Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Catherine McAuley House
Centre ID:	0125
Centre address:	Beaumont Woods Beaumont Dublin 9
Telephone number:	01-8379186
Email address:	divillyh@eircom.net
Type of centre:	☐ **Private** ☒ **Voluntary** ☐ **Public**
Registered provider:	Sisters of Mercy
Person authorised to act on behalf of the provider:	Sister Anne Doyle
Person in charge:	Ellen Monica (Helen) Divilly
Date of inspection:	3 September 2013
Time inspection took place:	**Start:** 09:45 hrs **Completion:** 17:50 hrs
Lead inspector:	Sheila McKevitt
Support inspector(s):	N/A
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	22 + 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 10 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 one day. As part of the monitoring inspection the inspector met with residents, relatives, and staff members. The Inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The inspector met with the management team which included the provider, person in charge and the clinical nurse manager. The inspector was informed that eleven residents continued to be accommodated in the adjoining building named Rockfield while the renovations to their bedrooms and the extension and was being completed. The remaining 13 beds were been used in Catherine McAuley House of which one

room was vacant these were linked to Rockfield by a temporary corridor. The inspector was satisfied that the building work was having no direct impact on the quality of life of the residents as the building site was completely segregated from the currently occupied section of the centre. The building works, including additional beds were due to be completed by end October 2013.

The centre appeared to be a peaceful place to live. Twenty one of the 23 residents are members of the sisters of mercy and together with the support of sisters from their congregation they were assisted to continue the religious orders routine of prayer within the centre.

Staff provided care to residents in a kind and considerate manner respecting their protected time for prayer. Staff numbers and skill mix were adequate to meet the needs of residents.

The inspector saw evidence that the provider had fully addressed all four actions from the last inspection which took place on 2 August 2012.

Nursing documentation reviewed showed residents' care plans had improved since the last inspection. However, nursing assessments, daily evaluation and general records required improvement. The inspector found that care and infection control practices were not always evidence based and therefore did not reflect best practice. Medication administration practices were in line with best practice and professional guidelines. However, medication prescription and safekeeping/storage practices required improvement. The action plans at the end of the report reflect the changes that require to be made in order to ensure the provider is meeting the conditions of registration.

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 1

There is a written statement of purpose that accurately describes the service 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

Action(s) required from previous inspection:

The action(s) required from the previous inspection were satisfactorily implemented.

Inspection findings

The inspector reviewed the statement of purpose and found that it described the services and facilities provided in the centre and the information was in accordance with Schedule 1 of the Regulations. The written statement of purpose reflected the most recent registration certificate issued to the provider on 13 February 2012. The provider was aware that an updated statement of purpose would have to be submitted with their application to vary conditions of current registration.

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

The person in charge was on duty on inspection. She works full-time in the centre and this was reflected on the staff roster. She has been employed in the centre since 2006 and is named person in charge on the registration certificate. She is supported in her role by a clinical nurse manager who also works fulltime and manages the centre in her absence.

Outcome 4
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:
Regulations 21-25: 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:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Residents' Guide

Substantial compliance ☒ Improvements required * ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required * ☒

The standard of resident care plans had improved somewhat and were now more person centred and linked to the resident risk assessments. However, further improvements are required and this is discussed in further detail under Outcome 11.

Resident assessment forms were not fully completed on admission and the records did not clearly show that they were appropriately re-assessed every three months.

Fluid balance charts were not completed in an accurately.

Accident and incidents forms did not always complete a clear record of the care provided by the nursing and care staff to the resident post a fall. It was not always clear if the resident was checked for injuries, blood pressure, pulse and respirations were checked and or when a resident sustained a head injury if neurological observations were recorded for a period of time post the incident/accident.

General Records (Schedule 4)

Substantial compliance ☒ Improvements required * ☐

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

A number of Schedule 5 policies were due to be updated. For example, the policy on the prevention, detection and response to elder abuse.

Directory of Residents

Substantial compliance ☒ Improvements required * ☐

Staffing Records

Substantial compliance ☒ Improvements required * ☐

Medical Records

Substantial compliance ☒ Improvements required * ☐

Insurance Cover

Substantial compliance ☒ Improvements required * ☐

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 inspector reviewed the centre's policy on the prevention, detection and response to elder abuse and found that it gave guidance to staff on the types of abuse, the procedures for reporting alleged abuse and the procedures to follow when investigating an allegation of elder abuse.

The Authority had received one notification of alleged abuse which allegedly occurred when the resident was out in another facility. The inspector was satisfied that this had been investigated as per policy by the provider and the management team of the other facility. Garda Síochána vetting was in place for staff employed by the provider and by the contract catering company.

Residents spoken to confirmed that they felt safe in the centre. The inspector observed an intercom system and closed circuit television camera at the front door, which staff had to answer and release prior to any person gaining access to the centre.

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

There was a risk management policy in place which met the legislative requirements. It outlined how to undertake a risk assessment and identified that a risk management committee had the role and responsibility of keeping the risk register up to date. The health and safety policy and safety statement was in place and it had been updated by qualified personnel and was signed and dated by the provider. A culture of managing any identified risk was evident and resident safety was a management priority.

An emergency plan was in place to outline clear procedures to follow in the event of loss of electric power, water, flood or security concerns.

There was a visitors log in place to monitor the movement of persons in and out of the building. There was a missing person policy which included clear procedures to guide staff should a resident be reported as missing.

Centre-specific infection prevention and control policies and procedures were found to be in place. Hand-washing and drying facilities and hand disinfectant gels were available at the front door and nurse's stations. However, the inspector found infection control practices within the centre did not follow best practice. The following were identified poor areas of practice:

- Commodes with rusty areas around wheels being used in resident bedrooms.
- Commodes left in resident bedrooms with hand towels covered them rather than the appropriate commode cover.
- Unclean equipment including bed rail protectors, mattress and a drip stand been stored in residents' assisted toilet.
- Use of cloth towels in communal toilets and bathrooms.
- Storage of incontinence wears on top of toilet cisterns.

The fire alarm, fire fighting equipment and emergency lighting was serviced by external personnel on a regular basis. All staff had attended fire safety and evacuation training. Means of escape were clear and unobstructed. However, records of fire drills were vague and therefore there was no evidence of learning by staff from practicing same.

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

The inspector reviewed the medication management policy and noted that it included the procedure for prescribing, administering, recording, safekeeping and disposal of unused or out of date medications.

There were clear guidelines in place for staff administering medication to residents that supported safe practice. The inspector observed drug administration practices and found they were safe and in line with An Bord Altranais guidance to nurses and midwives.

The practices observed for safekeeping of medications did not reflect the policy. The inspector noted that the clinical room, where large stocks of medications were stored was left opened on two separate occasions. In addition, the medication trolley was left unattended in the corridor on two separate occasions. On both occasions a bunch of keys were left within the medication trolley door. The keys which opened the controlled drug cupboard and the clinical room were held on this bunch of keys.

The medication prescription charts were not in line with best practice. They did not include the frequency medications were to be administered or the maximum dose for all PRN medications. Some contained an overall prescription order for medications to be crushed, which was unsafe. For example, one resident with an overall order for medication to be crushed was prescribed a medication in slow release format which should not be crushed. Some medication charts did not include a photo of the resident. Typed prescription charts did not clearly indicate what the date on the prescription chart related to. However, staff explained it was the date the resident was started on the medication in question.

The pharmacy delivered a pre-packaged medication system which staff nurses were familiar with. The Inspector saw evidence that the pharmacy supplying medications audited medication practices but the audit tool used was poor and therefore the audits did not pick up on issues identified on inspection and did not always lead to improvements in practice. The management had conducted an internal audit in July and during this audit had found that the clinical room door was being left opened. This had been fed back to staff. However, it was evident that practices had not improved to date.

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

The inspector cross referenced notifications submitted to the Authority since the last inspection with records of all accidents and incidents held in the centre since the last inspection. All serious accidents and incidents had been notified to the Authority by the person in charge in a timely manner. However, the inspector noted that staff did not always record the immediate nursing care they provided to the resident post a fall. For example, it was recorded if they were checked for injury or when they received a head injury if neurological observations were completed as there were no records available for two residents who had hit their head when they fell.

Completed incident and accident forms were found to be audited by the person in charge and the clinical nurse manager on a monthly basis. The outcome of the audit included a review of accident and incidents of the times accidents took place. This analysis clearly indicated where and when there was an increase or decrease in falls, allowing management to identify and respond to trends identified.

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 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(s) required from previous inspection:

The action(s) required from the previous inspection were satisfactorily implemented.

Inspection findings

The care and welfare of all residents was found to be adequate with appropriate healthcare provision and access to all allied health care professionals. Arrangements for GP services and access to on call cover for out-of-hours GP services were in place. Residents confirmed that their GP visited regularly. A review of a number of resident files showed that all residents' were seen by their GP and had their medications reviewed within a three month period as per the centres policy. This review also confirmed regular input from psychiatry of old age, palliative care team, physiotherapist and other health care professionals without delay.

The centre had a policy in place for the admission, temporary absence and discharge of residents. Pre-admission assessments had been completed by the person in charge or the clinical nurse manager to ensure the needs of the potential resident could be met. The admission policy included details of information required before any decision to admit had been made by the person in charge. The inspector was satisfied that the governance of admissions and discharges was to a high standard. Records of transfer and discharge letters to and from the centre were available in resident files.

Nursing care was delivered to residents in a kind and patient manner. One resident who the inspector was informed was receiving end of life care appeared comfortable and her relatives confirmed their satisfaction with the care she was receiving. The inspector observed incontinence draw sheets being used on a number of beds of residents who were identified on assessment as being at high risk of developing pressure ulcers and who had pressure relieving mattresses on their bed. Staff explained the purpose of the sheet was to retain any leakage from the incontinence wear worn by the resident thus preventing the bed sheet from getting wet. This practice was not in line with a high standard of nursing care and is not evidence based practice.

As mentioned in Outcome 4, the standard of resident care plans had improved somewhat and were now more person centred and linked to the resident risk assessments. Residents and their relatives confirmed to inspectors that they were involved in their own care plan review. However, the three monthly nursing re-assessment was not been completed accurately by staff nurses and therefore changes to the residents' were not recorded. Staff were signing and dating the original assessment document completed on admission staying, for example "reviewed, 08/08/2013 and signing their name" but not recording what the findings of their assessment on 08/08/2013 was. Therefore, it was unclear if the condition of the resident had changed. The nurses' daily evaluation was not linked to the residents care plan and therefore did not provide a complete daily evaluation of the care given.

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 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:

The action(s) required from the previous inspection were satisfactorily implemented.

Inspection findings

Lunch was observed being served in the dining room temporarily situated in Rockfield when renovations were in progress. The dining room was bright appropriately furnished and welcoming. Table settings were pleasant and included condiment, napkins and appropriate place settings for each resident.

A menu was displayed on each table detailing the choices for the day. The same menu choice was available for residents on a modified consistency diet. Catering staff served the meals. Staff spoke to residents and were knowledgeable about their likes and dislikes and offered residents choice. Care staff were available to provide assistance to residents who required it in the dining room. Residents told the inspector they enjoyed the food and the choices available to them.

There was a comprehensive policy now in place to guide and inform staff on the procedures to ensure residents' nutritional and hydration needs were met. Documentation showed that resident's weight was recorded on a monthly basis or more regularly if required. Nutrition assessments were used to identify residents at risk and monitor progress with nutritional supplementation. However, as mentioned under Outcome 4 above, fluid balance charts were not completed accurately.

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:

No actions were required from the previous inspection.

Inspection findings

There were three qualified nurses (including the person in charge and clinical nurse manager) and five carers on in the morning/afternoon with one qualified nurse and three carers on duty in the evening. On night duty there was one qualified nurse and two carers on night duty. The inspector found that the levels and skill mix of staff on duty was adequate to care for twenty two residents with the following assessed dependency levels: eleven maximum, seven high, three medium and one low.

All staff nurses' registration data for 2013 was available for review. Mandatory training was up to date for all staff working in the centre and the inspector saw evidence that staff had received additional training on a number of topics including Health and Safety, falls prevention and Infection prevention within the last year.

The person in charge had completed an audit on staff files which showed they were in compliance with Schedule 2 of the Regulations.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Sheila McKevitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

12 September 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:	Catherine McAuley House
Centre ID:	0125
Date of inspection:	3 September 2013
Date of response:	24th October 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 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:

The following resident records were incomplete:

- Resident assessments on admission.
- Resident three-monthly re-assessments.
- Resident fluid balance charts.
- Records of nursing care provided to a resident including observations immediately after an accident/incident.
- Nurses' daily evaluation was not linked to the residents care plan.

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

Action required: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) of the Regulations in a manner so to ensure completeness, accuracy and ease of retrieval.	
Action required: Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) of the Regulations up-to-date and in good order and in a safe and secure place.	
Reference: Health Act, 2007 Regulation 22: Maintenance of Records Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: In Catherine McAuley House all residents have a comprehensive needs and dependency assessment completed on admission in consultation with the resident or next of kin. The Director of Nursing, Clinical Nurse Manager is currently conducting Care Plan workshops with the Nurses to ensure a person centred care is provided and clearly documented and to identify any area that require to be addressed in order to ensure a continuity of care for residents. Nurses now complete a full evaluation of each Care Plan on a daily basis and document same in daily progress notes. Assessments are reviewed as indicated by residents changing condition and no less frequently than three monthly intervals and documented in a more detailed re-assessment form. Any changes to residents condition from previous assessment are noted and actioned as per Care Plan. We have developed a Quality of Life questionnaire with residents input and this will be discussed with resident/next of Kin at re-assessment and will help to inform us of our residents satisfaction with level of care and quality of life they receive in the Nursing Home. Fluid/food balance charts are documented by Healthcare Assistants and signed off by staff nurse at end of each shift. All incident forms have been amended to include details of any nursing care given, observations are recorded including neurological observations along with any medical care provided at the time of the incident.	14th December 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: Some policies require updating to ensure they reflect current practices in the centre. For example, the medication management policy and the policy on the prevention, detection and response to elder abuse.
Action required: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A full review of ALL operational Policies and Procedures including Medication Management and Elder Abuse Policies is currently taking place to reflect current practice in the Nursing Home and in line with evidence based practice. Staff are trained and familiarised in the Policies and Procedures of the Nursing Home. Policies are discussed with staff at daily report to ensure staff are delivering a high quality of care to residents in line with agreed policy and procedure. All policies are reviewed every three years or more frequently if any change occurs.	30th December 2013

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: The record held of fire drill practices included those that attended and date only. Further details are required to indicate compliance with the centres policy.
Action required: Maintain, in a safe and accessible place, a record of all fire practices which take place at the designated centre.

Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Since the last inspection the Nursing Home has now put into effect the recommendation of the inspector in relation to fire drills. A fire bell test is conducted by Health and Safety Officer and all staff are instructed to go firstly to the fire panel to identify the location of activation, check the map and then proceed to the location of the activation. This enables staff to read the panel, relate this information to the map and identify the location of the activation. Records to reflect this change in practice and any staff learning outcomes are maintained in the Fire Register at Nurses Station. All staff have received training in fire evacuation procedures in the last month. Our Policy will reflect this change in operational procedures.	Completed

Outcome 6: Premises

The provider is failing to comply with a regulatory requirement in the following respect: The following issues in relation to infection control practices/storage of equipment were identified on inspection: ▪ Commodes stored in resident bedrooms. ▪ Commodes with rusty areas around wheels been used in resident bedrooms. ▪ Unclean equipment including bedrail protectors, mattress and a drip stand been stored in residents' assisted toilet. ▪ Storage of incontinence wears on top of toilet cisterns.
Action required: Ensure suitable provision for storage of equipment in the designated centre.
Action required: Maintain the equipment for use by residents or people who work at the designated centre in good working order.
Reference: Health Act, 2007

Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A designated space has been identified for storage of all equipment currently in use for residents. Additional storage space will become available when the new extension is completed so that all equipment required for resident use is stored safely and securely. All commodes not fit for purpose have been removed and replaced by new ones and a maintenance contract put in place for all equipment to ensure it is maintained in good working order at all times.	20th Noovember 2013

Outcome 8: Medication management

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

The practices observed for safekeeping of medications did not reflect the policy and need to be addressed:

- Keys were left in an unattended medication trolley.
- The clinical room where medications were stored was left open when unattended.

The prescription practices were not in line with safe practice and the following issues were identified:

- No photo of the resident on all residents prescription charts.
- Prescription charts did not include the frequency medications were to be administered.
- Prescription charts did not include the maximum dose for all PRN medications.
- Prescription charts did not clearly indicate what the date on the prescription chart related to.
- Prescription charts contained an overall order for medication to be crushed.

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

Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Each staff nurse employed in Catherine McAuley House have a clearly defined duty to understand fully their roles and responsibilities in Medication Management under the Health Act 2007, Regulation 33, Guidance to Nurses and Midwifes on Medication Management 2007. We have a written Operational Policy and Procedure on ordering,prescribing,storing and administration of medicines and all staff receive training in order to familiarise themselves with the Policy. We provide a safe secure storage area that comprises of a locked press within a locked cabinet for controlled drugs and a locked drug cabinet for all other medications. Both of these cabinets are in the Clinical Room which is locked at all times. The keys are kept with the bunch of keys which is the property of the staff nurse on duty and maintained on her person throughout the shift. The medication trolley is kept locked when unattended and the keys are kept by the staff nurse. This is in accordance with our Medication Management Policy. A crushing order is now specific for each prescribed medication and this order is clearly documented in each residents kardex. A list of drugs unsuitable for crushing is documented in our policy for the information of staff. A medication competency assessment is completed for all nurses by the pharmacy on a regular basis. An Audit of each resident's kardex is completed weekly by CNM/Staff Nurse and the outcome communicated to all staff and any issue arising is addressed immediately. A full medication audit is completed regularly both in-house and by the pharmacy and any issues arising as a result of this audit are addressed with staff to ensure compliance with Medication Management Policy and evidence based best practice. All prescription charts have been reviewed to include a current photo of each resident. The date of commencement of medications is now clearly documented on all prescription charts. The frequency which medications are to be administered and the maximum dose of PRN medications are now included in each prescription chart.	20th November 2013

Theme: Effective care and support

Outcome 11: Health and social care needs

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

The use of "draw sheets" on maximum dependent residents' beds who were assessed as at high risk of developing pressure ulcers and had a pressure relieving mattress in place was not reflective of a high standard of nursing care.

Other practices including:

- Towels used to cover commodes instead of lids supplied were not in line with a high standard of nursing care.
- Use of cloth towels in communal toilets and bathrooms.

Action required:

Provide a high standard of evidence based nursing practice.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: In Catherine McAuley House the delivery of a high standard of quality care to our residents is a top priority for us at all times. All our resident's care needs are reviewed daily and discussed with resident/next of kin and any changes documented in the Care Plan. Residents are seen on a regular basis by their General Practitioner and if necessare are referred for specialist consultation to outside hospital. A physiotherapist and Chiropodist visit residents in the Nursing Home every week. Residents who are assessed as high risk of developing pressure ulcers and who have pressure relieving mattresses in place will have a full continence assessment completed by staff who are trained in continence promotion. The outcome of this assessment informs us which type of continence wear is suitable for each resident and thus reduce the risk of pressure ulcers.The practice of the use of draw sheets for residents has ceased. New commodes have been purchased to replace old ones and all residents have their own towels.Staff training and education in the area of continence promotion and continence care is ongoing. Resident meetings are held regularly and residents are asked	20th November 2013

about their Quality of Life in the Nursing Home. Each resident is given a choice in every aspect of their care and their independence is enabled at all times in Catherine McAuley House.	