Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007, as amended

Centre name:	Parke House Nursing Home
Centre ID:	0083
Centre address:	Kilcock Co Kildare
Telephone number:	01 6103585
Email address:	parkehousenh@gmail.com
Type of centre:	☐ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Parke House Nursing Home Ltd
Person authorised to act on behalf of the provider:	Alan Shaw
Person in charge:	Judy Glennon
Date of inspection:	9 and 10 April 2013
Time inspection took place:	**Day-1 Start:** 09:30 hrs **Completion:** 18:50 hrs **Day-2 Start:** 07:30 hrs **Completion:** 18:30 hrs
Lead inspector:	Linda Moore
Support inspector(s):	Marian Delaney Hynes
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	64 + 1 in hospital
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Summary of compliance with 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*.

This inspection report sets out the findings of a monitoring inspection, in which 11 of the 18 outcomes were inspected against. The purpose of the inspection was:

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

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

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

This monitoring inspection was unannounced and took place over two days. As part of the monitoring 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.

Inspectors found that there were 64 residents in the centre and one in hospital on the day of the inspection. These included 18 residents in the special care unit. Six of the residents had been transferred to the centre from mental health services.

On the first day of inspection, inspectors found that there was a significant number of areas of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). In particular the provider and person in charge were required to take immediate action to address the following risks to residents:

- there was inadequate supervision of residents in the special care unit
- residents received incorrect modified consistency diets and the positioning of residents at meal times placed residents at risk of choking
- poor medication management practices
- poor management of smoking risks
- poor restraint management.

These issues were discussed with the provider and person in charge and all areas apart from issues relating to the restraint practices and smoking risk were addressed prior to the end of the inspection. They had commenced addressing the remaining issues.

On the second day of inspection, inspectors again found further areas of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and in particular required the provider and person in charge to take immediate action to address the following risks to residents:

- residents were not being adequately protected from the risk of harm by some residents who had behaviour that challenged
- care arrangements for residents at risk of weight loss and epilepsy were not adequate
- the use of restraint was not being adequately managed to ensure the safety of residents
- risk issues associated with residents smoking had not been addressed.

An immediate action plan was issued to the provider on 11 April 2013.

Inspectors found that the provider and the person in charge had not addressed the areas of non-compliance that had been identified on the previous inspection. These related to restraint management, verification of references for staff and screening in shared bedrooms to ensure privacy for residents.

These items are discussed in the body of the report and are included in the Action Plan at the end of this report.

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

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

Theme: Leadership, Governance and Management

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

Outcome 2

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

References:

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors found that each long-term care resident in the centre did have an agreed written contract.

However, while there were service level agreements in place for short stay residents, they did not meet the requirements of the Regulations in relation to contracts of care. They did not include all of the details of the services to be provided or the fees to be charged.

Outcome 3

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

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors found that while there was a person in charge of the centre the governance arrangements were not satisfactory.

The person in charge was a registered nurse and met the criteria set out in the Regulations. While she worked full-time in the centre she was not full-time in the post of person in charge as she also provided front line nursing duties. As a result inspectors were concerned that she had not managed the service effectively. Inspectors identified non compliances in the areas of clinical leadership as outlined in Outcome 11 and insufficient staffing arrangements as outlined in Outcome 18.

Following the first day of inspection, the person in charge informed the Authority that there was an additional nurse appointed to relieve her from front line nursing duties so that she could fully engage in the role of person in charge.

The arrangements for cover in the absence of the person in charge were not sufficient. While there was a clinical nurse manager (CNM) appointed to deputise in the absence of the person in charge she was involved in delivering care to residents and did not have a role in managing the centre in the absence of the person in charge. Inspectors found that the provider had failed to ensure the arrangements provided sufficient oversight of key areas such as medication management.

While the person in charge had attended various seminars relating to her role, inspectors were not satisfied that the person in charge had effectively disseminated and implemented learning to ensure a high standard of nursing practice.

Theme: Safe care and support
Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

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

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The provider and person in charge had not taken sufficient measures to protect all residents from being harmed and from suffering abuse.

The management of residents with behaviour that challenged was not effective and did not protect other residents from harm. The incidents of these behaviours were impacting significantly on the safety of residents and staff. Residents and staff expressed their fear of these residents' behaviours. The provider was required to take immediate action to address this issue.

Examples of behaviours that challenged included episodes of threatening behaviour, hitting, kicking and other incidents of physical assault. There was a policy on the management of behaviours that challenged but this was not being used to guide the care delivered. Staff told inspectors that they did not feel they had the resources or skills to manage these episodes and to keep other residents safe. Training had not been provided in this area.

Inspectors reviewed the centre's policy on the prevention, detection and response to elder abuse and found that this policy gave guidance to staff on the types of abuse and included the procedures for reporting alleged abuse and the procedures to follow when investigating an allegation of elder abuse. This policy did not include the need to inform the Authority of any allegation, suspected or confirmed abuse of any resident.

Inspectors found inconsistency in the records maintained on allegations of abuse. Inspectors found that an allegation of abuse was reported to the person in charge in February 2013. At a meeting with the provider it was clarified that because it was determined that this was a disagreement between two staff members as opposed to abuse, records had not been maintained. He confirmed that records should have been maintained and would be maintained into the future. Appropriate interventions were taken in relation to this staff issue. There had been a further allegation in March 2013 and records indicated that this allegation had been responded to appropriately.

The provider had failed to report the February 2013 allegation of abuse to the Authority, as required by the Regulations.

Inspectors found that there was a system in place to manage residents' finances but this was not adequate, in that residents could not access their money at the weekend. The balances reviewed by inspectors were correct.

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

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Significant improvements were required in risk management and fire safety.

In addition to the risks discussed under Outcome 6, further risks were also identified in the following areas and the provider was required to take immediate action to address these:

- adequate risk assessments had not been implemented for residents who smoked to ensure their safety, even though there had already been a fire related incident. There was inadequate supervision for residents who smoked and some flammable materials were stored in the smoking rooms. There had been a fire in an ashtray bin in February 2013 and there were no additional control measures in place to minimise the risk of a reoccurrence and keep residents safe. Adequate risk assessments had not been undertaken for residents who smoked to ensure their safety
- the kitchenette was open and there was easy access to the hot water boiler which was a particular risk to residents who were cognitively impaired. This was discussed with the provider and was addressed during the inspection
- staff, including laundry staff were not sufficiently aware of the infection control status of residents which increased the risk of cross infection.

Inspectors found that there was insufficient understanding of risk by the provider, person in charge and staff. While there was a risk register in place, it was not kept up to date and did not include all risks in the centre.

There was a risk management policy dated December 2010, this did not reflect the current risk management arrangements in the centre. For example, new risk management, health and safety and clinical governance committees had been established but were not referred to in the policy. Inspectors read the minutes of the meetings and found that these committees were not yet effective in managing risks. All clinical and non-clinical risks were not discussed at these meetings.

The policy did not include the specific risks required by the Regulations including self harm, assault and the arrangements for identification, recording, investigation and learning from serious incidents. The risks associated with assault were not specific to guide staff.

Inspectors read the incident reports from January 2013 and found that the records were incomplete. Inspectors found that not all of the incidents of behaviours that challenged had been recorded. Inspectors found the records were not reliable. While the person in charge stated that she monitored incidents monthly, she had not signed recent reports and there was no evidence in the reports to indicate that she had reviewed them. There was very limited evidence that reviews had been used to improve practices and prevent a similar incident from recurring. For example, one resident had a bruise on his/her forehead, the resident told the inspector that he/she banged it off the bedrail but there was no incident report completed, record of investigation of the incident or evidence of measures taken to prevent reoccurrence.

While there was a system to collect clinical data on residents every week, inspectors found that there was very little evidence that the person in charge and staff responded to residents who had lost significant weight.

There was an emergency plan which identified what to do in the event of emergencies such as lost of power and heat. The plan included contingency arrangements for the evacuation of residents from the building in the event of an emergency.

Inspectors noted that the centre had a sign in book for all visitors to the centre.

Fire safety was well managed apart from managing the risks associated with residents who smoked as already discussed. Inspectors viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire and regular fire drills were carried out by staff at suitable intervals as required by the Regulations. Inspectors viewed the fire records which showed that fire equipment had been regularly serviced. Inspectors found that all fire exits were clear and unobstructed during the inspection. The maintenance staff checked fire exits daily and this was documented.

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

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors found that medication management practices were unsafe, and not in accordance with current professional guidelines and legislation.

Inspectors identified a number of issues in relation to the safe administration of medication. Nurses were signing the administration sheets prior to administering the medications which was unsafe and not in compliance with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) professional guidelines. In addition, inspectors observed medication left on a resident's table during the lunch period which was accessible to all residents and placed them at risk.

Inspectors identified issues with the storage of medication. The clinical room in the special care unit was not locked during the first day of the inspection and residents had potential access to medication in unlocked presses. The provider and person in charge were required to take immediate action on the first day of the inspection to address these risks and inspectors found that these issues had been addressed on day two.

While there was a medication management policy in place, this policy did not guide and inform staff practice. The policy only included procedures for the disposal of medications, the use of crushed medications and medication errors. It did not include the procedures for the prescribing and administration of medications or the recording, safekeeping and management of controlled medication (MDAs).

There was no guidance for nurses on the administration of "as required" (PRN) medication in the medication management policy. Inspectors found that some of these medications were being administered on a routine basis rather than as PRN, and also nurses were not recording the actual dose of PRN medication being administered to one resident.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 9
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Practice in relation to notifications of incidents was not satisfactory. The provider and person in charge were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. However, to date all relevant notifications had not been submitted to the Chief Inspector by the person in charge.

The person in charge had failed to notify the Authority of a grade two pressure sore and an allegation of abuse.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

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

Action required from previous inspection:

A record must be maintained of any occasion on which restraint is used, the nature of the restraint and its duration.

Inspection findings

Inspectors were concerned about the healthcare of some residents. Some aspects of care provision was inadequate and placed the health and well being of residents at risk in the following areas:

- Supervision

Dependant residents were left without support or clinical supervision for periods of time which could place them at risk. This is discussed further under outcome 18.

- Epilepsy care

Staff did not demonstrate competence in the management of residents with epilepsy. Staff were using unsafe practices such as moving residents during a seizure and staff were not trained to manage seizures. There was no policy or procedure to guide staff in the management of epilepsy. Staff gave different descriptions about how they would respond to a seizure should it occur which would place these residents at serious risk of harm. Staff told inspectors about practices such as the movement of residents during seizure activity which were unsafe. There was no comprehensive medical and nursing assessment for any residents who had a diagnosis of epilepsy. There was no care plan or guidance for staff in relation to the management of this medical condition in caring for any resident during and after seizures, responding to any potential complications or for recording of epileptic activity to guide future interventions.

- Restraint

The management of residents using restraint placed them at risk. Appropriate measures had not been put in place for a resident who attempted to get out of the bed with the bedrails in place. Another resident told inspectors that his/her lap belt was too tight and inspectors observed this to be the case. The person in charge was required to loosen the belt. The centre's policy on restraint was not based on the National Policy and had not been fully implemented. Residents were not appropriately assessed for the use of restraints. Inspectors found that the assessment process was not adequate and did not include the risks associated with the restraint or the alternatives tried prior to the use of restraint. Those who used restraint were not being appropriately monitored while using restraint. Staff who completed the assessments had not received training on restraint management and were not familiar with the assessment.The actual restraint in use was not identified on the assessments. One resident was placed in a harness during the day, however, the resident's feet were not supported in the chair. Inspectors also noted that there were no care plans in place for some residents with bed rails, lap belts and recliner chairs.

Inspectors noted that consultation between the GP and residents or their relatives before the use of the restraint measure was recorded on some residents' files but these were not up to date.

- Nutrition

Inspectors noted that there was a system in place to monitor residents' nutritional needs and weight. Residents' weights had been consistently recorded but there were no care plans in place to address identified weight loss. Records showed that some

residents had varying levels of weight loss in the previous month. In discussion with the person in charge she was unable to outline the care that was being delivered to all of these residents. Five of these residents had been referred for review to the dietician and were being reviewed on the day of the inspection. This had been planned prior to the inspection.

Inspectors found that three residents had difficulty swallowing and were at risk of choking when having their meals. These residents had been reviewed by the Speech and Language Therapist (SALT) and recommendations made relating to their seating however the recommendations of the SALT were not being implemented and so these residents were placed at risk. The provider and person in charge were required to take immediate action to address this risk. This had been addressed by the second day of the inspection.

Because of these risks the provider was issued with a written immediate action plan on 11 April 2013.

Inspectors read the policy on falls prevention and management and found that the policy did not adequately guide staff practice. Some interventions had been implemented to minimise the risk of falls such as provision of falls alarms for three residents and increased monitoring of residents every twenty minutes. Care plans that were in place for some residents identified at high risk of falling were not sufficient to guide care provision. Post falls assessment had not been completed, falls diaries were not up to date and residents' care plans were not updated with interventions to reduce the likelihood of reoccurrence.

There were two residents with pressure ulcers in the centre. While appropriate care was being provided to these residents, there were areas that required improvement. Inspectors noted that there was a policy on wound care but this was not guiding staff practice. Staff spoken to were not aware of the classification or grading of pressure ulcers and this was not included in the policy. Wound charts had been completed for residents with wounds. Some staff were not knowledgeable on the use of pressure relieving equipment. Inspectors noted that a resident's pressure relieving mattress had been incorrectly set.

There were some improvements required in the development of care plans. Many care plans were not based on the assessed needs of residents and did not guide practice. Not all care plans had been developed and agreed with residents. Daily nursing notes were inadequate. They generally stated "care as per care plan" and did not provide sufficient information on each resident's health and condition and treatment given as required by the Regulations.

Inspectors found that there was access to medical practitioners. Residents also had access to SALT, dietician and chiropody services.

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

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

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The complaints policy was reviewed and was found to be comprehensive and displayed in a prominent position in the centre. However, it did not fully comply with the requirements of the Regulations. The policy did not include an independent person separate to the nominated person in Regulation 39. While the general manager carried out this role, this was not documented in the policy.

Inspectors reviewed the complaints log and saw that complaints from residents and relatives were documented and there was evidence that all but one complaint were appropriately responded to by the person in charge, to the satisfaction of the complainant. One complainant was not satisfied and there was no record that this was responded too.

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

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The overall management of nutrition required improvement.

Residents' diet sheets being kept in the kitchen listed foods that were not suitable to meet the current special dietary requirements of some residents. Kitchen staff and staff who assisted residents with their meals were not aware of these residents' special dietary requirements.

There was inadequate monitoring of residents at risk nutritionally. Inspectors observed five residents' who had been identified as nutritionally at risk, and noted that they did not eat their meals. The meals were disposed of by staff as opposed to being identified as an issue. While staff said that one resident refused the modified consistency diet, this was not recorded to alert other staff.

Other aspects of mealtimes also required improvement. Some residents were not offered drinks by staff during the meal. Staff placed bibs on residents without first consulting them. There was a loud noise associated with a trolley which held the meals in the special care unit. The provider observed this on day two of the inspection and told inspectors he would address this immediately.

Outcome 16
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

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

Action(s) required from previous inspection:

Adequate screening curtains were not in place at beds in some shared rooms.

Inspection findings

Inspectors found that the systems in place to promote residents' privacy and dignity at times required improvement. Adequate screening curtains were still not in place at beds in some shared rooms. This had been an action from the previous inspection.

Some staff practices were not sensitive to residents' needs. For example, a resident's dignity was compromised when left unattended in a bedroom with the door open. The resident was attending to personal care at the time. This was observed by inspectors on both days of the inspection.

Inspectors noted that some staff were using terminology to address residents which did not promote the dignity and respect of residents.

There was an active residents' forum and advocacy meetings were held regularly within the centre. Inspectors reviewed the minutes of the residents' forum which met monthly and saw that improvements were made to the service based on recommendations from this group. This included purchasing a bird house and a green house. The person in charge chaired the meetings.

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

Outcome 18
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

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

Action(s) required from previous inspection:

Staff references had not been verified nor was there a system in place to do so.

Inspection findings

Inspectors were concerned that nursing levels and skill mix in the special care unit did not meet the assessed needs of residents. Improvements were also required in relation to recruitment of staff.

There were poor supervision arrangements in the special care unit. The nurse from the special care unit was responsible for administering medications and care to residents in this unit and to residents in bedrooms 30 – 40, as well as supervising the general delivery of care to dependent residents. As a result the nurse was away from the special care unit for up to three hours in the day to carry out her additional duties which meant there was no nurse to supervise the delivery of care. Some care staff told inspectors that they were often frightened that residents would have a seizure or be physically aggressive in the nurse's absence and they told inspectors that they felt they were not appropriately supported or trained to deal with these incidents.

Because of the risks identified in the nursing levels and supervision, the provider and person in charge were required to take immediate action. This issue was addressed on day two of the inspection. An additional nurse was allocated to the special care unit and the provider stated that this would be maintained going forward.

The provider did not have robust systems in place for the recruitment, selection and vetting of staff. There was a policy in place but it had not been implemented. Inspectors reviewed a sample of staff files and noted that some information required by the Regulations had not been obtained for staff. For example, the provider had not sufficient evidence of all employees' mental and physical fitness or three written references. There was only one reference for the person in charge. There were no professional references on file for the clinical nurse manager (CNM), they had not been requested by the provider. In the action plan from the previous inspection, the provider stated that a system to verify references for staff had been implemented but inspectors found that this had not been done.

Inspectors reviewed information with regard to the professional registration status of nursing staff and found that all had up-to-date registration with their professional body for 2013

All staff had completed mandatory training including moving and handling and fire safety training. Since January 2012 various members of staff had completed in service training in:

- elder abuse
- use of syringe driver
- wound care
- continence care
- use of the sensor mats

A draft training plan for 2013 was shown to inspectors. This included medication management, management of behaviours that challenged and wound management.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Linda Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

12 April 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	Parke House Nursing Home
Centre ID:	0083
Date of inspection:	9 and 10 April 2013
Date of response:	23rd May 2013

Requirements

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

Theme: Governance, Leadership and Management

Outcome 2: Contract for the provision of services

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

All residents did not have a contract of care. The contract did not fully include details of the services to be provided for that resident and the fees to be charged.

Action required:

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

Reference:

Health Act, 2007
Regulation 28: Contract for the Provision of Services
Standard 1: Information

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

Standard 7: Contract/Statement of Terms and Conditions	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Parke House Nursing Home have undertaken a full review of all residents contracts of care. We are currently addressing all outstanding contracts for: (i) Short term contracted HSE respite residents. These have been completed. The contracts will be included in the admission process. (ii) Long term 'contracted' beds. Individual contracts of care have been circulated to each of these residents and family representatives. The Provider and PIC will review the progress of the returned completed contracts on a weekly basis.	9th June 2013

Outcome 4: Records and documentation to be kept at a designated centre

The provider is failing to comply with a regulatory requirement in the following respect: Many of the operational policies did not guide the practice. This included the policy on recruitment, selection and vetting of staff and behaviour management.	
Action required: Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.	
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Operational policies are being reviewed by the PIC and the Manager to include Behaviours that Challenge, Medication Management, Elder Abuse, Risk Management, Epilepsy. As these policies were not guiding practice, the PIC and Manager have developed a checklist to record actual practice, to ensure adherence to policies in actual practice. Management are	9th July 2013

supervising on a daily basis to ensure these policies now guide practice. Parke House Nursing Home has undertaken a full review of our human resources policy. Operational practice and adherence to these policies have been revised and strengthened to avoid paperwork gaps and to ensure compliance with current regulations Schedule 2, 5.1 Staff. This audit has commenced and a checklist of the requirements has been developed. Management have addressed the issue with HR personnel and clarified the need for compliance in this area. HR personnel understand the requirement to have all relevant documentation for all new staff and also the staff who have been employed prior to the introduction of the current regulations. An external consultant has reviewed our procedures and advised on 'best practice' in this area. Subsequently management has identified a time frame of 2 months to have all files completed and up to date.	23rd July 2013

The provider is failing to comply with a regulatory requirement in the following respect: There was no nursing record maintained of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.
Action required: Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.
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:	**Timescale:**
Provider's response: Parke House Nursing Home has commenced an audit of all residents care plans, this will be completed by 27th May 2013. A daily progress sheet is now completed on each resident by the	27th May 2013

staff nurse on duty to inform on continuation of care with reference to any treatment administered and to outline the health status of each resident. This sheet is signed and dated by the staff nurse on duty thus enabling better information concerning each resident and easier access for this information. A review by PIC has been carried out to ensure adherence to the new regime. A meeting with all staff nurses was held to inform and demonstrate the usage of progress sheets. To date progress is as follows: All charts completed with new MUST tool. All charts completed with Waterlow assessment. Falls risk all charts in special care unit are completed and is underway in main unit. Restraints, Seizures and Smoking, all risks completed. We have devised a more systematic method for checking various medical matters, for example: bloods & nutritional status have now specific staff nurse allocation.	23rd June 2013

Theme: Safe care and support

Outcome 6: Safeguarding and safety

The provider has failed to comply with a regulatory requirement in the following respect: The provider was required to take immediate action on issues relating to the management of residents with behaviour that challenged.
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.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Individual Risk Assessments have been carried out. These assessments have changed the Care Plans of these residents.	4.00 pm 12 April 2013

Following these risk assessments, it was deemed two residents should transfer from Parke House to more suitable settings. We are using ABC charts, to identify some potential triggers for challenging outbursts and we have updated the staff with what to watch out for. Until our training is complete, we will endeavour to focus any staff with relevant training and experience into this unit's roster. Training in 'Behaviours that Challenge' is scheduled: 24/5/13 or before if can be sourced Elder Abuse training is scheduled: 8/5/13 and will continue weekly until all staff have been updated Additional clinical supervision, nurse in SCU has commenced since 10/4/13 We have reviewed our pre-assessment pack and have added significant additional clinical tools to enable us select suitable and appropriate residents. I, as Provider, along with PIC and Manager give an unqualified commitment to providing a safe environment for our residents to enjoy as their home. Our staff have been updated and are aware of the concerns that have been raised and are participating fully with the risk measures we have devised. I am happy that the residents are safe from following this review that has taken place.	24th May 2013 8th May 2013

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

There was no evidence that an allegation of abuse that was made in February 2013 was investigated or responded too.

The elder abuse policy did not include the need to notify the Authority of allegations of abuse.

Action required:

Take appropriate action where a resident is harmed or suffers abuse.

Action required:

Put in place a policy on and procedures for the prevention, detection and response to 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: Parke House Nursing Home has updated the elder abuse policy to include the requirement to notify HIQA of any suspected allegation of abuse. The particular incident of alleged abuse referred to in this report was discussed by management at the time of the reported allegation. We were satisfied that this was not substantiated upon review of the complaint. A completed NF06 has been sent. After the subsequent investigation in which both parties were interviewed, management concluded that it was a disagreement relating to the interpretation and subsequent disagreement of personal preferences of a resident by senior care staff and not a case of elder abuse and the complainant was in agreement with this finding. We were satisfied that this was a repetition of HR interpersonal issues between two staff members. We engaged an external consultant to devise and tutor a training course aimed at promoting effective and active team work amongst senior care assistants who are at floor supervisory level. All relevant staff have attended this course and feedback has been very positive. Annual Elder Abuse training commenced 8th May and will continue on a weekly basis until all staff have been updated.	10th May 2013 17th May 2013 11th February 2013 5th March 2013 26th March 2013 16th July2013

Outcome 7: Health and safety and risk management

The provider has failed to comply with a regulatory requirement in the following respect: The provider was required to take immediate action in relation to risk management and assessments.
Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale**
Provider's response: Smoking Room Risk Assessments have been carried out. Individual residents that are smokers Risk Assessments have been carried out. These assessments have changed the Care Plans of these residents. No uncontrolled access to cigarettes or lighters is possible. Staff supervision has increased and regular supervisory routines have been adopted. Staff have all been advised and management will ensure that the protocols are followed as per the revised Care Plans. We have ordered new equipment for the smoking rooms and have devised a plan to switch one room which will be a more appropriate setting, with better ventilation and CCTV monitoring in situ. We have looked at all physical aspects and we are confident that these measures will further enhance the safety of the smokers in the nursing home.	4.00 pm 12 April 2013

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

The provider did not have a robust system in place for the identification and management of risk in the centre.

This policy did not reflect the practice and did not meet the requirements of the Regulations.

The policy did not include the procedures for the identification and management of all risks in the centre.

A number of significant risks were not being identified and managed in the centre including those relating to the storage of medication and easy access to hot water boiler.

Action required:

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

Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Parke House Nursing Home has commenced a review of our risk management policy. This will ensure that there is adequate identification and management of risk. Our centre specific risk policy has been drafted and gives guidance on the sources of the identification of risks. We are in the process of updating each department with our new policy and tools for risk management. The inter-departmental Risk Management Committee has been established. This committee consists of staff from each department of the nursing home. The PIC, manager and allocated staff nurse have received training in risk management. The PIC will ensure the risk register is updated on a monthly basis. This risk management committee have met and are charged to revise and improve our overall risk management. The committee are currently contributing from all departments and a more comprehensive centre specific risk policy will result. The laundry has a safety station and this will be updated daily as to the status of infection of any resident as per Outcome 18 The kitchenette with the boiler has been fitted with a security key pad access panel.	9 June 2013

Outcome 8: Medication management

The provide is failing to comply with a regulatory requirement in the following respect: Medications were not administered as per professional guidelines and the centre policy. The medication policy did not guide and inform staff practice. It did not include the procedures for the prescribing, administration, recording, safekeeping and controlled medication (MDAs).

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 33: Ordering, Prescribing, Storing and Administration of Medication Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Parke House Nursing Home have updated the medication management policy to include the procedure for prescribing, administering, recording, safekeeping and controlled medications. The PIC and manager have updated the policy in consultation with the pharmacy. An audit by our pharmacist is scheduled for 22nd May 2013 and going forward an audit will be completed by our pharmacist on a quarterly basis. PRN medication has been discussed with the GP and the resident's Kardex now reflects the appropriate prescribing of PRNs. All staff nurses are scheduled to attend refresher training in the area of Medication Management starting this month. Both clinical room doors are kept locked when unattended. At shift handover the PIC has conducted a discussion with each staff nurse to inform the importance of this policy. All staff nurses have been instructed to adhere to the guidelines in medication management as outlined by An Bord Altranais.	29th May 2013 31st May 2013 22nd July 2013

Outcome 9: Notification of incidents

The person in charge is failing to comply with a regulatory requirement in the following respect: The person in charge had not notified the Authority of all incidents as required by the Regulations.

Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation, suspected or confirmed abuse of any resident.
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Management have been made aware of their obligation to report all matters as required, without exception, in accordance with the regulations. Two NF03 have been sent. One NF06 has been sent. Monthly management meetings are scheduled to review incidents. Incident forms are reviewed by the PIC daily to ensure timely reporting of incidents in the event that this is necessary.	13th April 2013 11th April 2013

Theme: Effective care and support

The timeframes are set by the Chief Inspector due to the immediacy of the actions required.

Outcome 11: Health and social care needs

The provider has failed to comply with a regulatory requirement in the following respect: The provider was required to take immediate action regarding: ▪ a high standard of nursing practice was not delivered to residents ▪ the management of residents with epilepsy was inadequate and unsafe ▪ the management of residents using restraint placed them at risk ▪ appropriate measures were not in place to respond to residents weight loss.

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.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Following an urgent clinical meeting with management and staff nurses, the following has resulted. Epilepsy: We have developed a Policy on Epilepsy & Seizures which will inform staff around protocol for, before, during and after seizure. We have completed Risk Assessments of residents with a history of seizures, these Care Plans have been updated to reflect the new measures. We have relocated residents with this factor within closer proximity to each other, to allow for closer and more directed observation. We have external training booked for 12/6/13 and have received a core module of the training by DVD, so we can start updating awareness of epilepsy care in advance of the course. Training will commence 22/4/13 or earlier if possible, with a sign-in sheet for record. Restraint: A thorough review of all aspects of restraint has been completed. We have been guided by the HSE document 'Policy on use of Physical Restraints in Designated Residential Care Units for Older People'. We have reduced the number of residents with any form of restraint from 23 to 12. Alternatives have been put in place, for example we have purchased, low low beds, sensor mats, crash mats, wedges, bumper rails. These 12 residents have had updated Risk Assessments completed and the Care Plans of these individuals have been changed to reflect this, we have added 'Restraint, Release & Review Charts' to all Care Plans. Additional	2.00 pm 17 April 2013

monitoring measures have been adopted. Weight Loss: All residents identified as having lost weight, have been reviewed by the Dietician. Recommendations from the Dietician have been implemented, such as supplements, weekly weights. Food delivery was reviewed to suit each individual resident's requirements. Care Plans have been revised to include 'Food Diaries'. We have established 'Link Nurses' for both units with the Dietician. They will liaise with Dietician on monthly basis to review the MUST tool and any nutritional issues. Refresher training around the MUST tool is booked for 23rd & 30th April. We have reviewed mealtimes and food quantities that had been served, recognising that the quantity of food being served at the fixed time could be too much food at once. We have staggered the serving of meals, for example 'lunch' now starts at 10.30am with soup, 12pm main course with dessert for residents who can manage it. For residents not able for dessert earlier it can be served 2.30pm with the tea round in the Special Care Unit. This is working very well and a noticeable increase in consumption as per food diaries. We are in the process of establishing a 'Risk Committee'.	

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect: The care plans did not consistently reflect the assessed needs of residents in the areas of: ▪ Falls ▪ Wound care There was insufficient evidence that residents and relatives were involved in the development and review of their care plans.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment

Standard 11: The Resident's Care Plan Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Parke House Nursing Home have reviewed all residents care plans and staff have been instructed about the importance of post fall assessments and the use of the falls diary which is part of the resident's chart. The review of falls showed that all residents that had a fall were reviewed post fall by the GP and other healthcare workers as required, but the post falls assessments had not been completed satisfactorily. The PIC will monitor and follow up from the falls assessment and falls diary which is part of the resident's chart. Training in wound assessment and classification was carried out on site and 10 out of 15 staff nurses attended so far. Further training is scheduled. With immediate effect, the care plans will record all evidence of the residents and relatives involvement in the ongoing review of care plans. Residents who use an air mattress have been reviewed and we have developed a procedure to ensure the correct setting is used for each individual resident.	12th April 2013 25th April 2013 30th May 2013 Completed

Theme: Person-centred care and support

Outcome 13: Complaints procedures

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

The complaints policy had not been fully implemented.

The complaints policy did not contain arrangements for a person separate to the complaints officer, to review and ensure complaints are responded to.

Action required:

Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

Action required: Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).	
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Parke House Nursing Home have adjusted the policy on complaints accordingly. The manager has been nominated as the separate person in the complaints process. This had been the practice but not recorded in the policy. The policy has been updated to reflect the requirements of the regulations and ensure compliance with standards. An unresolved complaint has been followed up and resolved.	Completed

Outcome 15: Food and nutrition

The provider is failing to comply with a regulatory requirement in the following respect: Appropriate and safe assistance was not provided to some residents with eating and drinking. Some residents on specialised diets did not have their specific needs met. Some residents were not offered drinks during the meal. There was no choice for residents who required modified consistency diets.
Action required: Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.

Action required: Provide each resident with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.	
Action required: Provide each resident with food that is varied and offers choice at each mealtime.	
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Parke House Nursing Home has made all the relevant staff aware of the correct and safe seating positions for residents when eating and drinking. Ongoing instructions by the PIC at each mealtime has been directed and indicated by SALT. We have reviewed all specialised diets and procedures have been put in place to ensure all residents receive the correct meals consistent with their individual dietary needs. A record of meal intake has been devised 'food diary', to ensure recording of meal quantities for those resident's deemed at risk. A choice is now offered for modified meals. This is reviewed weekly by PIC. All staff have been made aware of the requirement to offer drinks during meal times to residents. Training is scheduled for all relevant staff to increase their awareness of residents dietary requirements and the importance of specialised diets. This training was delivered by Abbott Nutrition and was attended by staff nurses, care assistants and catering staff on 15th May 2013 and remaining staff to attend training 29th May. We have highlighted the importance of links between all staff involved in the provision of resident's meals. The door closing of the food trolley that was creating the noise has been addressed with staff.	10th April 2013 15th May 2013 Completed

Outcome 16: Residents' rights, dignity and consultation

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

Some practices did not protect the dignity and privacy of residents, including:

- inadequate screening in some shared rooms
- staff used inappropriate terminology to refer to residents
- staff were not ensuring the privacy of residents during personal care.

Action required:

Put in place adequate arrangements to ensure the operations of the designated centre are conducted with due regard to the sex, religious persuasion, racial origin, cultural and linguistic background, and any disability of residents.

Action required:

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

Reference:

Health Act, 2007
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 4: Privacy and Dignity
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The relevant bedrooms have been fitted with additional screening providing privacy to residents in shared rooms. Staff have been reminded to close bedroom doors when personal care is being delivered. All staff have been instructed by the PIC on the use of appropriate terminology when referring to residents. Residents privacy and dignity is being highlighted in our annual elder abuse training programme which is currently in progress and we have emphasised this aspect of the course.	8th May 2013

Theme: Workforce

Outcome 18: Suitable staffing

The person in charge is failing to comply with a regulatory requirement in the following respect: Nursing levels and skill mix were not based on the assessed needs of the residents and the size and layout of the centre.	
Action required: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Parke House Nursing Home staffing levels have been reviewed and an additional staff nurse has been appointed daily to ensure continuity of care in our special care unit. This practice started on the day of inspection and has continued since. We are carrying out a full review of our training requirements to reflect the needs of our residents. An additional drugs trolley has been purchased. This eliminates the practice of the staff nurse in the special care unit leaving the unit to carry out other duties. There is no requirement for the staff in the special care unit to deliver care to any resident outside the unit.	13th April 2013

The provider is failing to comply with a regulatory requirement in the following respect: Staff files did not contain the information as required by the Regulations.
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.

Action required: Put in place recruitment procedures to ensure the authenticity of the staff references referred to in Schedule 2 of the Regulations.
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Parke House Nursing Home have undertaken a full HR review to establish the correct recruitment procedures in compliance with the regulations. HR personnel have been updated on the correct procedures relating to staff selection, documentation and vetting and are currently updating staff files with the required information. For example we have identified that while all personnel have provided a form of ID, we do not hold birth certificates for all staff.	9th July 2013

The provider is failing to comply with a regulatory requirement in the following respect: Staff had not been provided with sufficient education and training to enable them to provide up to date care in relation to such areas as management of behaviours that challenged and the management of infection control.
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.
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Staff training on 'behaviours that challenge' has been scheduled. Parke House Nursing Home has devised a system of better practice in the laundry specific to infection control. An information station has been positioned in the laundry that is updated daily. The information relates to the status of any resident in the nursing home with an infectious disease. We are currently sourcing laundry specific training to update and educate the laundry staff in this area of best practice.	 24th May 2013 13th May 2013 21st July 2013