special purpose award in ‘Gerontology Nursing’ in March 2012.

The person in charge was assisted in her role by a senior staff nurse. She also has considerable experience of working with older people and managing services.

**Outcome 14**

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

**References:**

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

**Inspection findings**

A registered nurse was on duty at all times. Staff informed the inspector that leave was planned in advance. Where there were unplanned absences, part-time staff worked extra shifts which ensured that residents were familiar with staff and staff were knowledgeable of residents’ needs. A staff handover occurred at the commencement of the morning and night shift.

Four staff files were reviewed by the inspector and all of them had a self declaration in relation to certification of physical and mental fitness. This does not provide sufficient evidence as none had been certified by a medical practitioner.
Verified identity photographs were not available on all staff files reviewed. Person identification numbers (PIN) were available for all nursing staff.

A staff training matrix was made available to the inspectors. This showed that training in continence management challenging behaviour, subcutaneous fluids had been delivered in 2012. Training in infection control and best practice in the use of restraint occurred in 2011. As documented in Outcome 5 not all staff had up to date fire safety training or training in safe moving and handling.

There was a recruitment policy available in the centre. The person in charge informed the inspectors that when new staff were recruited an induction would occur. Staff were supervised appropriate to their role and were aware of regulations and standards pertaining to the nursing home environment and aware of the centres policies and procedures. Staff spoken with informed the inspectors they were able to access copies of these documents.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

An action in the previous report related to the fact that the sluice room was used as sluice and cleaning room. On this inspection inspectors found that a new cleaning room is currently being developed but no sink or wash hand basin was available as yet.

The person in charge explained that it is proposed he new build will commence in mid to late 2012 and registration to be completed prior to March 2014. The provider has confirmed to the Authority that the new build will be constructed in advance of the expiry of the current registration in March 2014.

Areas which required review included:

- light fitting glass broken in room 23
- wash-hand basin not accessible to resident in room 19
- poor sound proofing between rooms
- joint smoking/visitors room
- inadequate staff changing facilities
- inadequate storage space for equipment
- size of some toilets – inaccessible for some residents
- height of doors into some rooms
- sloped flooring
- steps at various intervals throughout the centre.

An inspector visited the laundry and found that it was small with limited space to segregate clean and soiled clothes.

The inspector found there was suitable and sufficient equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents’ needs. There was a service contract in place which covered breakdown and repair for all beds, air mattresses and other equipment used by residents. Inspectors reviewed the records of servicing of equipment. Equipment was serviced on the 2 February 2012. Hoists were serviced bi-annually. A maintenance programme was in place and a part-time maintenance person was employed. The staff had a logging system to ensure that maintenance issues were addressed in a timely manner.

7. Records and documentation to kept at a designated centre

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<th>Outcome 16</th>
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The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

**References:**
- Regulation 21: Provision of Information to Residents
- Regulation 22: Maintenance of Records
- Regulation 23: Directory of Residents
- Regulation 24: Staffing Records
- Regulation 25: Medical Records
- Regulation 26: Insurance Cover
- Regulation 27: Operating Policies and Procedures
- Standard 1: Information
- Standard 29: Management Systems
- Standard 32: Register and Residents’ Records

**Inspection findings**

All of the operating policies and procedures required by schedule 5 of the legislation were in place. As discussed under Outcome 9 the nutritional policy required review. A register of residents was available. This complied with current legislation.
The resident’s guide was reviewed by the inspectors. A copy of the most recent inspection published report completed by the Authority was not attached to the copy of the resident’s guide reviewed but was available in the centre.

Records relating to health care and staff recruitment are discussed under outcomes 7 and 14 of this report respectively.

Outcome 17

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

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents’ Records

Inspection findings

Inspectors found that all accidents and incidents were recorded in the centre and were maintained in a log. The person in charge was aware of the timescales within which notifications must be forwarded to the Authority. Notifiable incidents were notified to the Authority within three days of the occurrence. Quarterly reports were provided, where relevant.

Outcome 18

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings

The person in charge had not been on extended leave since her appointment to her post but she and the area supervisor were aware of the need to notify the Authority if the person was on leave for more than 28 days. A deputy person in charge was available to cover for such absences.
Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge, the area supervisor, staff nurses, care catering and administration staff 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:

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

22 August 2012
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre:</th>
<th>Fearna Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>0338</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>31 July 2012</td>
</tr>
<tr>
<td>Date of response:</td>
<td>06 September 2012</td>
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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 2: Reviewing and improving the quality and safety of care

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

A report on the quality and safety and quality of care of residents in accordance with regulation 35 was not available.

Action required:

Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement

* 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:

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<tr>
<th>Action</th>
<th>Timescale:</th>
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<tr>
<td>Provider’s response:</td>
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<tr>
<td>Being compiled at present.</td>
<td>15 October 2012</td>
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### Outcome 5: Health and safety and risk management

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

The risk management policy did not comply with current legislation. It failed to adequately guide and inform staff of measures to take in response to a variety of risk situations, for example, assault of residents in the centre, accidental injury to residents or staff, aggression, violence and arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Where falls were un-witnessed there was inconsistent evidence available to demonstrate that the resident was assessed for possible head injury. Neurological observations were not recorded routinely to monitor residents to ensure that a head injury had not been sustained and that consciousness had not been affected.

The risk register failed to cover the identification and assessment of all hazards throughout the centre.

There was a lack of hand sanitizers strategically placed throughout the 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.

**Action required:**

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

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

**Action required:**

Ensure practices are in place to ensure residents are monitored post incident of fall to prevent further injury.
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:

Provider’s response:

Risk management documentation was recently updated by our new external consultant. She is reviewing the inspectors’ comments and will revert in due course.

Residents who fall will continue to be monitored post incident and records will be formally updated

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<td>31 October 2012</td>
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Outcome 6: Medication management

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

Prescribing practices did not comply with best practice.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference:
- Health Act, 2007
  Regulation 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:

Provider’s response:

Our current operating policies will be further developed.

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<td>31 October 2012</td>
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Outcome 7: Health and social care needs

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

The inspector noted that there was poor written evidence available on medical files
reviewed of consultations with the GP.

**Action required:**

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health in relation to the GP service.

**Reference:**

Health Act, 2007  
Regulation 9: Health Care  
Standard 13: Healthcare

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<td>Provider's response:</td>
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<tr>
<td>The GP sees all residents on a regular basis and documentation surrounding these visits will be more robust in future.</td>
<td>Immediate</td>
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5. The person in charge has failed to comply with a regulatory requirement in the following respect:

Assessments were not fully utilised to inform the care plans and the care plans required further input to ensure that they guided the care.

Residents or relatives were not formally involved in the development or the review of the care plans.

**Action required:**

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

**Action required:**

Revise each resident’s care plan, after consultation with him / her

**Action required:**

Notify each resident or their representative of any review of his/her care plan.

**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
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<th>Please state the actions you have taken or are planning to take with timescales:</th>
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<tr>
<td>Provider's response:</td>
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<tr>
<td>Care plans are updated every three months or earlier if required. Discussion does take place with residents and their families and this will be documented from now on.</td>
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**Outcome 9: Food and nutrition**

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

A policy was not in place to inform nutritional intake review and monitoring.

**Action required:**

Implement a comprehensive policy and guidelines for the monitoring and documentation of residents’ nutritional intake.

**Reference:**

- Health Act, 2007
- Regulation 20: Food and nutrition
- Standard 19: Meals and Mealtimes

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<th>Please state the actions you have taken or are planning to take with timescales:</th>
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<tr>
<td>Provider's response:</td>
<td>30 September 2012</td>
</tr>
<tr>
<td>This is being developed and will be implemented shortly.</td>
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</table>

**Outcome 10: Contract for the provision of services**

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

The contract of care which detailed the terms and conditions of the occupancy were not complete in many cases. The provider kept the signed page of the contract and the rest of the contract was given to the resident or relative responsible for paying the fees.

Fees to be charged were not clearly documented in each case in relation to funding provided by the Nursing Home Support Scheme and contribution paid by the resident. They also failed to detail fees to be charged or the cost of services not included in the fee such as hairdressing.

**Action required:**

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

**Reference:**  
Health Act, 2007  
Regulation 28: Contract for the Provision of Service  
Standard 7: Contract/Statement of Terms and Conditions

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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
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</table>
| Provider's response:  
All contracts of care will undergo review and be updated where required. | 30 November 2012 |

**Outcome 12: Residents’ clothing and personal property and possessions**

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

While residents’ personal property and possessions was documented on admission, this was not updated at regular intervals to ensure the safety of residents’ personal effects.

Management of the residents’ finances this did not comply with best practice.

**Action required:**  
Maintain an up to date record of each resident's personal property that is signed by the resident.

**Reference:**  
Health Act, 2007  
Regulation 7: Residents’ Personal Property and Possessions  
Standard 17: Autonomy and Independence

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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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</table>
| Provider's response:  
This will be done. | 15 November 2012 |

**Outcome 14: Suitable staffing**

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

All required documentation in relation to recruitment of staff employed in the centre was not available for inspection.
**Action required:**

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

**Reference:**

Health Act, 2007  
Regulation 16: Staffing  
Regulation 18: Recruitment  
Standards 22: Recruitment  
Standard 23: Staffing Levels and Qualifications

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

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<tr>
<th>Provider's response:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>A template has been devised with regard to validation of physical and mental fitness. A copy of this will be given to each employee with a request that they request their GP to confirm in writing that they mentally and physically fit for the purpose of the post that they are to perform at the centre. All other documentation is in place.</td>
<td>Immediate</td>
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</table>

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

Not all staff had up to date training in safe moving and handling or in fire safety control and prevention.

**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:**

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<thead>
<tr>
<th>Provider’s response:</th>
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<tbody>
<tr>
<td>Regular training takes place in many areas as required or as identified by staff. Sometimes people cannot make a course and</td>
<td>31 October 2012</td>
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usually make the next available course. Any training required in the mentioned areas will be carried out shortly.

---

**Outcome 15: Safe and suitable premises**

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

The premises did not comply with current regulations. Areas which required review included:

- the hot water at the point of contact with residents was hotter than the recommended safe level of 43 degrees centigrade
- light fitting glass broken in room 23
- wash-hand basin not accessible to resident in room 19
- poor sound proofing between rooms
- joint smoking/visitors’ room
- inadequate staff changing facilities
- inadequate storage space for equipment, consequently hoists and other equipment were being stored on the corridor
- size of some toilets – inaccessible for some residents
- height of doors into some rooms
- sloped flooring
- steps at various intervals throughout the centre
- the laundry was inadequate
- the cleaning room requires a sink and wash-hand basin
- sluice room needs to be secure.

**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.

Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

Provide a sufficient supply of piped hot and cold water, which incorporates thermostatic control valves or other suitable anti-scalding protection.

**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.

Provide suitable changing and storage facilities for staff.

**Reference:**

- Health Act, 2007
- Regulation 19: Premises
<table>
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<th>Please state the actions you have taken or are planning to take with timescales:</th>
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<tbody>
<tr>
<td>Provider’s response:</td>
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<tr>
<td>All issues will be dealt with in the new build.</td>
<td>March 2014</td>
</tr>
<tr>
<td>Current premises is of sound construction and kept in good repair both internally and externally.</td>
<td>31 October 2012</td>
</tr>
<tr>
<td>Control valves will be installed.</td>
<td></td>
</tr>
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</table>

Any comments the provider may wish to make:

Provider’s response:

None supplied

Provider’s name: Martin O Dowd  
Date: 06 September 2012