Health Information and Quality Authority
Social Services Inspectorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

Centre name:	St. Brendan's High Support Unit
Centre ID:	0389
Centre address:	Mulranny Westport, County Mayo
Telephone number:	098-36027
Email address:	stbrendansoffice@eircom.net
Type of centre:	☐ **Private** ☒ **Voluntary** ☐ **Public**
Registered provider:	Mulranny Day Centre Housing Co. Ltd
Person authorised to act on behalf of the provider:	Dr. Jerry Cowley
Person in charge:	Susan Moran
Date of inspection:	15 November 2012
Time inspection took place:	**Start:** 8:45 hrs **Completion:** 16:00 hrs
Lead inspector:	Mary McCann
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	32
Number of vacancies on the date of inspection:	8

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 well-being 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 eight 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 carried out as part of the Health Information and Quality Authority's (the Authority) regulatory monitoring function, to check progress on any outstanding actions from previous inspection and to monitor 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*.

The inspection was unannounced and took place over one day. This was the fourth inspection of this centre. Previous inspection reports are available on www.hiqa.ie. As part of the monitoring inspection the inspector met with residents, the provider and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident and incident logs, policies and procedures and staff files. The centre had also submitted the required notifications, which were reviewed prior to the inspection.

The last inspection report from the inspection completed in January 2012 identified non compliance in five regulatory areas with six actions attached. The inspector found that all actions had been addressed.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Regulations and the Authority's Standards. These actions include medication prescribing practices, care planning and further review of quality and safety of care and quality of life.

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: Governance, Leadership 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 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 is Susan Moran. She was appointed to this post on 14 January 2011. She is a registered general nurse and holds a qualification in leading an empowered organisation. She is currently on planned leave. She holds a full-time

post. She was deemed to be appropriately qualified and experienced and has been interviewed and deemed a fit person to act as person in charge of this centre. During the last year she has undertaken training to become a manual handling instructor, cardiac resuscitation, dysphagia signs and symptoms, venepuncture and wound management. She has up to date training in adult protection and fire safety.

The person in charge was not on duty on the day of inspection but arrived to the centre approximately one hour into the inspection. She facilitated the inspection in a professional manner and demonstrated knowledge of the Regulations and the Authority's Standards and her reporting responsibilities. She displayed good knowledge with regard to current residents care needs and informed the inspector that while she was on planned leave she called into the centre daily.

Appropriate deputising arrangements are in place. Seema Jose, who has been interviewed by the Authority for this role and has been deemed competent is deputising for the person in charge. She currently works full-time at the centre.

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 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.*

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required * ☐

Medical files medication records and care files reviewed. Improvements required with regard to care planning and medication prescription records. Commented upon in the report.

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

The centre did not have a policy on management of residents' finances. See Outcome 6. There was no overarching risk management policy in place. See Outcome 7.

Staffing Records

Substantial compliance ☒ Improvements required * ☒

Three staff files were reviewed by the inspector and all complied with the Regulations.

Medical Records

Substantial compliance ☒ Improvements required * ☐

See Outcome 11.

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 found that there were appropriate arrangements in place to protect residents being harmed or suffering abuse.

The Authority has received no notifications to date from this centre with regard to allegations, disclosures or suspected abuse. The person in charge confirmed that they have never had a concern re abuse expressed by any of the residents.
All staff has had training in adult protection and a policy was in place to guide and inform staff to ensure residents were protected. Validation of Garda Síochána vetting was available on all staff files reviewed.

Staff were aware of the importance of respecting the privacy and dignity of residents and staff told the inspector that they saw the welfare of the resident as their primary duty. They confirmed if they had any concerns with regard to abuse they would report immediately to the most senior person on duty.

Procedures with regard to management of allegations involving senior staff is dealt with in the whistle blowing policy. The provider confirmed that if there was an allegation against him or the person in charge this would be investigated by a member of the board of management.

Contact details for the HSE Adult protection Officer and for the local Gardaí were available in the centre.

The centre did not have a policy on management of residents' finances. Staff informed the inspector that they were managing petty cash on behalf of the residents. The inspector reviewed this procedure and found that it was transparent and there were two staff signatures for all transactions.

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:

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

Provide training for staff in the moving and handling of residents.

Provide suitable training for staff in fire prevention.

Inspection findings

The actions required from the previous inspection were satisfactorily implemented.

The first action related to the extent of the opening of the windows. Safety catches/restrictors have been installed on all windows in the unit. Covers have been installed on all storage heaters in the unit to alleviate the potential risk of burning to residents.

All staff have been trained in safe moving and handling and fire safety. The person in charge is an instructor in safe moving and handling.

Records indicated that all staff had received training by a competent person in theoretical and practical aspects of fire safety and evacuation techniques in the past 12 months. This was confirmed by the person in charge. In addition all staff had participated in regular fire drill practices within the past 12 months to ensure staff are aware of the procedures to follow to include simulated evacuation and safe placement of all persons in the event of fire. The inspector found that all fire exits were clear and unobstructed on the day of inspection. The health and safety officer at the centre informed the inspector that all fire exits are checked daily to ensure they are unobstructed. A record was maintained of this procedure. Records were available to support that the fire alarm is serviced annually. The health and safety representative told the inspector that he checked the fire alarm monthly to ensure it was functioning properly.

The inspector found that there were systems in place to control or minimise risk. There was a health and safety statement, risk register, infection control policy and a challenging behaviour policy. However, there was no overarching risk management policy in place. The person in charge was in the process of finalising an influenza policy. The risk assessments detailed the controls in place to minimise the risk and any additional controls required to reduce and manage the risk to ensure residents are protected. Measures in place to prevent accidents included handrails, grab rails and safe floor covering. The showers were wet room style with non slip flooring which contributed to protecting residents.

The inspector reviewed records of accidents and incidents that had occurred in the designated centre and was satisfied that all relevant incidents were notified to the Chief Inspector as required by the Regulations.

A comprehensive policy was in place to guide practice when responding to emergencies. Contingency arrangements with a list of all staff that could/would assist should evacuation be necessary was available.

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:

No actions were required from the previous inspection.

Inspection findings

A medication management policy was in place. The inspector reviewed this and found that procedures did not provide sufficient detail to guide and inform staff in all areas of medication management. For example, the section on 'drug error', does not documents the reporting procedure and what procedure to be enacted to ensure the safety of residents is maintained, for example contact the general practitioner (GP), completed specific record, and monitor residents observations.

The inspector noted that prescribing practices did not comply with best practice. The prescription sheets and medication records for ten residents were inspected. The prescription sheets reviewed were unclear.The following omissions were noted:

- date of discontinuation of medication was not documented
- no signature when medication discontinued
- medication administration times not specifically recorded on prescription.

Photographic identification was available on the medication prescription chart for most residents to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The administrator and person in charge confirmed that they would address this as a matter of priority. They informed the inspector that some residents had not consented to having their photograph taken.

Surplus supplies and out of date drugs were returned to the pharmacy on a frequent basis. Medications that required special control measures were not checked on this inspection.

A medication management audit had been completed by the person in charge of nursing staff in October 2012. While this showed a high rate of compliance. No report was prepared with regard to the analysis from the audit and there was no information available to inform the reader as to how the information was shared with all appropriate staff.

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

Outstanding action(s) required from previous inspection:

No actions from the previous inspection.

Inspection findings

The inspector found that while advances had been made with regard to establishing and maintaining 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, further work was required in this area to ensure that the data is analysed, trends and deficits are recognised and a programme of review and action is put in place to ensure enhanced outcomes for residents.

Residents were complimentary of the service provided. However, there is a need to review areas which impact on resident's life in the centre such as satisfaction surveys and to try and gain greater involvement of residents and relatives.

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:

Put in place appropriate and suitable practices relating to the use of restraints in accordance with evidenced-based practice.

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

Inspection findings

The actions required from the previous inspection were satisfactorily implemented.

The inspector reviewed three care files on the computerised system. Evidence was available that all members of the multidisciplinary team are involved in the restraint policy. Each member signs the consent form along with the resident or the next of kin/significant other where applicable. An assessment review is carried out fortnightly and consent is obtained every three months.

Individual care plans were available for each resident. The centre was using a computerised care documentation system. On reviewing case files it was evident to the inspector that assessments were carried out on each resident. Staff utilised validated tools to risk rate residents. For example, a nutritional assessment tool was used to identify risk of nutritional deficit, a falls risk assessment tool to assess risk of falling. Additionally assessments were reviewed post an incident. A post falls risk assessment was completed post each fall. The inspector noted that the level of falls had reduced considerably over the last 18 months. The person in charge contributed this to the specific allocation of staff to the sitting room area for supervision, the appointment of the occupational therapist and the provision of a physiotherapist two mornings per week.

The inspector saw that care plans were not written in a person-centred manner - consequently this did not take account of individual residents' choices and preferences in all aspects of their care. Where person-centred care wishes are recorded and incorporated into care plans, this gives guidance in daily routines and management plans for staff to follow with the aim of ensuring residents are involved in their care and care is delivered in a consistent manner.

The inspector noted that a care plan review was completed on a three-monthly basis. Reviews were used to evaluate the care provided and to change the care plan where indicated. There was a signature of the resident and/or their significant other on the review template. However, there was no narrative available of a discussion between the resident and/or their significant other with regard to the care plan as to whether they agreed, disagreed or wished to make any comment with regard to the care plan.

The inspector found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. The person in charge described good access to the GP and stated that the provider representative who is a local GP attended the centre very frequently and was available at all times.

Reviews of medication were occurring at three-monthly intervals and the medication charts were rewritten by the GP every three months. However, a narrative note was not documented by the GP in the medical notes or on the medication charts to comment upon the review and what changes had occurred, if any. A chiropody service was available to the centre. Dental and dietetic services were available. Audiology services were arranged as required via GP referral. Eye checks were also arranged as required. There was access to the local palliative care team.
The person in charge informed the inspector that there were no residents with wounds on the day of inspection. The centre has access to tissue viability services.

A policy on behaviour that challenges was available. Nursing staff told the inspector that there were no residents presenting with behaviour that challenged. Staff confirmed that they had received training in dealing with behaviour that challenged and dementia care. The person in charge confirmed that they had good input from mental health services.

Activity provision included group and one to one sessions. Residents with a cognitive impairment were encouraged to take part in activities, or where this was not possible, their attention was regularly enhanced by staff's interaction. Activities for residents with dementia/cognitive impairment included reminiscence and social interaction work with talking mats to enhance communication. Mass took place weekly. The occupational therapist had recently completed a course in Sonas therapy (a group session involving stimulation of all five senses particularly useful for people with cognitive impairment). Other activities included music, bingo and art. There was a social care assessment completed for each resident. These assessments were used to assess the suitability of activities to different residents and informed the staff of the background interests of the residents. A record was available of the participation of each resident in their chosen activity. Weekend activities in the unit were dictated by the residents. If there are request for specific activity e.g. music, DVDs these requests are accommodated by staff. Residents confirmed that they could go out with their families or had visitors at the weekend.

There is a resident committee in place with an advocate as chairperson. Minutes were available of these meetings. There was documentation to support that residents went on outings.

The policy on restraint was based on the national policy and the person in charge and provider were keen to promote a restraint free environment. Restraint measures in place included the use of bedrails and specialist chairs. The inspector reviewed records with regard to restraint measures in place. There was a risk assessment completed prior to the use of the restraint. A rationale was provided for the requirement of the restraint measure. The risk assessments documented the safety issues with regard to using or not using the restraint measure and a balancing clinical judgement was made as to whether it was in the best interest of the resident to use the restraint measure. The inspector noted on some assessments it stated that the restraint measure was at the request of the resident and the restraint measure increased comfort and independence. For example, 'using bedrail as a positioning aid'.

The person in charge confirmed that seating assessments had been completed by the occupational therapist. No residents spent long periods of time in bed.
Many residents were using specialist chairs which were enabling as they provided them with greater independence, for example, being able to eat independently or support them to spend long periods out of bed or have a drink thereby enhancing resident function. There was evidence of other health professionals' and the GP involvement in the decision to use the restraint measure.

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:

No actions were required from the previous inspection.

Inspection findings

An actual and a planned rota was made available to the inspector. This detailed all staff in the centre. The inspector viewed the staff duty rota for a two week period. The rota showed the staff complement on duty over each 24-hour period. The planned staff rota matched the staffing levels on duty on the day of inspection. There were two nurses and six carers on duty on the morning of inspection. There were three additional staff allocated to activities and day room supervision. There was one staff member in the dining room, two catering, two cleaning, one laundry and one administration staff on duty. In addition there were three maintenance personnel, some of these were on a FAS training course. The provider was in the

centre when the inspector arrived and remained in the centre for most of the inspection. There was one nurse and three care assistants on night duty.

Residents told the inspector that staff were 'great' and 'they looked after them well' and were always available and willing to help them. Staff interviewed stated that there was adequate staff on duty to meet the needs of the residents. It was clear from observing lunch that residents were assisted at meal times in a timely fashion and staff spent lots of time with residents. Residents were supervised at all times in the day room/sitting room.

The rota indicated that there were always two nurses on duty when the person in charge was on duty. This was to ensure that the person in charge had sufficient time for management and governance tasks. Mandatory training in safe moving and handling, adult protection and fire safety training was up-to-date for all staff. Other training for staff included challenging behaviour, dementia care, dysphasia signs and symptoms, venepuncture, anaphylaxis, wound management and end of life care. A register was in place detailing which staff had received the flu vaccine.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Mary McCann
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

19 November 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre Name:	St. Brendan's High Support Unit
Centre ID:	0389
Date of inspection:	15 November 2012
Date of response:	10 December 2012

Requirements

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

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 centre did not have a policy on management of residents' finances. There was no overarching risk management policy in place.
Action required: Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.
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.

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

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: All written operational policies and procedures outlined in Schedule 5 are currently under review and will be updated accordingly. A new finance policy has been written and a new risk management policy will be written.	31 March 2013

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: The inspector noted that prescribing practices did not comply with best practice.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Reference: Health Act, 2007 Regulation 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 medication management policy has been reviewed and updated. A meeting has been held with the nurses and GP to ensure that all staff are familiar with the policy relating to the ordering, prescribing, storing and administration of medicines to residents.	Complete

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 a system in place with regard to quality assurance and continuous improvement, this required further development to ensure that the data is analysed, trends and deficits are recognised and a programme of review and action is put in place to ensure enhanced outcomes for residents.

Additionally, there is a need to review additional areas which impact on resident's life in the centre such as satisfaction surveys, minutes of residents meetings and to try and gain greater involvement of relatives.

Action required:

Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Action required:

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

Action required:

Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

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: Currently satisfaction surveys are completed by the kitchen to ensure residents catering needs are met. A new satisfaction survey is being implemented by the activities coordinator and a review of these by the person in charge will be carried out regularly and a report compiled in order to improve the quality and safety of care and the quality of life of residents. Talking mats are also used at present to ensure resident satisfaction. Regular reviews of these will take place and a report compiled.	31 January 2013

Outcome 11: Health and social care needs

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

The inspector saw that information in care plans was not written in a person-centred manner - consequently this did not take account of individual residents' choices and preferences in all aspects of their care.

The inspector noted that reviews were used to evaluate the care provided and to change the care plan where indicated. There was a signature of the resident and/or their significant other on the review template which had a pre typed paragraph to state that the care plan was reviewed. However, there was no narrative available of a discussion between the resident and/or their significant other with regard to the care plan as to whether they agreed, disagreed or wished to make any comment with regard to the care plan.

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 as and no less frequent than at three-monthly intervals.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
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: Resident care plans are currently being reviewed and updated to ensure that all care plans are person centred. The person in charge is working with staff nurses to ensure that resident choices and preferences in all aspects of their care is included in the care plans. The care plan review form has been updated to include a section where the resident or their next of kin can discuss the care plan and include any comments they wish to make. Care plans are reviewed every three months or earlier if necessary. A report on care plan audits will be carried out and all issues discussed with staff nurses to ensure that the findings are implemented and care plans improved.	31 January 2013

The person in charge is failing to comply with a regulatory requirement in the following respect: The inspector noted that prescribing practices did not comply with best practice.	
Action required: Provide staff members with access to education and training on medication management to enable them to provide care in accordance with contemporary evidenced-based practice.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Staff Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Medication management policy has reviewed and updated. This has been discussed with all nurses. It is hoped that all nurses will attend a medication management study day as soon as places become available.	30 June 2013

Any comments the provider may wish to make[1]:

Provider's response:

All our residents, staff and management appreciate the ongoing support and guidance of the Health information and Quality Authority. We wish to thank Ms Mary McCann for her courtesy and professionalism and we look forward to continuing to work with the Authority in the future.

Provider's name: Dr Jerry Cowley
Date: 11 December 2012

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