Health Information and Quality Authority
Regulation Directorate

Inspection report
Designated centres for older people

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

Centre name:	Cherryfield Nursing Home
Centre ID:	0213
Centre address:	Ballygarret Gorey Co Wexford
Telephone number:	053-9427286
Email address:	larrydoylecherryfield@yahoo.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Larry Doyle
Person authorised to act on behalf of the provider:	Larry Doyle
Person in charge:	Catherine Murphy
Date of inspection:	25 July 2013
Time inspection took place:	**Start:** 09:40 hrs **Completion:** 20:45 hrs
Lead inspector:	John Greaney
Support inspector:	Noelene Dowling
Type of inspection:	☐ Announced ☒ Unannounced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	2

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.

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

This inspection report sets out the findings of a monitoring inspection to:

☒ follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken

☐ address a specific issue based on information received.

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 was an unannounced follow-up inspection which took place over two days. As part of the inspection, inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

This inspection was a follow-up to an inspection carried out on 4 October 2012 and 5 October 2012. On that inspection the inspector found that a significant number of improvements were required, including:

- the policy on abuse did not provide adequate guidance to staff on the management of abuse
- there was no centre specific safety statement
- the risk management policy was not comprehensive
- the emergency plan was inadequate

- fire safety checks were not always completed
- not all staff members had received up-to-date training in manual handling
- the medication management policy was not centre specific
- there was no system in place for reviewing and improving the quality and safety of care
- not all residents were regularly reviewed by their GP
- there was insufficient evidence of referral to allied health and specialist services
- inadequate programme of activities
- risk assessments were not carried out prior to the use of restraint and there were inadequate records of safety checks when restraint was in place
- there was insufficient space for equipment
- there was insufficient communal space for residents
- there were insufficient toilet and shower/bath facilities
- records were not available to verify preventive maintenance of equipment
- inadequate infection prevention and control practices
- the complaints policy was not centre-specific
- inadequate monitoring of nutrition
- incomplete personnel records.

During this inspection inspectors found a poor level of compliance, as many of the actions identified at the last inspection were not addressed satisfactorily and a number of additional improvements were required. The action plan at the end of this report identifies where improvements are needed to meet the requirements of 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*.

Actions reviewed on inspection:

Theme: Safe care and support

Outcome 6: Safeguarding and safety

Action required from previous inspection:

Put in place a policy on and procedures for the prevention, detection and response to abuse.

Not completed.

There was a centre-specific policy on the prevention and detection of abuse, which was most recently reviewed in 2013. However, the policy was not sufficiently detailed as it did not adequately address the process for investigating all sources of abuse, such as when an allegation of abuse is made against management. The provider informed inspectors that training was facilitated for staff on the prevention and detection of abuse in December 2012 and again in March 2013. However, there was

insufficient evidence that the training was facilitated by a person that was suitably qualified and experienced on the prevention and detection of abuse.

There was a policy in place for the management of residents' personal property and finances. Inspectors were unable to examine records of financial transactions as they were not available in the centre on the day of the inspection. The inspectors were given conflicting information on whether the centre took responsibility for safekeeping money and valuables on behalf of the residents. Inspectors were not satisfied that there were adequate systems in place for the management of residents' finances.

Outcome 7: Health and safety and risk management

Action required from previous inspection:

The centre did not have a centre-specific safety statement.
Partially completed.

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.
Partially completed.

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

Put in place a comprehensive centre-specific emergency plan to deal with emergencies.
Not completed.

Make adequate arrangements for detecting, containing and extinguishing fires; giving warnings of fires; the evacuation of all people in the designated centre and safe placement of residents; the maintenance of all fire equipment; reviewing fire precautions, and testing fire equipment, at suitable intervals.
Partially completed.

Provide suitable training for staff in fire prevention.
Completed.

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.
Not completed.

Put in place a centre-specific smoking policy.
Completed.

Ensure that all staff members have up-to-date manual handling training.
Partially completed.

There was a centre-specific safety statement. However, it was not signed or dated.

There was a risk management policy that complied with the regulations. However, there was no evidence that it was implemented in practice. There was no evidence of a review of accidents and incidents in order to identify trends as an opportunity for learning. Inspectors reviewed the policy on missing persons and were not satisfied that it was centre-specific. The policy referred to a search of a basement, however, there was no basement in the centre and it did not take into consideration periods of low staffing levels or the rural location of the centre. Not all residents' records contained a recent photograph.

The inspectors reviewed the emergency plan that detailed what to do in the event of emergencies such as a power outage and loss of water. However, it did not adequately address the evacuation and safe placement of residents in the event of an emergency. Records indicated that the generator was most recently serviced in February 2012, however, the provider stated that the generator was serviced in 2013 and undertook to forward records to the inspectors. These records had not been received by the inspector at the time of writing this report.

Inspectors viewed the fire safety register that detailed the annual maintenance of fire extinguishers and the quarterly maintenance of the fire alarm. Records detailing the maintenance of emergency lighting were not available in the fire safety register. Records indicated the daily inspection of means of escape and all emergency exits were seen to be free of obstruction on the day of the inspection. However, there was a door ledge, approximately six to seven centimetres in height at one of the emergency exits that was a potential trip hazard. All staff had received up-to-date training in fire safety.

The provider stated that the centre has a no-smoking policy and no residents of the centre smoked.

There was evidence that manual handling training was facilitated in February 2013. However, based on records viewed by inspectors, not all staff had received up-to-date training. Inspectors observed practices and were not satisfied that contemporary evidence-based practice was followed at all times when assisting residents to transfer.

Outcome 8: Medication management

Action required from previous inspection:

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.
Not completed

Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.
Completed

There was a medication management policy dated February 2010 and most recently reviewed in December 2012. However, the policy did not provide adequate centre-specific guidance on the management of medications in the centre.

The centre maintained a record of unused and out-of-date medications returned to the pharmacy.

The medication prescription sheet and administration record did not contain a photo of all residents, the residents' date of birth was not always recorded and the GPs name was not always detailed on the prescription sheet. The inspectors reviewed a sample of residents' prescriptions, and based on the administration record of one resident, the resident was not receiving a medication that was prescribed to be administered weekly. The inspectors were unable to obtain a reasonable explanation for this omission.

The inspectors were informed that when medications were delivered from the pharmacy they were checked against the prescription to ensure they were correct, however, there was no record maintained to identify who carried out the check or when it was done. An audit of medication management carried out by a pharmacist in July 2013 did not identify any deficits in medication management.

There was insufficient evidence that nurses had received up-to-date education on contemporary evidence-based medication management even though the medication management policy specified that nurses should attend medication management training annually.

Theme: Effective care and support

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

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.
Not completed

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.
Not completed

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.
Not completed

There was no evidence of a systematic process for reviewing and improving the quality and safety of care. There was a process of monthly data collection. However, this was not correlated or analysed. There were no records of a process of consultation with residents or their relatives, either through residents meetings or residents'/relatives' surveys. However, the provider and person in charge informed inspectors that they met with residents and relatives on an informal basis. There was not evidence that routines and practices in the centre were informed by the views and wishes of residents or their relatives.

Outcome 11: Health and social care needs

Action required from previous inspection:

Keep each resident's medical plan of care under formal review as required by the resident's changing needs or circumstances and no less frequent than at 3-monthly intervals.
Not completed

Facilitate each resident's access to dietitian services, speech and language therapy occupational therapy, or any other services as required by each resident.
Not completed

Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.
Not completed

Carry out risk assessments in relation to risk posed to residents by the use of restraint and the level of supervision required when restraint are in place.
Not completed

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.
Not completed

Maintain a record of safety checks of residents, based on individual risk assessments, while restraint is in place.
Not completed

Inspectors were not satisfied that residents were adequately assessed on admission or at regular intervals thereafter. Based on a sample of records reviewed not all residents were reviewed by their GP at three monthly intervals and some records contained documentation suggesting that residents received an annual review.

Records viewed by inspectors indicated that one resident had been admitted to the centre for in excess of two weeks prior to being reviewed by a GP.

Inspectors were informed that a pre-admission assessment was carried out on residents prior to admission. However, there was no pre-admission assessment record created or maintained. Inspectors were not satisfied, based on the profile of residents, that there was an adequate pre-admission assessment carried out to ensure that the centre could adequately meet the needs of residents.

There was evidence of the use of evidence-based tools for issues such as dependency levels, the risk of developing pressure sores and falls risk assessment. However, the falls risk assessment tool for a number of residents was completed incorrectly resulting in an over estimation of the risk of falls. Based on records viewed by inspectors, a small number of residents had falls. However, there was no evidence of learning from accidents and incidents, including falls. There were no records to support an evidence-based falls management programme for residents with a history of falls or for residents assessed as high risk of falls.

A nutritional assessment was not routinely carried out on all residents on admission and there was not sufficient evidence that residents' nutritional status was appropriately monitored on an ongoing basis. This is discussed further in the report under Outcome 15.

Care plans were developed for residents. However, they were generic in nature and did not adequately address issues relevant to individual residents. For example, care plans for residents that had urinary catheters in place did not set out in sufficient detail the plan of care for the appropriate management of the catheters.

A small number of residents had wounds. However, an evidence-based tool was not used demonstrating a detailed assessment of the wounds or the protocol for dressing changes for all wounds. There was no evidence that staff were suitably trained on the management of wounds. There was no evidence that advice had been sought from a wound care specialist when wounds had shown evidence of deterioration following discharge from an acute care facility. There was evidence in a resident's records that a wound assessment and dressing chart had been commenced in another healthcare facility and this had been partially continued in the centre. However, based on records viewed by the inspectors, there were significant inconsistencies in the records in relation to when the dressings were changed and by whom, based on a cross reference between the nurses' progress notes, the wound dressing chart and the staff roster.

There was insufficient evidence that residents were referred to allied and specialist services. For example, there was no evidence of referral and assessment of residents that may benefit from specialist seating and there was insufficient evidence of referral for review of residents that may benefit from assessment by allied health/specialist services such as dietetic services or speech and language therapy.

Inspectors viewed the programme of activities that included Sonas, exercises that were facilitated by an external organisation, hand massage and a "sing song".

Based on inspectors' observations, the activity programme did not adequately meet the needs of residents and in particular residents with a cognitive impairment. For example, inspectors noted that a number of residents spent a significant amount of time in the sitting room with minimal interaction by staff. Additionally, on the day of the inspection the inspectors noted that residents that may benefit from one-to-one activities were not included in the activities that day.

There was a policy on the use of restraint. However, it was not implemented in practice. Restraint in the form of bedrails was in place for a number of residents and a vest restraint was also used. Assessments for the use of restraints were partially completed for some residents. However, the assessments did not adequately explore alternatives to the use of restraint, the risk posed by the use of restraint or the level of supervision required when the restraint was in place. Records in residents care plans gave conflicting information regarding the reason for restraint and not all staff members were familiar with the process of assessing residents for the use of restraint. There was insufficient evidence of consultation with residents regarding the use of restraint.

Inspectors observed the use of a vest restraint for one resident. Inspectors were informed that this was for the purpose of preventing the resident from falling from the chair. There was no evidence that the resident had been referred for assessment and review by an occupational therapist with regard to suitable seating arrangements. Records indicated that bedrails were in place for residents known to attempt to climb over bedrails, which was in contravention to the centre's own policy on the use of restraint. There were incomplete records maintained of occasions on which restraint was used and a record of safety checks of residents while restraint was in place. However, the intervals of safety checks were not based on individual risk assessments.

Outcome 12: Safe and suitable premises

Action required from previous inspection:

Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.
Not completed.

Ensure suitable provision for storage of equipment in the designated centre.
Not completed.

Provide suitable communal space for residents and suitable facilities for residents to meet visitors in private which is separate from the residents' own private rooms.
Not completed.

Provide a sufficient number of toilets having regard to the number of dependent residents in the home and ensure that there are a sufficient number of toilets which are designed to provide access for residents in wheelchairs, having regard to the number of residents using wheelchairs in the designated centre.

Not completed.

Provide a sufficient number of assisted baths and showers, having regard to the dependency of residents in the designated centre.
Not completed.

Ensure the premises are of sound construction and kept in a good state of repair externally and internally.
Not completed.

Provide adequate hand washing facilities having regard for good infection prevention and control practice.
Not completed.

Provide suitable equipment for cleaning and keep all parts of the designated centre clean and suitably decorated.
Partially completed.

Ensure by training or other means that all staff members are familiar with good practice in relation to cleaning procedures.
Not completed.

Maintain the equipment for use by residents or people who work at the designated centre in good working order.
Completed.

Put in place adequate arrangements for the proper disposal of clinical waste.
Not completed.

Overall, there were no structural improvements to the premises since the last inspection. The provider informed inspectors that design work was at an advanced stage, however, there was insufficient evidence of sufficient progress to ensure the premises was suitable for the purpose of achieving the aims and objectives set out in the statement of purpose.

The premises was in a reasonable state of repair. However, improvements were required. For example, the window closing device broke in an inspectors hand when opening a window, tiles were missing from around a wash-hand basin and mould was noted on some windows.

There continued to be insufficient space for the storage of clinical equipment. For example, the dressing trolley was stored in the shower room and the medication fridge was stored in the kitchen.

The sitting room contained seating for nine residents, the sun room contained seating for five residents and the dining room contained seating for five residents. There were no suitable facilities for residents to meet visitors in private which was separate from the residents' own private rooms.

There were a total of three toilets that were designated for use by residents. However, one of the toilets was in the sluice room and was not suitable for use by residents. The second toilet was contained in a room that had a standard shower tray and a non-functioning shower. The third toilet was in a bathroom that also contained a standard bath and wash-hand basin. Inspectors were not satisfied that there were sufficient toilets to meet the needs of residents.

There was a small shower room that contained one assisted shower. However, the size of the room would make it difficult for staff to provide assistance to residents that required full assistance to shower. There was one bathroom that contained a standard bath that was unsuitable for use by residents as one of the taps did not appear to be in good working order. Records of personal care viewed by inspectors indicated that residents received showers infrequently. For example, a number of residents had not received showers in the eleven days preceding this inspection and a number of others had received one shower during this period. The inspectors were not satisfied that there were adequate shower/bath facilities to meet the needs of residents.

The faulty door closing device in the toilet had been repaired since the last inspection.

Cloth towels continued to be available for use by residents in one of the toilets. The provider stated that one of the residents requested a cloth towel in the toilet.

The trolley used as a cleaning cart was no longer used as a dressing trolley.

In response to the previous inspection the provider stated that a new cleaner would be employed and training would be provided to all staff. On this inspection, inspectors were informed that no new staff had been recruited since the last inspection and there was no evidence available that training had been provided to staff.

Maintenance records viewed by inspectors indicated that equipment such as beds and hoists received routine preventive maintenance.

There was a clinical waste bin in the sluice room. However, it was inaccessible due to the storage of equipment that obstructed access.

Theme: Person-centred care and support

Outcome 13: Complaints procedures

Action required from previous inspection:

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

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.
Completed.

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.
Ongoing.

Since the last inspection the provider had put in place a new policy on the management of complaints identifying the nominated person responsible for dealing with complaints and the independent appeals process. The complaints procedure on display in the centre did not adequately outline the procedure for making a complaint or the person responsible for dealing with complaints. Not all staff members were familiar with the policy on the management of complaints. The most recent entry in the complaint log was in 2010 and the provider stated that they had not received any complaints since then.

Outcome 15: Food and nutrition

Action required from previous inspection:

Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.
Not completed.

There was a nutritional policy. However, it did not provide adequate guidance to staff on the management of nutrition. There was a menu on display in the kitchen. However, the option available on the day of inspection did not comply with the menu. Food appeared to be nutritious and was available in sufficient quantities.

Residents did not routinely have a nutritional assessment as part of their admission process and there was insufficient evidence that residents' nutritional status was assessed on an ongoing basis. Some residents were weighed on admission and at regular intervals thereafter. However, not all residents were weighed regularly. Where there was evidence of weight loss there was no evidence of food monitoring charts or of referral to a dietician for assessment and review.

Staff confirmed to inspectors that residents were not referred to speech and language for assessment and review of swallowing difficulties. A number of residents had speech and language assessments completed while they were patients in acute care facilities, however, not all staff were aware of the amount of thickener to be added to fluids as prescribed by the speech and language therapist.

Theme: Workforce

Outcome 18: Suitable staffing

Action required from previous inspection:

Put in place written policies and procedures relating to the recruitment, selection and vetting of staff.
Not completed.

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.
Not completed.

Supervise all staff members on an appropriate basis pertinent to their role.
Not completed.

Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.
Not completed.

The provider stated that there was a policy on the recruitment, selection and vetting of staff. However, it was not viewed by inspectors on the day of inspection. The provider undertook to forward a copy of the policy to inspectors. However, it had not been received at the time of writing this report. A sample of staff files viewed by inspectors indicated that not all information and documents specified in Schedule 2 had been obtained in respect of each person employed in the centre. There were not always three references for all members of staff, including a reference from the most recent employer and there was not always proof of identification, including a recent photograph. The provider informed inspectors there were no new members of staff recruited since the last inspection.

There was evidence of a registered nurse on duty at all times who was directly involved in the provision of care. However, inspectors were not satisfied that staff had adequate knowledge of current evidence-based nursing practice to ensure that care was delivered to achieve the best possible outcome for residents. This was supported by findings in relation to wound management, falls management and restraint as discussed in Outcome 11.

Inspectors reviewed the staff roster and observed practices and were not satisfied that there were sufficient numbers of staff on duty at all times to meet the needs of residents, based on the dependency levels and size and layout of the centre. This was supported by discussions with a resident who informed inspectors that residents were given breakfast by night staff prior to 07.00 hrs each morning, which was not their expressed preference. The resident had not brought this to the attention of the provider and stated he/she had become accustomed to the practice.

Inspectors were not satisfied that there was an adequate system in place to consult residents regarding routines and practices in the centre and this was also discussed in Outcome 10. Staff confirmed that the morning medication round was completed by night staff prior to the arrival of day staff at 08:00 hrs.

Staffing levels consisted of one staff nurse and one care assistant on duty during the day and at night to provide direct care to residents. Additional staffing included a staff member allocated to cleaning duties between 09:00 hrs and 14:00hrs and the kitchen was staffed between 08:00 hrs and 14:00 hrs and again between 16:00 hrs and 18:30 hrs. Inspectors formed the view that routines and practices in the centre were predominantly influenced by staffing levels. Based on dependency levels provided to inspectors indicating that five residents were assessed as being high dependant and require the assistance of two staff members for transfers and personal care, inspectors were not satisfied that there was adequate staffing levels and skill mix to meet the needs of residents. The provider was informed by inspectors to review and increase staffing levels to ensure that residents' needs and preferences were met at all times.

Training records reviewed by inspectors indicated that mandatory training, such as fire safety, abuse and manual handling was facilitated. However, not all members of staff had up-to-date training. There was insufficient evidence that staff were facilitated with ongoing education to support the provision of contemporary evidence-based practice, for example in wound care, falls prevention or dementia training.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider and person in charge to highlight where improvements were needed.

Acknowledgements

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

Report compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

01 August 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report *

Centre Name:	Cherryfield Nursing Home
Centre ID:	0213
Date of inspection:	25 July 2013
Date of response:	04 September 2013

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: Safe care and support

Outcome 6: Safeguarding and safety

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

The policy on the prevention and detection of abuse was not sufficiently detailed as it did not adequately address the process for investigating all sources of abuse, such as when an allegation of abuse is made against management.

Not all staff members had up-to-date training from a suitably qualified person on recognising and responding to allegations to abuse.

Inspectors were not satisfied that there were adequate systems in place for the management of residents' finances.

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

Action required: Put in place a policy on and procedures for the prevention, detection and response to abuse.
Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.
Action required: Make all necessary arrangements, including the management of residents' finances, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Our policy on Prevention detection and response to abuse has been amended to address the issue raised in your report. Staff training on our policy on abuse will be held in October Issues raised will be specifically discussed and explained. Receipt books for all cash received stored in Office. Staff property book available in Office.	 30 October 2013 30 October 2013 30 September 2013

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: There was a centre-specific safety statement. However, it was not signed or dated. There was insufficient evidence that the risk management policy was implemented in practice. The policy on missing persons was not centre-specific and did not adequately address

the rural location of the centre or times of low levels of staffing.

The emergency plan was not sufficiently comprehensive and did not adequately address the evacuation and safe placement of residents in the event of an emergency.

Maintenance records for the generator were not available in the centre on the day of the inspection.

Records detailing the maintenance of emergency lighting were not available in the fire safety register.

There was a door ledge, approximately six to seven centimetres in height at one of the emergency exits that was a potential trip hazard.

Contemporary evidence-based practice was not always followed when transferring residents and not all staff had received up-to-date training in manual handling.

Action required:

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

Action required:

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

Action required:

Put in place a centre-specific policy and procedure in relation to missing persons.

Action required:

Put in place a comprehensive centre-specific emergency plan for responding to emergencies.

Action required:

Maintain the equipment for use by residents or people who work at the designated centre in good working order.

Action required:

Make adequate arrangements for reviewing fire precautions, and testing fire equipment, including emergency lighting at suitable intervals.

Action required: Provide adequate means of escape in the event of fire.	
Action required: Provide training for staff in the moving and handling of residents.	
Reference: Health Act, 2007 Regulation 30: Health and Safety Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Action 1: A centre specific Safety Policy to address all issues has been developed.	30 November 2013
Training on its full implementation will commence October 1st and be completed by November 30th.	30 November 2013
Action 2: Training on the implementation of this Policy will commence on October 1st and be completed by November 30th 2013.	1 October 2013
Action 3: The Policy on Missing Persons has been amended to address this issue in your report. A "Missing Person Pack" has been developed and to be available in any such emergency.	1 October 2013
Action 4: The Emergency evacuation plan has been amended to address the issue raised in your report.	1 October 2013
Action 5: All Equipment will be maintained and serviced as required.	Completed
Action 6: All fire fighting systems, testing, etc. to be maintained as per regulations	Completed
Action 7: Fire escape routes will be kept free and maintained as per regulation.	30 October 2013

Action 8: All staff to have Manual Handling Training completed. All staff to be reminded that it is the duty of all staff to work as per manual handling training.	

Outcome 8: Medication management

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

The medication management policy did not provide adequate centre-specific guidance on the management of medications in the centre.

The medication prescription sheet and administration record did not contain all the items required by the regulations as there was not a photo of all residents, the residents' date of birth was not always recorded and the GPs name was not always detailed on the prescription sheet.

Based on the medication administration record, one resident was not receiving a medication that was prescribed to be administered weekly. The inspectors were unable to obtain a reasonable explanation for this omission.

There were no records of checks to demonstrate that medications delivered to the centre were verified against the prescription.

There was insufficient evidence that nurses had received up-to-date education on contemporary evidence-based medication management even though the medication management policy specified that nurses should attend medication management training annually.

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: A new Centre Specific Medication Management Policy has been introduced to Cherryfield. Staff have been introduced to the policy and it is the duty of all staff to implement the policy in	September 2013

full. Arising from the Retirement of the Person In Charge the process of recruiting a new person in charge will be put in place A.S.A.P. It will be the express duty of this new appointment to ensure the Medication Management Policy is fully implemented. Meanwhile Person in Charge, Deputy In Charge and all Nursing staff will be obliged to co-operate and ensure full implementation. Our Pharmacist has agreed to attend next delivery of drugs to Cherryfield and supervise the hand over and checking in process.	 Person in Charge Advertised 24 September 2013 September 2013 4 November 2013

Outcome 9: Notification of incidents

The provider/person in charge is failing to comply with a regulatory requirement in the following respect: The Chief Inspector was not notified of the occurrence of pressure ulcers in residents.	
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident, including pressure ulcers.	
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems 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: Completed	 1 October 2013

Theme: Effective care and support

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

The provider/person in charge is failing to comply with a regulatory requirement in the following respect: There was no evidence of a systematic process for reviewing and improving the

quality and safety of care.

There were no records of consultation with residents or their relatives, either through residents meetings or residents'/relatives' surveys.

Action required:

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

Action required:

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:	
Action 1: A system to review quality and safety of care currently being finalised	30 October 2013
Action 2: to be completed by Oct 30th 2013. This is an integral part of our new Health and Safety Policy. See outcome 7. Training will commence on Oct 1st 2013 and to be completed by Nov 30th 2013.	30 October 2013
Action 3: A system of consulting with Residents and Representatives currently being finalised and fully operational.	30 October 2013

Outcome 11: Health and social care needs

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

Not all residents were reviewed by their GP at three monthly intervals and some

records contained documentation suggesting that residents received an annual review. One resident was first reviewed by their GP in excess of two weeks following admission to the centre.

Inspectors were not satisfied, based on the profile of residents, that there was an adequate pre-admission assessment carried out to ensure that the centre could adequately meet the assessed needs of residents.

There was insufficient evidence that residents were adequately assessed following admission and on an ongoing basis.

Care plans were generic in nature and did not adequately address issues relevant to individual residents.

There were inconsistencies in the records in relation to when dressings were changed and by whom, based on a cross reference between the nurses' progress notes, the wound dressing chart and the staff roster.

There was insufficient evidence that residents were referred to allied and specialist services.

The activities programme did not adequately meet the needs of residents and in particular residents with a cognitive impairment.

There were inadequate practices in place in relation to the management of restraints.

Action required:

Provide appropriate medical care by a medical practitioner of the residents' choice or acceptable to the residents.

Action required:

Ensure that all residents are adequately assessed in order to determine each resident's dependency and health/social care needs to ensure that the centre can adequately meet those needs.

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 3-monthly intervals.

Action required:

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

Action required: Provide a high standard of evidence-based nursing practice, including the management of wounds.	
Action required: Facilitate each resident's access to physiotherapy, chiropody, speech and language therapy, occupational therapy, or any other services as required by each resident.	
Action required: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.	
Action required: Put in place suitable practices in relation to the assessment of residents prior to the use of restraints, the consultation with residents about the use of restraints, the suitability of restraints, the risks associated with the use of restraints and the monitoring of residents while restraint is in place.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 8: Assessment and Care Plan Regulation 9: Health Care Regulation 25: Medical Records Regulation 29: Temporary Absence and Discharge of Residents Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 13: Healthcare Standard 15: Medication Monitoring and Review Standard 17: Autonomy and Independence Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Arising from the retirement of our person in charge as outlined in Outcome 8, the implementation of actions required will be immediately addressed. The incoming person in charge will of course ensure that all Health & social care needs are fully implemented. Action One: Close liaison with all GPs to be maintained to	1 October 2013

ensure appropriate medical care is delivered. Action Two: Pre admission and post admission assessment reviewed to ensure appropriate care is delivered. Action Three: Rather than amend our existing care plan we have adapted a new care plan from an independent source. This is being introduced to staff on a phased basis and fully implemented by 30th October 2013. Action Four: Introduced 24th Sept 2013 Completed: 30th October 2013 Action Five: All nurses must provide evidence based nursing as part of employment. All nurses instructed at meeting Sept 23rd that ongoing training is an integral part of nursing employment and have agreed to comply. e.g. on line training with An Bord Altranais. This training must then be reflected in implementation of evidence based nursing. The following internal training has been done in relation to Management of Wounds. A representative from an external organisation has attended the nursing home to implement a wound therapy system on a resident as prescribed by Wexford General Hospital. She has supervised staff implementing system and has certified nursing staff capable of implementing the system in a professional manner. The system has been, to date, successful as per observation and measurements. The representative is happy that staff of Cherryfield have been and are very successful in our treatment of the Resident. The HSE. Tissue Viability Nurse has given a commitment to call and train Staff in Cherryfield at earliest possible opportunity hopefully Oct 2013. Action Six: Residents, their families and staff will co-operate to ensure that specialised services which could be of benefit to residents will be sourced and supplied. Action Seven: Activities appropriate to wishes of residents will be provided. Action Eight: Restraints Policy must be fully adhered to.	1 October 2103 Introduced 24 September 2013 Fully Implemented: 30 October 2013 Introduced 24 September 2013 Completed: 30th October 2013 Start 1October 2013 Completion November 30 2013 Commenced 3 September 2013 30 October 2013 30 October 2013 1 October 2013

Outcome 12: Safe and suitable premises

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

The window closing device broke in an inspectors hand when opening a window, tiles were missing from around a wash hand basin and mould was noted on some windows.

There was insufficient space for the storage of clinical equipment.

There was insufficient communal space and there were no suitable facilities for residents to meet visitors in private, separate from the residents' own private rooms.

There were insufficient toilets to meet the needs of residents.

There were inadequate shower/bath facilities to meet the needs of residents.

Cloth towels continued to be available for use by residents in one of the toilets.

There was no evidence available that training had been provided to staff in relation to cleaning.

The clinical waste bin in the sluice room was inaccessible due to the storage of equipment that obstructed access.

Action required:

Provide written, explicit, costed plans with timescales for structural improvements to the premises for the purpose of achieving the aims and objectives set out in the statement of purpose and to comply with the requirements of 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.

Action required:

Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

Action required:

Ensure suitable provision for storage of equipment in the designated centre

Action required:

Provide adequate sitting, recreational and dining space separate to the residents' private accommodation and provide suitable facilities for residents to meet visitors in a suitable private area which is separate from the residents' own private rooms.

Action required: Provide a sufficient number of toilets which are designed to provide access for residents in wheelchairs, having regard to the number of dependent residents in the home.	
Action required: Provide a sufficient number of assisted baths and showers, having regard to the dependency of residents in the designated centre.	
Action required: Provide adequate hand hygiene facilities having regard for good infection prevention and control practice**.**	
Action required: Ensure by training or other means that all staff members are familiar with good practice in relation to cleaning procedures.	
Action required: Put in place adequate arrangements for the proper disposal of clinical waste.	
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: Following discussions with the Health Information and Quality Authority and the acquisition of additional land, our architect has been given instructions to finalise plans and submit proposal to Wexford County Council as a matter of urgency. Once planning as been obtained we will immediately obtain costings etc. and submit to HIQA for approval. This is being pursued as a matter of urgency. In the meanwhile we will do all in our power to adopt the current building where necessary. Action 1: Building being surveyed and repairs identified will be repaired immediately. Action 2: We will provide temporary storage facilities.	31 October 2013 31 October 2013 13 October 2013

Action 3: Adequate seating has been provided in Dining Area.	1 October 2013
Action 4: Major structural amendments can only be made as integral part of our proposed extension.	Depending on Planning Permission
Action 5: Major structural alterations can only be made as integral part of our proposed extension. Meanwhile current facilities will be used to maximise their potential. Provision of showers, bed baths etc strictly supervised and implemented.	Depending on P.P.
Action 6: Completed	Completed
Action 7: An outside contractor was employed to survey our cleaning procedures. This was completed on September 14th. New system commencing October 1st. Company will address and train staff on new practices and procedures. Next training day Sept 2013.	Completed 1 October 2013
Action 8: Our clinical waste policy fully operational	1 October 2013

Theme: Person-centred care and support

Outcome 13: Complaints procedures

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

The complaints procedure on display in the centre did not adequately outline the procedure for making a complaint or the person responsible for dealing with complaints.

Not all staff members were familiar with the policy on the management of complaints.

Action required:

Display the complaints procedure in a prominent position in the designated centre.

Action required:

Ensure that all staff are knowledgeable of the policies and procedures relating to the making, handling and investigation of complaints.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Action 1: Complaints procedure on display as requested Action 2: Staff Training will be completed at Sept Training Day.	 30 September 2013 30 September 2013

Outcome 15: Food and nutrition

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

The nutritional policy did not provide adequate guidance to staff on the management of nutrition.

There was a menu on display in the kitchen, however, the option available on the day of inspection did not comply with the menu.

Residents did not routinely have a nutritional assessment as part of their admission process and there was insufficient evidence that residents' nutritional status was assessed on an ongoing basis.

Action required:

Put in place comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.

Action required:

Provide each resident with food and drink that offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.

Action required:

Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.

Reference:

Health Act, 2007
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

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

Provider's response: See outcome 8 1- Current Policy and Guidelines on Nutritional intake under review for immediate attention. To further assist us we have engaged outside expertise to develop and implement new policy. This meeting has been arranged for Oct 2013. 2- Current Policy being updated e.g. pre-admission. Once new Policy established it will be fully implemented.	Commence 1 October Conclude 30 October 2013 Commence 1 October Conclude 30 October 2013

Theme: Workforce

Outcome 18: Suitable staffing

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

Not all information and documents specified in Schedule 2 had been obtained in respect of each person employed in the centre.

The provider informed inspectors that an appraisal process had recently commenced, however, no appraisals had been completed prior to the day of inspection.

There were insufficient numbers of staff on duty at all times to meet the needs of residents, based on the dependency levels and size and layout of the centre.

There was insufficient evidence that staff were facilitated with ongoing education to support the provision of contemporary evidence-based practice.

Action required:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

Action required:

Supervise all staff members on an appropriate basis pertinent to their role.

Action required:

Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Reference: Health Act 2007 Regulation 16: Staffing Regulation 17: Training and Staff Development Regulation 18: Recruitment Standards 22: Recruitment Standard 23: Staffing Levels and Qualifications Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1- An external organisation have put in place a full and detailed Policy on Human Resources. This policy ensures that we are in full compliance with all requirements following meetings the Policy is centre-specific. I have appointed a new staff position to liaise with the organisation and fully implement the new policy. 2- The policy as outlined above ensures that all staff are supervised as appropriate. 3- We have carried out an internal review of staffing relating to needs of the residents. At meeting of staff on Sept 23rd these alterations were explained and accepted by staff and full implementation commences Oct 1st. e.g. breakfast times changed. 4- At staff meeting on Sept 23rd it was emphasised that ongoing training is an essential part of employment when dealing with the elderly. Management will be fully supportive of all staff seeking further training.	Commencing 1 October Concluding 30 October 2013. Commencing 1 October Concluding 30 October 2013 1 October 2013 1 October 2013