Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Owen Riff Nursing Home
Centre ID:	0375
Centre address:	Camp Street Oughterard County Galway
Telephone number:	091 866946
Email address:	owenriff@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Riverside Nursing Home Ltd
Person authorised to act on behalf of the provider:	Theresa O'Toole
Person in charge:	Grace Kelly
Date of inspection:	14 March 2012
Time inspection took place:	**Start:** 09:10 hrs **Completion:** 20:00 hrs
Lead inspector:	Fiona Whyte
Support inspector:	Jackie Warren
Type of inspection	☐ **announced** ☒ **unannounced**
Date of last inspection:	9 August 2011

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.

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.*
Outcome 2 *The quality of care and experience of the residents are monitored and developed on an ongoing basis.*
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*
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.*
Outcome 5 *The health and safety of residents, visitors and staff is promoted and protected.*
Outcome 6 *Each resident is protected by the designated centre's policies and procedures for medication management.*
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.*
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.*
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.*
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.*

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 designed 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

Owen Riff Nursing Home is a two-storey, purpose-built centre which opened in 2003. It is a family run business and there are places for 40 residents. At the time of inspection, there were 23 residents receiving long-term care and one resident was in hospital. Some of these residents had a cognitive impairment and dementia related conditions.

The entrance door leads to a reception area and the nurses' station is located opposite the reception desk. There is a variety of communal accommodation including a dining room and small day room on the ground floor and another day room, oratory and recreational room on the first floor. There is a visitors' room on each floor where residents can meet visitors in private and a smoking room which is also used as the hairdressing room. The kitchen and food storage rooms are adjacent to the dining room downstairs. The catering staff toilet and laundry room are located in this vicinity. There are two sluice rooms, one on each floor of the building.

There are 35 bedrooms in total, 30 single bedrooms and five twin bedrooms. Fourteen single bedrooms and five twin rooms are located on the first floor with the remaining 16 single bedrooms on the ground floor. One twin room has an en suite assisted bath, toilet and hand-washing facilities while the remaining four twin rooms have en suite assisted shower, toilet and hand-washing facilities. The single bedrooms have an en suite toilet and hand-washing facilities. There are four assisted bathrooms - two on the first floor with bath, toilet and hand-washing facilities and two on the ground floor and one with bath and shower and the second with assisted shower, toilet and hand-washing facilities.

Staff changing facilities are on the first floor and a designated toilet for non catering staff is provided in this facility. A separate residents' toilet and visitors' toilet are located on each floor. There is a wheelchair accessible visitors toilet on the first floor.

There is a passenger lift servicing the floors. Car parking for relatives, staff and visitors is available to the front of the building. There is no secure garden for use by residents.

Date centre was first established:	2003
Date of registration:	16 September 2010
Number of registered places:	30
Number of residents on the date of inspection:	23

Dependency level of current residents as provided by the centre:	Max	High	Medium	Low
Number of residents	5	11	3	4

Gender of residents	Male (✓)	Female (✓)
	✓	✓

Management structure

Owen Riff Nursing Home is owned by a limited company, Riverside Nursing Home Ltd. One of the Directors, Theresa O'Toole is the named person to act on behalf of the Provider. The Person in Charge is Grace Kelly and she reports directly to the Provider. A team of nurses, care assistants and the activities coordinator report to the Person in Charge. Catering and housekeeping staff report to the Provider or the Person in Charge. Maintenance work is the responsibility of Kevin O'Toole, Theresa O'Toole's husband. There is also an accountant employed three days per week reporting to Theresa O'Toole.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	1	2	1	1	0	4*

* The provider, accountant, activities coordinator and a student on work experience.

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 report set out the findings of an unannounced inspection which took place over one day. As part of the inspection inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Owen Riff Nursing Home was inspected by the Health Information and Quality Authority (the Authority) Social Services Inspectorate on 3 and 4 June 2010. It was an announced registration inspection. The provider had applied for registration under the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). This inspection report can be found at www.hiqa.ie Registration was granted subject to specific conditions such as the requirement to obtain prior written agreement from the Chief Inspector before increasing the number of residents over 30. The provider had since applied to remove the conditions. This inspection was carried out to monitor compliance and make a recommendation to the Chief Inspector regarding the provider's application to remove the conditions. Inspectors assessed the provider's application under areas such as governance, staffing, quality of life and healthcare.

At the start of this inspection the inspectors were informed of a change to the person in charge since the previous inspection. The previous person in charge had recently resigned and the current person in charge had commenced in the post on 12 March 2012. The provider had not notified the Chief Inspector of this change in management as required by the Regulations. The newly appointed person in charge had previously worked in the centre but had predominantly worked on night duty. She had deputised for the person in charge on some weekends and for annual leave.

During this inspection many significant improvements were identified as being required including the provision of mandatory training, medication management and practices, risk management, staff files, access to allied services and assessment and care planning. Inspectors were not satisfied that there were sufficient staffing levels and skill-mix on duty and the provider was required to review the staffing levels to ensure that the needs of residents were met. During the inspection specific environmental risk issues were required to be addressed.

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

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 residents.

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

Inspection findings
Inspectors reviewed the statement of purpose and found that it required updating to meet the requirements of the Regulations. While the statement of purpose had been updated to reflect the recent changes in the management structure it did not include the criteria used for emergency admissions, the sex of the residents to be accommodated and the staffing complement in whole time equivalents (WTE).

The provider was requested to submit the updated statement of purpose to the Chief Inspector. The updated statement of purpose has not as yet been received by the Authority.

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 were not satisfied that the quality of care and experience of the residents were monitored and developed on an ongoing basis. The person in charge did not have systems in place to gather and audit information to identify possible trends and for the purpose of improving the quality of service and safety of residents.

The person in charge had commenced the process of gathering some clinical data for the purpose of auditing. Information on the type and number of infections was audited on a monthly basis in 2012. While trends were identified there was no evidence of learning as a result. Minutes of staff meetings reviewed did not show that the results were discussed with staff for the purpose of improving practice.

A food safety audit was carried out in April/May 2011. However, this was not undertaken on a planned regular basis for the purpose of continuous improvement. There had been no audit undertaken since.

A resident satisfaction survey had been undertaken in 2011. While the overall findings were documented the questionnaires to support the findings were not available. There was no evidence that the findings were discussed at staff meetings and therefore no evidence of learning or improvements made as a result.

There was no process for reviewing information as a result of adverse events or medication error therefore there was no learning or improvements in the quality of service and safety of residents. A medication audit tool was available however no audits had been undertaken as yet.

There was no auditing of information on accidents and incidents. There were eight falls recorded in 2012 to date. The information recorded for each fall was detailed and comprehensive. However, any additional action taken following the fall was not documented and any measures put in place to minimise the risk of reoccurrence was not recorded.

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

Inspection findings
The management of complaints was satisfactory. Inspectors reviewed the complaints policy and procedure. The complaints procedure was displayed in a user friendly format at the entrance and described in the Residents' Guide and attached as an appendix to the statement of purpose. There was a clear process outlined to ensure all complaints were appropriately managed and responded to within the identified timeframes. The complaints policy and procedure contained an independent appeals process.

There was an 'improvement form' available to record concerns, compliments and complaints. The provider stated that to date there had been no complains received. Both relatives and residents spoken to confirmed they had no complaints but would speak to the person in charge of they had any concerns.

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

Inspection findings
Improvements were required to ensure residents were protected from being harmed or suffering abuse.

Inspectors found that the centre's policy on the prevention, detection and response to elder abuse was inadequate and did not provide guidance to staff. It did not contain the procedures to be followed if an allegation of abuse were made. It did not outline the responsibilities of the provider and staff in the prevention and management of abuse such as the provision of training. Some information within the policy was incorrect. For example, it stated that 'staff should report concerns to the complaints investigation scheme' but that 'staff would not be protected when making such disclosures'. The provider was unsure what this information referred to. It also incorrectly stated that 'the provider could use discretion in reporting allegations of abuse if the resident was cognitively impaired'.

There were no comprehensive training records maintained to show that staff had received training in the prevention and detection of elder abuse or what to do in the event of an allegation of abuse. The provider stated that staff had received training and some staff did confirm this with inspectors. However, staff recently employed had not received training. Inspectors found that staff spoken to were knowledgeable in this area and could state what they would do if they suspected elder abuse or if an allegation of abuse was made to them. There were no allegations of abuse notified to the Authority and the provider confirmed there had been no allegations of abuse to date.

The provider stated that no resident finances were managed in the centre.

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
Inspectors found that practice in relation to the health and safety and the management of risk did not promote the safety of residents, staff and visitors.

There was a health and safety statement available. There was a risk management policy in place but the guidance provided was too generic and the specific environmental risks associated with this centre were not identified and managed. For example, risks relating to infection control and moving and handing were identified but specific risks such as smoking in the centre were not identified.

On the day of inspection serious risks were identified which were discussed with the provider and the person in charge who were required to take action. For example:

- some of the hot water to wash-hand basins was scalding to the touch
- doors within the centre had a keypad locking system. However, the inspectors noted that two doors from the first floor to ground floor were not secure and provided direct access onto stairs posing a serious risk to residents
- cleaning chemicals were noted to be stored in the laundry, on trolleys in corridors and in some toilets which posed a risk to residents
- a trolley on one corridor was unattended and was seen to contain scissors, equipment for repair and maintenance purposes such as screwdrivers, topical medication and unlabelled cleaning chemicals
- the doors to the sluice rooms were left open as was the laundry room. They were unattended at the time
- the laundry was used to store general equipment and cleaning equipment including mops which were stored in mop buckets filled with dirty water. This practice posed an infection control risk
- the sink in the laundry was being used by the cleaners to empty and fill their cleaning buckets posing a risk of infection
- a raised electrical socket was noted in the middle of the kitchen floor posing a risk of falls.

There was no comprehensive training records maintained to show what training had been provided therefore it was difficult to ascertain if all staff had received mandatory training or not. The provider stated that the certificates for training were maintained in individual staff files. Staff files were checked and showed that not all staff had received up to date moving and handling training. It was also unclear from the certificates what the qualifications of the person delivering the course were and there were no details of the course content. However, staff were observed employing safe moving and handling techniques and were knowledgeable when discussing techniques with inspectors.

There was a fire policy and emergency plan in place. The emergency plan was inadequate as it did not provide specific guidance on electrical failure, heating failure, disruption to water supply and other such emergencies. The plan did not identify a suitable location to evacuate residents to in the event of an emergency.

Not all staff had attended mandatory fire training including evacuation procedures. Fire drills carried out consisted of a simulated evacuation but did not include setting off the fire alarm and assessing the response. Some staff were knowledgeable on the procedures to be followed in the case of a fire. However, recently recruited staff were not. Inspectors read the service records which showed that the fire alarm system was serviced on a three monthly basis and the emergency lighting and fire equipment on a yearly basis. In house fire safety checks were required to be carried out. However, this was not done on a consistent basis. One nurse was scheduled on night duty the week following inspection but she had not received any fire training. The provider gave an undertaking that fire training scheduled for April would be brought forward and no staff member would be rostered on night duty until fire training was provided.

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
Although inspectors found some evidence of good medication management practices they were concerned that some practices could pose a risk.

Inspectors read the medication management policy and found that it did not contain sufficient guidance on areas such as anti coagulation therapy, the prescribing of 'as required' (PRN) medications, self medication, management and reporting of adverse effects, medication errors and auditing. Inspectors observed staff administering medication and noted that this was generally in line with An Bord Altranais guidelines.

Inspectors carried out a review of medication practices and found that:

- some of the medications on the prescription charts including discontinued medications were not signed and dated by the general practitioner (GP)
- the maximum dose of PRN medications to be administered in 24 hours was not stated on the prescription charts
- nutritional supplements were not prescribed by the GP
- medications which required to be crushed were not prescribed by the GP
- nurses transcribed medications and there was a policy in place to guide practice. The policy stated that transcribed medications should be signed by the transcribing nurse and witnessed and signed by the second nurse. This was not being done, only the transcribing nurse signed
- the GP did not check and sign transcribed medications in a timely manner increasing the risk of error
- the temperature of the medication fridge was not checked and recorded on a daily basis

- inspectors saw medications stored in the fridge and noted that the fridge was unsecured in that it was unlocked and located in an open store room. The fridge was also used to store products other than medications
- three residents were self medicating. However, there was no assessment carried out on these residents to ensure it was safe for them to self administer their medications. The nurse described clearly how the residents were supervised and monitored in relation to self medication but there was no documentation to support this
- there was no signature sheet available, the provider subsequently located one in her office however it had not been updated to reflect staff leaving and new staff being recruited.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1982. Nurses kept a register of MDAs. Two nurses signed and dated the register on administration of MDAs during weekdays however at weekends and out of hours only the one nurse on duty checked and signed the balance which posed a risk. The medication policy did not provide any guidance to staff on this issue. This was discussed with the provider and person in charge. They undertook to update their policy to ensure it provided guidance to staff on this issue. The MDA stock balance was checked and signed by two nurses at the change of each shift.

The provider had submitted to the Authority in advance of this inspection a training schedule for 2011 which indicated that refresher medication management training was provided in May and June 2011. However, there was no records of who had actually attended this training therefore it was unclear if all nurses had received refresher training or not.

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
The inspectors were concerned that the care delivered to residents was not evidence-based and of a high standard. Improvements were also required around the provision of meaningful engagement for all residents.

Medical services were provided by a local GP service. While resident's medications were signed by the GP on a three-monthly basis following nurse transcribing there was no evidence that residents had a medical review carried out or their medications comprehensively reviewed on a planned regular basis. Residents were reviewed as and when they became ill or their condition altered. There was no record of a medical review, on or since admission, for one resident admitted to the centre three weeks previously.

Staff told inspectors that residents had limited access to allied health professionals. A physiotherapist visited once a week for one hour to provide a group session. She was available for referrals by the GP if required. Other peripatetic services such as speech and language therapy (SALT) were available on a referral basis by the GP but staff said that this service was not always provided even with a referral. The provider had not investigated access to private SALT services. However, one nurse was qualified to carry out swallow assessments on residents. Ophthalmology and chiropody services were available and records of referrals were maintained. Dietetic advice was available from the acute hospital by telephone only. Occupational therapy (OT) was not easily accessible and again the provider had not investigated access to a private OT service if required. Inspectors questioned staff about one resident who appeared

to be seated very uncomfortably in her chair and falling to one side. This resident had not been referred for a seating assessment.

Inspectors reviewed the files of a number of residents including the files of residents with wounds, at risk of falls, those nutritionally compromised and residents at end of life. There were inconsistencies in the nursing documentation, for example in some files there was a summary nursing assessment while in others there was no nursing assessment undertaken. The summary assessment provided very little information and related mainly to biographical information. It was not a comprehensive nursing assessment of needs.

Risk assessments were not consistently completed and those that were completed were not updated and so were not current to inform a care plan. Some residents had falls risk assessment completed but it was not always updated following a fall and any outcomes or measures put in place were not documented. Residents who had a fall were not routinely referred to the GP for review, instead the GP recorded a medical note the next time he visited the centre. In one instance this was over three weeks after a resident had a fall.

Inspectors found that while a number of residents had some care plans in place, other residents had no care plans in place. The care plans that were in place were inconsistent in that some were well detailed while others provided very little information to guide care. For some residents there was an absence of care plans for specific needs such as falls and nutrition. Residents were unaware of their care plan and there was no evidence to show that residents and relatives were involved in discussions around their care.

Residents at risk of malnutrition were not managed appropriately. There was a nutrition policy in place which was very detailed and recommended the use of an assessment tool on admission to assess risk. Inspectors noted that resident's weights were not recorded on a consistent and regular basis. As a result inspectors found it difficult to determine whether any residents had any significant weight loss. For example, the person in charge said she was concerned about one resident who was loosing weight. However, this resident's weight was not recorded on or since admission. There was no nutritional assessment completed for this resident and no care plan in place.

Practice in relation to the use of restraint required improvement. The person in charge told inspectors that approximately six residents were using bedrails and some recliner chairs were in use. The files of residents using restraint were reviewed. Chemical restraint was also in use and documented on a restraint consent form maintained in the residents' files. A policy was in place but it did not guide practice. For example, contrary to the policy there was no assessment or care plan in place for the use of restraint and no evidence that alternatives had been considered. Consent for the use of restraint was maintained on residents' files but some were not completed and some were not signed by the resident or relative to show consultation.

At the time of inspection there were four residents with wounds. Inspectors reviewed some of the files. There was a wound assessment chart in place which recorded detailed information relating to the wound including the measurements. However, this was not completed at every dressing change and so it was difficult to track the progress of the wound. A care plan was in place for wound management which was detailed and provided guidance to staff. There was also a wound progress plan in place which noted general changes at the time of dressing change but again contained insufficient detail to allow staff to track the progress of the wound. Inspectors noted that one resident who had developed multiple pressure ulcers was not referred to dietetics or a tissue viability nurse (TVN). He was on a pressure relieving mattress but the mattress was set at the maximum level and not set in accordance with his most recent weight record. This resident's weight was also not recorded regularly and staff questioned were not sure how to set the pressure relieving mattresses correctly.

There was a policy in place for the management of behaviour that challenged which was detailed and comprehensive. The person in charge stated there were no residents in the centre presenting with behaviour that challenged. The inspectors did not observe any resident with behaviour that challenged.

The daily nursing notes were comprehensively recorded giving clear information about the residents' current condition and care needs.

There was an activities coordinator employed for six afternoons each week including weekends. She had developed an activities programme which included singing, bingo and art. While activities were scheduled for the afternoons, during the morning time there was no evidence of any activity going on for residents except for the television. The programmes being shown were not age appropriate for the residents. Staff appeared to be very busy in the morning and a student on work experience was allocated to supervise the residents in the day room. While it was noted she sat and supervised the residents there was no provision of any meaningful stimulation or interaction. Inspectors found that further improvements were required in providing opportunities for meaningful engagement for residents with cognitive impairment and those highly dependent. Some residents were immobile and in bed, staff were noted to interact and visit these residents but this was limited and only at times of the day when staff were not too busy. There was no evidence that these residents were included in any planned meaningful engagement.

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 was a policy on end-of-life care which was read by the inspectors. The policy was detailed and comprehensive. However, there was no evidence that it informed practices. The policy included guidelines for involving the resident and their family in planning the end of life care. However, one resident who was receiving end of life care at the time of inspection did not have an end-of-life care plan developed.

There was access to the local palliative care team if required and one nurse was trained in the use of syringe drivers for the management and treatment of pain and other related symptoms.

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
Inspectors were satisfied that residents mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff. Inspectors observed residents having lunch. Some residents had their meals in the dining room while others chose to take their meals in the sitting room or in their bedrooms. This choice was facilitated by staff. The dining room was nicely laid out with groups of up to four residents at each table. Residents could choose to use napkins or bibs. There was a choice of meals and the menu was written up daily on a blackboard. Staff provided assistance where needed. Residents who required their meal to be mashed or pureed had their meal presented in an appetising way with the different elements in separate portions. Inspectors also observed residents who choose to have their meals separately being assisted and supported appropriately and in a timely manner. Residents were offered drinks regularly, and told inspectors that they could have snacks or drinks outside of mealtimes, whenever they asked for them.

Inspectors visited the kitchen and spoke with the cook. The kitchen was well-equipped and had a plentiful supply of fresh and frozen foods. The cook knew the residents well and had information on almost all residents' special dietary requirements. However, the dietary requirements of one resident admitted recently was not documented and available in the kitchen.

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
Inspectors read a sample of completed contracts and noted that they complied with the Regulations. They contained details of the services provided and the fees to be charged.

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.

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

Inspection findings
Inspectors noted during the inspection that while generally residents' privacy and dignity were respected some improvements were required. Inspectors saw some bedroom doors propped open with residents lying on their beds uncovered while waiting for assistance.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for permission to enter. Inspectors observed staff interacting with residents in a courteous and friendly manner and addressing them by their preferred name. Inspectors also heard good humoured banter which some residents were enjoying.

Mass took place every two to three weeks, some residents went out to mass weekly in the local church. The person in charge said that residents from all religious denominations were supported to practice their religious beliefs.

A residents' committee had been established. However, the meetings were held infrequently and not on a regular planned basis. The last meeting was in February 2012 but the previous meetings were in August 2011 and October 2010. Inspectors read the minutes of these meetings and noted that some suggestions had been made by residents relating to food choices which were facilitated.

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
Standard 17: Autonomy and Independence

Inspection findings
Residents and relatives expressed satisfaction with the laundry service provided and the safe return of their clothes to them. The laundry room was spacious and equipped with domestic washing machines and dryer. The care assistants were responsible for doing the laundry and the cleaner also did some laundry duties. They were generally knowledgeable about the different processes for different categories of laundry. The clothes were sorted after laundering and brought back to each resident's room. Adequate storage space was provided.

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
During this inspection the inspectors were informed of a change to the person in charge. The previous person in charge had resigned and the current person in charge had commenced in the post two days previously. The new person in charge had worked in the centre for many years and was familiar with the staff and residents. A fit person interview was not carried out as the person in charge requested it to be arranged at a later date.

The inspectors met with the person in charge and discussed the needs of the residents and other clinical issues. She was confident in her responses and acknowledged the substantial improvements that were now required in order to be compliant with the Regulations. She stated she aimed to prioritise the clinical and environmental risk issues to be addressed. She was full time in the post and had the required qualifications and clinical experience for the post. However, she acknowledged that she had not undertaken continuous professional development in the last number of years and would be focussing on this area in her new post.

The provider had not notified the Chief Inspector of this change in management as required by the Regulations. The provider was informed of her legal obligation to notify the Chief Inspector however this notification had still not been received by the Authority.

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
Inspectors had concerns that given the dependency levels of the residents and the lay out of the building with residents' accommodation over two floors there were insufficient staff on duty to supervise and deliver the care to residents. This was an issue identified at previous inspections and as yet there had been no comprehensive review of the nursing hours required in order to determine the staffing levels and skill mix. Residents' dependency levels did not inform the roster. The inspectors reviewed the roster against the actual staff on duty. On average there was one nurse and two care assistants on duty from 8.00 am to 8.00 pm during the day to care for up to thirty residents. There was one nurse and one care assistant on duty at night time.

Inspectors requested information from the provider on the proposed increase in staffing levels and skill mix if the conditions attached to registration were removed and resident numbers could be increased. This information was not available and has not been submitted since.

The Authority had received written confirmation from the provider on 12 August 2011 following the previous inspection stating that an additional care assistant was employed permanently from 8.30 am to 12.30 pm and from 7.00 pm to 10.30 pm daily. However, inspectors noted at this inspection that this was not the case. An additional care assistant was employed from 8.00 pm to 10.00 pm each evening to provide additional supervision to residents. The provider, roster and staff confirmed this and staff stated that while this was of some benefit to the residents they were still very busy at times during the day. They said that residents had to be returned to bed early and they did not have time to read the policies and practices or to update nursing documentation due to the workload. Care assistants also carried out laundry duties during the day and at night time. This work was substantial as all residents clothing was laundered on site as well as towels and blankets. Inspectors reviewed the minutes of a staff meeting held in February 2012 which showed that staff had raised the issue of the heavy workload stating that it 'was difficult to get everything done', the providers response was to reduce staff break times.

Supervision of residents at times was poor and posed a risk. Inspectors noted one resident at a dining room table with a cup of tea mid-morning. There was no staff member in the area to supervise. The resident had fallen asleep while holding the cup and as a result spilt the tea on himself. The tea was not hot, but the potential for serious injury was evident.

The roster did not accurately reflect the hours of some staff members. For example, the roster did not specify the hours worked by the activities coordinator. This person also covered the 8.00 pm to 10.00 pm shift in the evenings but this was not recorded on the roster. The accountant was not on the roster despite being employed in the centre three days per week. Another staff member was recorded in the roster as working a 'full week' but the hours or days worked were not recorded.

Inspectors read the recruitment policy and found that it was adequate and contained all of the requirements as set out in the Regulations. Inspectors read a sample of personnel files for staff and noted they did not meet the requirements of the Regulations or the centres policy. For example, in some there was no evidence of physical or mental fitness while in others Garda Síochána vetting was not available. This was discussed with the provider who stated Garda Síochána vetting had been applied for all staff and she showed inspectors evidence of this. Some files did not have photo ID. Not all nurses had evidence of up to date registration with their professional body.

Staff were knowledgeable about residents, had established a good relationship with them and inspectors saw them responding to residents' needs in an informed way. Staff were clear about their roles and responsibilities and were able to explain these to inspectors.

A staff appraisal system had been introduced but had not been carried out on all staff. The appraisals that were completed were reviewed by inspectors. The information was very limited and it was not clear from the form what the purpose of the appraisal was. For example there was nothing to indicate that training and development needs were discussed or identified.

The provider had not prioritised staff training as a means of ensuring contemporary evidence-based practice and a high quality of care. Inspectors requested details of training provided to staff. The provider stated that a training schedule for 2011 had been previously submitted to the Authority, she was unable to locate this schedule on the day of inspection. Instead she showed the inspectors a list of training provided in 2011. It stated that three care assistants had completed the Further Education and Training Awards Council (FETAC) Level 5 training. Medication management was provided in May 2011. It stated a DVD and workbook on elder abuse was given to staff in January 2011 and a DVD on dementia was watched in January 2011, no other details were provided. There was no arrangement to provide FETAC training for the remaining care assistants. The inspectors reviewed the training schedule submitted following the previous inspection and noted it to be at variance with the list provided on the day of inspection. For example, the schedule did not show that a DVD on dementia was given to staff nor was a DVD on elder abuse shown in January 2011, instead it was recorded as being shown in March 2011. Both documents did not indicate how many or which staff had attended training and there was no details of any training taking place in the latter half of 2011 to date. There was no schedule of training available for 2012.

Staff meetings were held and minutes recorded. However, they were infrequent and not regularly planned. The last staff meeting was held in February 2012 while the previous meeting was in September 2011.

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

Some general improvements were required to the premises. The premises were purpose built and bright and spacious throughout. Bedroom accommodation was generally spacious and well designed to meet the residents' needs for leisure and comfort. There were adequate en suite shower and toilet facilities. Bedrooms had specialised beds, call bell facilities and adequate personal storage space. They were personalised with residents' own personal items.

There was appropriate assistive equipment available such as hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. Inspectors noted that one wheel was broken on the hoist and while it was still working it was very difficult to manoeuvre when a resident was on the hoist and being transferred. The provider stated that a replacement wheel was on order and the hoist would be

repaired shortly. The corridors were wide and enabled easy accessibility for residents in wheelchairs or those with mobility aids. Hand rails were available to promote independence. Records showed that the lift was serviced on an annual basis and repaired quickly in the event of breakdown. The records of servicing for assistive equipment was reviewed by inspectors and generally found to be up-to-date. However, the boiler had been recently serviced but the credentials of the service contractor was not evident. The information did not clearly indicate if the contractor was qualified and accredited or not.

Storage facilities were inadequate. Inspectors noted assistive equipment, continence supplies and general equipment stored inappropriately in corridors, under stairs, in open areas at the top of stairs, in the laundry room and sluice rooms. Equipment was also stored in the oratory and the main sitting room on the first floor which meant these rooms could not be used by residents. Storage of equipment and general items was unsafe, haphazard and disorganised.

The kitchen facility was bright and clean. It was found to be well organised and equipped with sufficient storage facilities. Inspectors observed a plentiful supply of fresh and frozen food.

The communal areas in use on the ground floor were spacious and had strong natural light. Residents could choose the seating areas which suited them best.

Sluice rooms were equipped with bedpan washers and a macerator. Laundry facilities were available as discussed under Outcome 12.

Inspectors visited the smoking room as ventilation was an issue at previous inspections. The window was open and a vent was noted to be installed but the room was still very poorly ventilated. Inspectors noted two hairdressing sinks in the room and staff confirmed that the room was also being used for hairdressing. This was not an appropriate environment for hairdressing.

Training had not been provided to staff in infection control and as well as the risks identified under Outcome 5 inspectors also identified additional improvements required in relation to infection control. The system for segregating mops for use in different areas of the building to prevent cross infection was inadequate. There was no clear colour coding system and staff had difficulty identifying which mop was to be used for specific areas. The communal and bedroom accommodation used by residents was kept clean. However, the areas currently unoccupied were not maintained clean. Inspectors noted water damaged ceilings on the first floor and dampness on walls and ceilings on both floors.

Arrangements were in place for the segregation and disposal of waste, including clinical waste. Staff had access to supplies of latex gloves and disposable aprons and they were observed using the alcohol hand gels which were available throughout the centre.

There was still no safe and secure garden accessible to residents.

7. Records and documentation to kept at a designated centre

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).

References:
Part 6: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings
Inspectors reviewed the general records in the centre and noted improvements required.

The Residents' Guide was available and up to date. The directory of residents was up to date and contained all the information required by the Regulations. Records were stored securely.

Nursing and medical information on residents were maintained in a number of files which made it difficult to locate and access the information. Staff files were disorganised and information required by the Regulations were stored in various locations again making information difficult to access.

All of the operating policies and procedures as listed in Schedule 5 of the Regulations available had been developed by an outside company and adapted for local use. However, as previously stated staff said they did not have time to read these policies due to the workload. Not all policies reflected practices in the centre and there was no system in place to indicate staff had read and understood the policies.

Adequate insurance cover was available.

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
Practice in relation to notifications of incidents was not satisfactory.

Quarterly notifications had been received and the person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents but she had failed to notify the Chief Inspector in relation to wounds of Grade 2 and upwards.

Some residents had pressure ulcers at the time of inspection, while the grade of the ulcers was not documented it was clear from the assessments and nursing documentation that some of these wounds were grade two or higher and these had not been notified to the Chief Inspector.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed 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 provider was aware of her responsibility to notify the Authority. However, the Authority had not been informed of the resignation of the person in charge and the new arrangements in place for the management of the centre.

Closing the visit

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

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

Report compiled by:

Fiona Whyte

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

16 March 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Owen Riff Nursing Home
Centre ID:	0375
Date of inspection:	14 March 2012
Date of response:	10 April 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 1: Statement of purpose and quality management

1. The provider is failing to comply with a regulatory requirement in the following respect: The statement of purpose required updating to meet the requirements of the Regulations. The updated statement of purpose has not as yet been received by the Authority.
Action required: Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.
Action required: Make a copy of the statement of purpose available to the Chief Inspector.

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

Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Statement of purpose has been revised.	 15/02/2012

Outcome 2: Reviewing and improving the quality and safety of care

2. The provider is failing to comply with a regulatory requirement in the following respect: Systems were not in place to gather and audit information to identify possible trends for the purpose of improving the quality of service and safety of residents. There was no process for reviewing information as a result of accidents/incidents, adverse events or medication error therefore there was no learning or improvements in the quality of service and safety of residents.	
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.	
Action required: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.	
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have an extensive policy and procedures practice in place for improving the quality and safety of care to the residents which is updated regularly in accordance with the residents individual care plans. This policy was first drawn up in March 2010 and is regularly reviewed.	

Outcome 4: Safeguarding and safety

3. The provider is failing to comply with a regulatory requirement in the following respect: The centre's policy on the prevention, detection and response to elder abuse was inadequate and did not provide guidance to staff. Not all staff had received training in the prevention and detection of elder abuse.
Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.
Action required: 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: Policy has been in place and reviewed also an elder abuse DVD supplied by the HSE has been viewed by all members of staff. Residents care plans reviewed monthly and more frequently if required. Staff can at all times review with the person-in-charge any queries that might arise to do with elder abuse, which is extensively covered in our safe environment policy folder book located in the Nurse's station at all time and ready available to every member of staff.	Completed

Outcome 5: Health and safety and risk management

4. The provider is failing to comply with a regulatory requirement in the following respect: Practices in relation to the health and safety and the management of risk did not promote the safety of residents, staff and visitors. The risk management policy did not identify the specific environmental risks associated with this centre.

A number of serious risks were identified as outlined under Outcome 5 in the report and the provider was required to take action.

There was no comprehensive training records maintained to show what training had been provided. Not all staff had received up to date moving and handling training. It was also unclear from the certificates what the qualifications of the person delivering the course were and there were no details of the course content.

The emergency plan was inadequate as it did not provide specific guidance on electrical failure, heating failure, disruption to water supply and other such emergencies. The plan did not identify a suitable location to evacuate residents to in the event of an emergency.

Not all staff had attended mandatory fire training including evacuation procedures. Fire drills did not include setting off the fire alarm and assessing the response. Some staff were not knowledgeable on the procedures to be followed in the case of a fire. In house fire safety checks were required to be carried out however this was not done on a consistent basis.

Action required:

Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

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.

Action required:

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

Action required:

Put in place an emergency plan for responding to emergencies.

Action required:

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

Action required: Provide training for staff in the moving and handling of residents.	
Action required: Provide suitable training for staff in fire prevention.	
Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.	
Action required: Provide sufficient numbers of wash-hand basins fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.	
Reference: Health Act, 2007 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	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. Policies and procedures relating to Health and Safety are in place, food safety has been implemented to cover residents, staff and visitors and will be added into the files. 2. Risk Management has already been commenced with a project supervisor overseeing procedures throughout the designated centres. 3. There is already an extensive policy and procedure on assault and aggression, violence and self harm, It is inclusive of resident and staff but will always be updated and reviewed accordingly. 4. The policies cover identification, recoding, investigation. A audit of incidents will be recorded. 5. There is an extensive policy already in place on emergency procedures which has been updated to include evacuation of building to a designated centre which is our local community hall. 6. Point 6 covered in Point 2.	15/05/2012

7. All staff trained in moving and handling except for one new member of staff which she will have done by first week in May. 8. This point was covered in Correction of factual inaccuracies. 9. The project supervisor is in the process of sourcing means to resolve this problem.	

Outcome 6: Medication management

5. The provider is failing to comply with a regulatory requirement in the following respect: The medication management policy did not contain sufficient guidance on all areas. Medication management practices posed a serious risk to residents as outlined under outcome 6 in the report. Practice in relation to medications that required strict control measures (MDAs) posed a risk. There was no evidence that all nurses had received refresher medication management training.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Action required: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out-of-date medicines and ensure staff are familiar with such procedures and policies.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: The new person in charge took responsibility of her duties on 12 March 2012, two days prior of inspection and is in the process of revising medication policy in conjunction with the local GP and Pharmacy and also nursing staff. This point has already been dealt in the factual inaccuracies. There is a book which is kept for the pharmacy for orders been placed and all prescriptions are faxed directly to the pharmacy and then handed to the Pharmacist on delivery. A written operation policy is in place relating to the ordering, prescribing, storing and administration of medicines to the residents and staff nurses are aware of such procedures and policies. At the nurses station there is a log book for return of out of date drugs which is signed by the RGN and the Pharmacist.	Completed

Outcome 7: Health and social care needs

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

The care delivered to residents was not evidence-based and of a high standard. The provision of meaningful engagement for all residents was inadequate.

Residents were not medically reviewed on a regular planned basis.

There was limited access to allied health professionals.

There were inconsistencies in the nursing documentation. There was no comprehensive nursing assessment of needs. Risk assessments were not consistently completed and those that were completed were not updated.

Some residents had no care plans in place for specific needs and the care plans that were in place provided very little information to guide care.

Residents at risk of malnutrition were not managed appropriately.

Practice in relation to the use of restraint required improvement. There was no assessment or care plan in place for the use of restraint and no evidence that alternatives had been considered.

Wound management required improvement.

The provision of meaningful activities for all residents including those that were cognitively impaired or highly dependent required improvement.

Action required:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Action required:

Provide a high standard of evidence-based nursing practice.

Action required:

Maintain, in a safe and accessible place, a record of the medical, nursing and where appropriate, psychiatric condition in respect of each resident at the time of admission.

Action required:

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

Action required:

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

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 three-monthly intervals.

Action required:

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

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 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 25: Medical Records
Standard 13: Healthcare
Standard 11: The Resident's Care Plan

Standard 10: Assessment Standard 13: Health Care Standard 18: Routines and Expectations Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Part of this point has already been dealt with in Factual inaccuracies. The new person in charge had already identified herself before the date of inspection, care plans were already in the process of being reviewed and will be reviewed monthly. The restraint policy is already in place in our Health and Lifestyle Manual and is extensive and covers all your major points and as stated above care plans are ongoing and will be reviewed monthly. A save and an accessible place is already been maintained in the nursing station within a locked filing cabinet which is regularly updated.	

Outcome 8: End of life care

7. The provider is failing to comply with a regulatory requirement in the following respect: The policy on end-of-life care did not inform practices.
Action required: Provide appropriate care and comfort to each resident approaching end of life to address his/her physical, emotional, psychological and spiritual needs.
Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The policy has been reviewed and updated.	26/03/2012

Outcome 11: Residents' rights, dignity and consultation

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

The privacy and dignity of some residents was not upheld.

Residents meetings were held infrequently and not on a regular planned basis.

Action required:

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

Action required:

Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.

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: Dealt with this in factual inaccuracies.	

Outcome 14: Suitable staffing

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

There were insufficient staff on duty to supervise and deliver the care to residents.

Supervision of residents at times was poor and posed a risk.

The roster did not accurately reflect the hours of some staff members.

The personnel files for staff did not meet the requirements of the Regulations or the centres policy.

A staff appraisal system had been introduced but had not been carried out on all staff and was not comprehensively completed.

Staff education and training was not prioritised as a means of ensuring contemporary evidence based practice and a high quality of care. There was no schedule of training available for 2012. Staff meetings were held and minutes recorded. However, they were infrequent and not regularly planned.
Action required: Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.
Action required: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.
Action required: Supervise all staff members on an appropriate basis pertinent to their role.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.
Reference: Health Act, 2007 Regulation 16: Staffing Regulation 17: Training and Staff Development Regulation 18: Recruitment Standard 23: Staffing Levels and Qualifications Standard 24: Training and Supervision Standards 22: Recruitment

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

Provider's response: The rota has been revised and reviewed to show the working hours of all staff. All Personal files have been updated including new staff. Schedule of training for 2012 has been included in SOP which you have already received. Staff members are supervised and their roles are documented in our staff handbook available to all members of staff. The new person in charge is going to do her fit person programme and has already completed a medical for both mental and physical well being which she has already received by yourselves, The provider completed her programme in 2010 all other staff have given a declaration of mental and physical well being in accordance with Schedule 2 Section 10 of the Health Act.	Completed

Outcome 15: Safe and suitable premises

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

General improvements were required to the premises.

Some areas not in use were not clean and well maintained.

There was water damage to ceilings and walls on all both floors.

Assistive equipment was not maintained in good working order, one wheel was broken on the hoist and it was very difficult to manoeuvre when a resident was on the hoist and being transferred.

Storage facilities for all equipments and supplies were inadequate.

The smoking room had inadequate ventilation. The room was also being used for hairdressing. This was not an appropriate environment for hairdressing.

Training had not been provided to staff in infection control and systems in place were inadequate to prevent cross contamination.

There was still no safe and secure garden accessible to 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: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.	
Action required: Maintain the equipment for use by residents or people who work at the designated centre in good working order.	
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: 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 19: Premises Regulation 17: Training and Staff Development Standard 25: Physical Environment Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The project supervisor is in the process of bringing the maintenance works up to date both internal and external. Depending on the environment climate works will be carried out throughout the summer months. Areas that are not in use are thoroughly cleaned and maintained before any of the areas are inhabited by residents. As explained on the day a wheel has been ordered for one of the hoist and we are awaiting delivery this was explained verbally on the day. Storage has been sorted.	31/08/2012

The situation with the smoking room and hairdressing has been dealt with in the factual inaccuracies. Infection control systems are in place and will be reviewed regularly with all staff members at in house training sessions as the new person in charge is undertaking a course in how to train the trainer. The training course commences the end of April and runs for six weeks. The ventilation in smoking room will be addressed with all internal works and there is always more than adequate heating and lighting in this centre.	

Outcome 16: Records and documentation to be kept at a designated centre

11. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: Files were disorganised and information on residents and staff were maintained in a number of files which made it difficult to locate and access the information. Not all policies reflected practices in the centre and there was no system in place to indicate staff had read and understood the policies.	
Action required: Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.	
Action required: Make staff members aware, commensurate with their role, of the provisions of the Health Act 2007, the Regulations, the statement of purpose and any policies and procedures dealing with the general welfare and protection of residents.	
Reference: Health Act, 2007 Regulation 22: Maintenance of Records Regulation 17: Training and Staff Development Standard 32: Register and Residents' Records Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: The new person in charge is in the process of collating all files on residents both care plans and personal files and will have completed and updated monthly. All staff will be made aware of the Health Act 2007 and its update of 2009.	01/06/2012

Outcome 17: Notification of incidents

12. The person in charge is failing to comply with a regulatory requirement in the following respect: Practice in relation to notifications of incidents was not satisfactory. The person in charge had failed to notify the Chief Inspector in relation to wounds grade two and upwards.	
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.	
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems Standard 30: Quality Assurance and Continuous Improvement Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Dealt with in non factual inaccuracies and incidents logs not due till 30 April 2012.	

Outcome 18: Absence of the person in charge

13. The provider is failing to comply with a regulatory requirement in the following respect: The Authority had not been informed of the resignation of the person in charge and the new arrangements in place for the management of the centre.
Action required: Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

Action required: Give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the matters contained in Regulation 38(2).	
Reference: Health Act 2007 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	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The provider has written to the chief inspector regarding the change to the person in charge.	Completed

Any comments the provider may wish to make:

Provider's response:

We wish to express our thanks to the two inspectors who came to our premises. However, we do feel that in some places of the draft report there are contradictory statements which we did address in factual inaccuracies and also we feel that some of the comments made were taken out of context and not giving a true reflection of our centre especially comments made concerning break-time and staffing inadequacy.

Provider's name: Theresa O'Toole