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:	St Anne's Private Nursing Home
Centre ID:	0387
Centre address:	Sonnagh Charlestown Co Mayo
Telephone number:	094-9254269
Email address:	kathsmyth@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Kathleen Smyth
Person authorised to act on behalf of the provider:	Kathleen Smyth
Person in charge:	Audrey Harrington
Date of inspection:	18 June 2013 and 19 June 2013
Time inspection took place:	**Day 1 - Start:** 09:00 hrs **Completion:** 17:45 hrs **Day 2 - Start:** 08:45 hrs **Completion:** 16:30 hrs
Lead inspector:	P.J Wynne
Support inspector(s):	N/A
Type of inspection	☒ **announced** ☐ **unannounced**
Number of residents on the date of inspection	24
Number of vacancies on the date of inspection:	4

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 all 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 report set out the findings of a registration renewal inspection, which took place following an application to the Health Information and Quality Authority (the Authority) Regulation Directorate, to renew registration of the designated centre. This inspection was announced and took place over two days. The findings of previous inspections concluded that improvements were required to meet all of the requirements in the Regulations. These inspection reports can be found at www.hiqa.ie.

There were 11 action plans identifying areas of non compliance with the legislation outlined in the action plan report of the inspection report dated 20 June 2012. These

mainly related to care planning, training in fire safety and restraint management. These were reviewed during this inspection. The inspector found that eight actions had been completed satisfactorily. Further work was required in the area of care planning, promoting a restraint free environment and developing a system for reviewing the quality of life and safety of care.

As part of the inspection the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Overall, the inspector found evidence of positive outcomes for residents. The inspector found that residents were well cared for and their needs socially were well met. The staff provided care in a dignified manner and had a very good knowledge of residents. The health care needs of residents were met. There was evidence that residents were consulted and their suggestions responded to by the provider.

The provider and person in charge promoted the safety of residents. A risk management system was in place. Staff had received training and were knowledgeable in the protection of vulnerable adults. The centre provided a welcoming and home like environment for residents. There were separate sitting room areas where residents could sit together or where they could choose to spend time in quieter rooms. Mealtimes were varied and nutritious. Residents could practice their religious beliefs.

The inspector identified aspects of the service that needed improvement. Aspects of care planning and the promotion of a restraint free environment required improvement. There was limited evidence of residents or their representative being consulted or agreeing to their care plan when reviewed and updated. The management of falls required review and an improvement in documenting end of life wishes was required.

The Action Plan at the end of this report identifies mandatory improvements to comply 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*.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector was satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided.

The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. The provider was aware that the statement should be kept under review and made available to residents on admission and following updating. The statement of purpose is kept under review by the provider and had been updated in May 2013.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Each resident had been provided with a contract of care. The inspector viewed a signed contract of care for the two most recent admissions. The contract had been agreed with the residents within the timeframe required by the regulations.

The overall fee was included in the resident's contract. The contracts of care viewed included the terms and conditions. There was a separate schedule that outlined services incurring an additional fee. Items not included in the overall fee to include dry cleaning and hair dressing was clearly identified and their cost explained.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge has not changed since the last registration inspection. She is a registered nurse and holds a full-time post. She was well known by residents. She had good knowledge of residents care needs and could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

She maintained her professional development and attended mandatory training required by the regulation in fire evacuation, safe moving and handling of residents and adult protection. She had completed training in dementia care and health and safety procedures.

A clear organisational structure was in place and the provider was actively involved in the day-to-day operation of the centre providing ongoing support to the person in charge. The provider attends the centre daily and assisted in facilitating the inspection. She outlined her role to the inspector as supporting the person in charge, managing finances and the governance operations of the centre. She assisted with the activity programme with residents in the afternoon on a daily basis. A senior nurse is appointed to deputise in the absence of the person in charge and has been in this post for the past four years. The arrangements and reporting systems were known to staff and were described in the statement of purpose.

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 * ☐

General Records (Schedule 4)

Substantial compliance ☒ Improvements required * ☐

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☒ Improvements required * ☐

Directory of Residents

Substantial compliance ☐ Improvements required * ☒

The directory of residents' did not have the facility to record the name and address of any authority, organisation or other body, which arranged a resident's admission to the designated centre.

Staffing Records

Substantial compliance ☐ Improvements required * ☒

The improvements related to staffing records are discussed in more detail under Outcome 18.

Medical Records

Substantial compliance ☒ Improvements required * ☐

Insurance Cover

Substantial compliance ☒ Improvements required * ☐

Outcome 5
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The provider was aware of her responsibility to notify the Authority of the absence of the person in charge. There were appropriate arrangements in place for the absence of the person in charge. The senior nurse deputised for the person in charge.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. The policy was specific to the centre and defined the various types and signs of abuse and the reporting arrangements. The policy outlined procedures to investigate any allegation of suspected or confirmed abuse. The contact details of of the elder abuse officer in the Health Service Executive (HSE) were included in the policy.

Residents spoken with stated that they felt safe in the centre. There was a visitors log in place and entrance and exit doors were monitored by CCTV. No incidents, allegations or suspicions of abuse have been recorded or notified to the Authority in the preceding 12 months at this centre.

Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. Garda Síochána vetting had been applied for all staff members. This was evidenced by a review of returned Garda Síochána vetting forms examined by the inspector. However, the provider was awaiting the return of Garda Síochána vetting forms for the three most recently recruited members of staff.

The financial controls in place to ensure the safeguarding of residents' finances were examined by the inspector. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. A petty cash system was in place to manage small amounts of personal money for residents. Each resident's petty cash was held in a separate envelope and secured in a locked safe. A record of the handling of money was maintained for each transaction. Two signatures were recorded in all instances. The ongoing balance was transparently managed.

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

Actions required from previous inspection:

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

Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be

followed in the case of fire, including the procedure for saving life.

Ensure policies and procedures and practice are consistent with best practise guidelines on prevention of infection. Keep all parts of the designated centre clean.

Provide restrictors to windows.

Inspection findings

The inspector was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. The actions in the previous inspection which related to the risk management policy, fire safety training and infection control policies had been completed.

The risk management policy was revised during 2012. The governance arrangements to manage risk situations were specified. Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy.

Risk assessments included an environmental and clinical identification and assessment of hazards throughout the centre. Controls were specified and rated to minimise risks for the care environment, communal areas, catering area and the external grounds. The premises was designed to meet the needs of dependent older people. Core systems to maximise safety were provided.

An example of systems in place for the management of a range of risk situations included:

- hand-rails were provided on both sides of the corridors throughout the building
- all entrance and exit doors were ramped ensuring ease of access for residents with mobility impairment, two additional external ramps were provided since the last inspection
- floor covering in bedrooms and communal areas was safe, all door saddles were recently removed to minimise the risk of trips or falls
- windows were fitted with restrictors' and the temperature of hot water was controlled to minimise the risk of scalds
- there was a service maintenance contract in place, which covered breakdown and repair for all beds, air mattresses and other equipment, used by residents
- there was a food safety system in place
- there were procedures in place for the prevention and control of infection and hand gels were located around the building. Staff were observed wearing aprons and gloves at appropriate times
- a risk assessment was completed for all residents who smoke to ensure they were safe to smoke independently and a plan of care was provided in their case file.

There was a missing person policy in place which included clear procedures to guide staff should a resident be reported as missing. Procedures to guide staff actions in the event of violence, aggression and self harm were included in the policy.

An emergency plan was in place that addressed what to do in the event of fire, loss of power, water shortage and other possible emergency events. It included details of alternative accommodation and emergency contact phone numbers.

The Authority was provided with written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for dependent older people. The inspector viewed records of fire safety training which had been completed by all staff. Records indicated all staff had been trained in fire safety procedures in the past 12 months by a fire safety consultant. Staff spoken with were clear about the procedure to follow in the event of a fire. However, not all staff had participated in regular fire drill practices within the past 12 months to reinforce their theoretical knowledge.

Two additional fire exits were provided since the last inspection. The procedure to follow on hearing the fire alarm was displayed along corridors. A record of the maintenance of fire fighting equipment including the number and type was maintained. The inspector viewed contracts which indicated the fire alarms; smoke and heat detectors were checked and serviced regularly. Records viewed indicated fire extinguishers were serviced yearly.

The inspector viewed evidence staff were trained in the safe moving and handling of residents. A moving and handling assessment was available for each resident in case files reviewed. The inspector observed safe moving and handling practices during the course of the inspection.

There were arrangements in place for recording and investigating untoward incidents and accidents. All incident and near miss events were recorded which were reviewed by the person in charge. Information recorded included factual details of the accident/incident, date and time event occurred, name and contact details of any witnesses. However, all parts of the form were not completed in full in each case to indicate whether the GP and next of kin had been contacted. No falls resulting in serious injury were reported to the Authority since the last inspection. Residents with a high risk of falls had a plan of care in place. However, vital signs and neurological observations were not checked and recorded in the accident form in each sample reviewed. While falls were investigated there was limited exploration and documenting of preventative strategies to minimise the risk of reoccurrence for example the utilisation of chair/bed sensor alarms. The falls policy reviewed by the inspector did not provide clear procedures to guide staff actions, for example completing neurological observations in line with best practice for defined period of time post fall.

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

Actions required from previous inspection:

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

Inspection findings

This action was completed. Procedures were in place to check medications on delivery against prescribed drugs to ensure that errors do not occur. A pharmacist conducted a review of medication in conjunction with the GP and the nursing staff to review alternative form of drugs for some residents.

There was a medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

The inspector reviewed a sample of residents' prescription and administration cards. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. There was evidence of residents' medication being regularly reviewed by the GP. The prescription sheets reviewed were clear, legible and distinguished between PRN (as needed), regular and short term medication.

Medication was being crushed for two residents prior to administration due to swallowing difficulty by the residents. However, the drugs were not prescribed on the medication charts for administration in a crushed form. There was space to record when medication was discontinued and these were signed on the sample reviewed.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. There was only one resident at the time of inspection being administered medication that required special control measures (MDAs). Nurses kept a register of controlled drugs. Controlled drugs were checked at the change of each shift and signed by two nurses. The inspector checked the medication balance and found them to be correct. The temperature ranges of the medicine refrigerator was being appropriately monitored and recorded.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Practice in relation to notifications of incidents was satisfactory. The inspector reviewed a record of incidents/accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required.

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 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

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

Action required from previous inspection:

Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Inspection findings

There was no clear system in place for reviewing and improving the quality and safety of care provided to, and the quality of life of, residents in the designated

centre at appropriate intervals. While falls were reviewed and the person in charge had identified residents who had successive falls and an audit tool was available to audit care plans this had not been completed to date.

This had been identified as an area for improvement at the last inspection and had not been addressed satisfactorily.

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

Actions required from previous inspection:

Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances as and no less frequent than at 3-monthly intervals. Set out each resident's needs in an individual care plan developed and agreed with the resident.

Maintain, in a safe and accessible place, a record of any occasion on which restraint is used, the nature of the restraint and its duration, in respect of each resident.

Inspection findings

The centre can accommodate a maximum of 28 residents who need long-term care, or who have respite, convalescent or palliative care needs. There were 24 residents in the centre during the inspection admitted for continuing care with the exception of one resident for convalescent. There were 12 residents assessed as highly dependent and six with medium care needs. Six residents were assessed as having low dependency needs.

A new model of care planning had been implemented since the last inspection. All information pertaining to residents' care was compiled in a single file ensuring the information was easily accessible and well organised. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and moving and handling assessments. There was a record of each resident's health condition and treatment given completed daily. In addition daily flow sheet was completed by care staff outlining their care interventions.

The inspector reviewed four residents' care plans in detail and certain aspects within other plans of care. However, some risk assessments were not always regularly revised to inform care planning. Assessments were not effectively utilised in the implementation and planning of care in all cases. It was noted in some case files moving and handling assessment were not reviewed regularly. In some cases there was a review date on the revised assessment tool but the assessment tool was not re-completed fully. While care plans were reviewed when there was a change in a resident's condition, not all care plans were reviewed at the required three monthly intervals periodically. There was a good range of care plans in place for each resident's identified needs. However, the inspector identified two residents with a diagnosis of epilepsy. There was no emergency plan of care in place to guide and inform staff of the procedures to follow in the resident's case file. Emergency medication was not prescribed should the residents develop status epilepticus.

While care plans were discussed with residents or their families and documented consent was obtained, for example for restraint, there was limited documented evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when reviewed or updated in files reviewed.

Each resident had an assessment of social needs completed in the sample reviewed including a 'key to me' which outlined resident's likes, dislikes and preferences in relation to interests and activities. Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector.

Residents had access to GP services and there was evidence of regular medical reviews. A review of residents' medical notes showed that GPs visited the centre routinely. The chiropodist attended the centre routinely and recorded their treatment. The physiotherapist attends the centre two days each week and undertakes individual and group rehabilitive exercises with residents. The inspector spoke with the physiotherapist and saw the programmes in place for residents with mobility problems in case files reviewed. Access to the occupational therapist was available on referral to the HSE. Access to a dietetic service was sourced privately by the provider.

The person in charge explained that the psychiatrist for later life and his team provided support for residents when required. Medication was reviewed routinely to

ensure optimum therapeutic values. Good links had been made with this service and there was documentary evidence to support this.

The person in charge and nursing staff confirmed to the inspector there were no incidents of pressure wounds at the time of inspection. The person in charge described the preventative and monitoring strategies in place to maintain residents' skin integrity. Those identified at risk were provided with suitable equipment to include an air mattress on their bed.

The inspector reviewed a sample of assessments that underpinned restraint practice. Restraint measures in place included the use of bedrails by nine residents. There was a risk assessment completed prior to the use of the restraint and the rationale for the need was identified. However, there was limited evidence of exploring alternative options prior to using a restraint measures such as ultra low beds, perimeter mattresses or increased safety checks in the documentation reviewed. There was limited evidence of a multi-disciplinary input in the concluding decision to use physical restraint for example the physiotherapist was not included in the decision making process. All nursing staff were not trained on the aspects of promoting a restraint free environment.

There was a detailed activities assessment completed for each resident in case file reviewed based on the 'Pool Activity Checklist' linked to the residents 'key to me'. Activities were led by care assistants and the provider and included bingo games, cards and newspaper reviews. The inspector observed an activity in the afternoon enjoyed by many residents. The physiotherapist undertook a fit for life exercise class with the residents twice weekly, this was observed by the inspector. Residents were facilitated to practice their religious beliefs and Mass was celebrated each week and an oratory was available to residents. The hairdresser visited the centre weekly and residents confirmed to the inspector they enjoyed this time. Birthdays were celebrated with resident's consent.

Outcome 12

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

References:

Regulation 19: Premises
Standard 25: Physical Environment

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The building is designed and adapted to meet the needs of dependent older people. The building was well maintained both internally and externally. It was found to be clean, comfortable and welcoming. All accommodation for residents is on the ground floor. There are ten single bedrooms and nine twin bedrooms, each with an ensuite toilet and wash-hand basin. Bedrooms were suitable in size to meet the needs of residents. There are three assisted bathrooms which were upgraded since the last inspection. The showers provided are now level with the floor ensuring easy accessibility. There were a sufficient number of toilets, baths and showers provided for use by residents.

Communal accommodation consists of a dining area adjacent to the kitchen, three sitting rooms (including the foyer), a smoking room, an oratory. There was a good standard of décor throughout and very high levels of personalisation evident in residents' bedrooms and communal areas. Residents spoken with confirmed that they felt comfortable in the centre.

The staff facilitates were upgraded since the last inspection and are now relocated to a larger area on the ground floor. All staff were provided with a locker and separate toilet facilitates for care and catering staff were available in the interest of infection control.

The inspector noted the building was comfortably warm. Hand testing indicated the temperature of radiators and hot water did not pose a risk of burns or scalds. All radiators were fitted with covers.

The laundry was not suitable in size and some clean clothing was located in the lobby area adjacent to the sluice room posing an infection hazard. The cleaning room provided was not suitably equipped and did not contain a sluice sink and wash hand basin for use by cleaning staff.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The provider demonstrated a positive attitude towards complaints. The complaints policy had been updated and the inspector found that it was comprehensive and met the requirements of the regulations.

The complaints procedure was displayed prominently in the entrance foyer. The inspector reviewed the complaints log which contained the facility to record all relevant information about the complaint, investigation made and the complainant's satisfaction with the outcome. No complaints were being investigated at the time of inspection.

The residents told inspectors they could talk with the provider or person in charge if they had any complaints. Complaints and feedback from residents were viewed positively by the provider and used to inform service improvements. The provider explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise. This ethos was underpinned in the complaints policy.

The inspector reviewed the complaints policy and noted it met all the requirements of the regulations. A designated individual was nominated with overall responsibility to investigate complaints. A nominated person who would monitor that the complaints process was followed and recorded was identified. An independent appeals process if the complainant was not satisfied with the outcome of their complaint was ensured. Timescales were outlined to investigate or inform a complainant of the outcome of their complaint.

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

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There were no residents' receiving end-of-life care on the day of inspection; however, the inspector found that there were adequate procedures in place to ensure that appropriate end-of-life care could be provided when necessary.

There was a policy on end-of-life care and the person in charge explained that they accessed the services of the local palliative care team who provided support and advice when required. The person in charge confirmed the palliative care team will attend the centre outside of core hours if required. Single occupancy bedrooms which allowed for privacy and dignity at end-of-life were available. There was evidence of residents having access to members of the clergy to ensure their spiritual needs were attended to if they wished.

The inspector was satisfied that caring for a resident at end-of-life was regarded as an integral part of the care service provided in centre. A dedicated ensuite bedroom was available on the first floor for visitors who may wish to stay overnight. Tea and snacks were also provided for families.

One resident had specific end of life wishes documented, and nursing staff were knowledgeable of personal wishes in relation to end of life care for residents. However, personal choices and spiritual plans of care were not documented sufficiently in care plan files reviewed.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There was a policy in place to guide and inform staff on the procedures to ensure residents' nutritional and hydration needs were met. Nutritional risk assessments were used to identify residents at risk of malnutrition. Nutritional care plans were in place which identified those at risk of losing weight.

Weight records were examined which showed that residents' weights were checked monthly or more regularly if required. There was specialist equipment available to record the weights of those residents unable to stand on a weighing scales.

The inspector visited the kitchen and noticed that it was well organised and had a plentiful supply of fresh and frozen food which was stored appropriately. The inspector was satisfied that mealtimes were an unhurried social occasions that provided opportunities for residents to interact with each other and staff. Staff were seen to assist residents discreetly and respectfully with their meals if required.

Residents' dietary requirements were met to a high standard. The chef discussed with the inspector the special dietary requirements of individual residents and information on residents' dietary needs and preferences. Residents' food likes and dislikes were ascertained. Nursing staff informed the chef of any changes in residents' dietary needs. There was a wide range of choice at mealtimes. There was a four week rolling menu to ensure a variety of choice at meal times.

The person in charge confirmed there were no residents on a food intake or fluid balance chart at the time of inspection.

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

Actions required from previous inspection:

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

Inspection findings

It was identified on the last inspection total privacy in shared bedrooms fell short due to the layout of curtain partitions. Additional curtains with a revised layout were provided in all twin bedrooms to ensure privacy for each resident.

There was evidence of a good communication culture amongst residents and the staff team to include the provider and person in charge. The provider attended the staff afternoon handover report daily. Staff were observed knocking on bedroom, toilet and bathroom doors. Residents were dressed well and according to their

individual choice. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

An advocate facilitated the residents' committee. A meeting was held monthly chaired by the external advocate. The advocate individually met residents who were unable to attend and brought their comments or suggestions to the provider. This was confirmed by reviewing the minutes of the previous meetings.

Residents' civil and religious rights were respected. Residents and staff confirmed that they had been offered the opportunity to vote at each election either in house or their own locality. Residents could practice their religious beliefs. Mass took place on a weekly basis. The inspector observed the majority of residents attend Mass on the first day of the inspection in the oratory. The person in charge said that residents from all religious denominations were supported to practice their religious beliefs.

Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move around the centre freely. All residents had the option of a phone in their room or they could use a cordless phone to receive calls in their own bedroom. Some residents had their own mobile phones. Televisions were provided for all residents. Copies of the Residents' Guide and statement of purpose were provided to each resident. The inspector observed these in residents' bedrooms.

Residents had access to a variety of national and local newspapers and magazines to reflect their cultural interests and heritage. These were located in easily accessible areas and available to residents daily.

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

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector reviewed a policy for the managing of residents' monies, valuables and personal belongings; it provided guidance to staff on the storage and care of residents' belongings. There was evidence that residents had adequate space for

their belongings, including secure lockable storage. Each resident was provided with their own wardrobe.

A staff member was assigned to the laundry five days of the week. The staff member assigned to laundry duties sorted clothes after laundering and brought them back to each resident's room. A labelling machine was used to ensure all clothes were labelled. However, as discussed under outcome 12, the laundry was limited in size and did not ensure sufficient space for segregation, sorting and storing clothing.

Residents' were encouraged to personalize their bedrooms. Many residents had framed photographs and ornaments located within the vicinity of their beds.

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

Actions required from previous inspection:

Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Inspection findings

The provider employs 24 staff in total which includes a whole-time equivalent of six registered nurses and ten care assistants. In addition, there is catering, cleaning and laundry staff employed. The inspector viewed the staff duty rota for a three week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched

the staffing levels on duty. The rota was outlined in the 24 hour clock format and it was clear when work shifts started and finished. A planned and actual staff rota, showing staff on duty at any time during the day and night was maintained as required from the last inspection. There was an adequate number and skill mix of nursing, care assistants, catering and cleaning staff rostered on the day of inspection to meet the assessed care needs of residents. Call bells were answered promptly and there was a visible presence of staff in the day rooms and around the building during the inspection.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. This was evidenced by a review of staff files. Recently recruited staff confirmed to the inspector they undertook an interview and were requested to submit names of referees. The staff files were well organised and the information easily accessible. A sample of five staff files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the regulations was available in the staff files reviewed with the exception of certification by a medical practitioner that staff member was physically and mentally fit for the purpose of the work they perform. All files examined had a self declaration and this was not sufficient evidence of physical and mental fitness.

There was a training matrix available which conveyed that staff had access to on-going education and the range of training provided. The inspector found that in addition to mandatory training required by the regulations staff had attended training on caring for residents with dementia, health and safety and food hygiene. Staff were caring and making every effort to provide a good quality of life for all residents, including residents with behaviours that challenge. However, there was not a sufficient number of staff trained to meet the needs of the current resident profile in caring for people with behaviours that challenge. While there was a good outline of the difficulties presented and interventions in care plans outlined staff did not have specialist training to guide their actions. While good infection control practices were observed formalised training in hand hygiene and infection control was not provided to all staff.

A record of An Bord Altranais PINs (professional identification numbers) for all registered nurses was maintained and reviewed by the inspector. All care staff were formally trained with the majority trained to the Further Education and Training Awards Council (FETAC) level five training qualification.

Closing the visit

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

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, provider and person in charge and staff during the inspection.

Report compiled by:

P.J Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

1 July 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report *

Centre Name:	St Anne's Private Nursing Home
Centre ID:	387
Date of inspection:	20 June 2013 and 21 June 2013
Date of response:	16 July 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 person in charge is failing to comply with a regulatory requirement in the following respect:

The directory of residents' did not have the facility to record the name and address of any authority, organisation or other body, which arranged a resident's admission to the designated centre.

Action required:

Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

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

Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A new register in now in place modified to include all requirements of Schedule 3.	Completed

Theme: Safe care and support

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: Not all staff had participated in regular fire drill practices within the past 12 months to reinforce their theoretical knowledge.	
Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	
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: A fire drill is planned for 30 July 2013. Fire drills will take place regularly from now on to ensure all staff partake in minimum of two fire drills yearly.	30 July 2013

The provider is failing to comply with a regulatory requirement in the following respect: All parts of the accident/incident form were not completed in full in each case There was limited exploration and documenting of preventative strategies to minimise the risk of reoccurrence of falls for example the utilisation of chair/bed sensor alarms. The falls policy reviewed by the inspector did not provide clear procedures to guide staff actions.
Action required: Ensure a high standard of evidenced-based nursing practice is met with regard to residents who have sustained a fall.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 31: Risk Management Procedures Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Where a resident encounters an unobserved fall, vital signs and neurological observations will be taken in line with best practice and recorded on the incident report form. Options will be explored to prevent reoccurrence of falls through chair/bed alarms being sourced. Section 4 of the policies and procedures sets out the action to be taken by staff in the event of a fall this will be revised to guide best practice. As part of the new QMS all parts of all forms involving adverse incidents will be completed and reviewed by the person in charge.	30 July 2013

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: Medication was being crushed for two residents. However, the drugs were not

prescribed on the medication charts for administration in a crushed form. Emergency medication was not prescribed should the residents develop status epilepticus.
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: The drugs not prescribed on the medication charts for administration in a crushed form has been brought to the attention of all GPs. Emergency medication will be available should a resident develop status epilepticus.	Immediately

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

The provider is failing to comply with a regulatory requirement in the following respect: There was no clear system in place for reviewing and improving the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A new quality management System (QMS) has been installed and will have the facility to determine preventative action from adverse occurrences. The purpose of the QMS is to improve the quality of life of the residents at St Anne's and to prevent the reoccurrence of problems through a learning process in the form of the quality meeting. Areas to be audited will be selected and data reviewed to introduce improvements.	30 July 2013

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect: Assessments were not effectively utilised in the implementation and planning of care in all cases. Not all care plans were reviewed at the required three monthly intervals periodically. The inspector identified two residents with a diagnosis of epilepsy. There was no emergency plan of care in place to guide and inform staff of the procedures to follow in the resident's case file. There was limited documented evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when reviewed or updated.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.
Action required: Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances, and no less frequent than at three-monthly intervals.
Action required: Notify each resident of any review of his/her care plan.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment

Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All residents' care plans will be reviewed and completed by 31 August 2013 and revised on a regular basis. Risk assessment will be reviewed to guide the development of care plans. A care plan will be developed to meet the needs of the two residents with a diagnosis of epilepsy. Residents or their next of kin's involvement in their care plan will be documented.	31 August 2013

The person in charge is failing to comply with a regulatory requirement in the following respect: There was limited evidence of exploring alternative options prior to using a restraint measures in documentation reviewed. There was limited evidence of a multi disciplinary input in the concluding decision to use physical restraint.	
Action required: Put in place appropriate and suitable practices relating to the restraints in accordance with evidenced-based practice.	
Reference: Health Act, 2007 Regulation 8: Assessment and care plan Regulation 6:General Welfare and protection Standard 11:The Resident's Care plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A policy and procedure is now in place based on the HSE guidelines and this procedure will be followed accordingly. The physiotherapist will be involved in the restraint risk assessments alongside nursing staff to ensure a multidisciplinary	16 July 2013

approach.	

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect: The laundry was not suitable in size and some clean clothing was located in the lobby area adjacent to the sluice room posing an infection hazard. The cleaning room provided was not suitably equipped and did not contain a sluice sink and wash-hand basin for use by cleaning staff.
Action required: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.
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: We are engaged with an architect concerning modification to the laundry and a sluice sink and wash hand basin to the cleaning room.	30 November 2013

Theme: Person-centred care and support

Outcome 14: End of life care

The provider is failing to comply with a regulatory requirement in the following respect: Personal choices and spiritual plans of care were not documented sufficiently in care plan files.
Action required: Put in place written operational policies and protocols for end of life care to identify end of life choices.

Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A policy and procedure is in place documenting the physical and spiritual management of end of life. We will ensure that this aspect is fully applied in future. We will endeavour to establish the resident's wishes concerning their end of life.	Immediately

Theme: Workforce

Outcome 18: Suitable staffing

The provider is failing to comply with a regulatory requirement in the following respect: Not all files examined had a certification by a medical practitioner the staff member was physically and mentally fit for the purpose of the work they perform. The provider was awaiting the return of Garda Síochána vetting forms for the three most recently recruited members of staff.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A medical cert will be required for all staff members. Garda Síochána vetting applied for all staff and will be ensured for each member of staff.	Immediately

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

There was not a sufficient number of staff trained to meet the needs of the current resident profile in caring for people with behaviours that challenge.

Formalised training in hand hygiene and infection control was not provided to all staff.

All nursing staff were not trained on the aspects of promoting a restraint free environment.

Action required:

Provide staff members with access to education and training on best practice in caring for people with behaviour that challenges, infection control and promoting a restraint free environment to enable them to provide care in accordance with contemporary evidence-based practice.

Reference:

Health Act, 2007
Regulation 17: Training and Staff Development
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff will be trained in restraint free environment, hand hygiene and behaviours that challenge. We are currently recruiting accredited trainers and are waiting for confirmation of a date regarding training regarding above action required.	30 November 2013