Health Information and Quality Authority
Social Services Inspectorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

Centre name:	D'Alton Community Nursing Unit
Centre ID:	0643
Centre address:	Castlebar Road Claremorris Co. Mayo
Telephone number:	094-9362727
Email address:	teresa.loughnane@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive
Person authorised to act on behalf of the provider:	Michael Fahey
Person in charge:	Teresa Loughnane
Date of inspection:	2 and 3 October 2012
Time inspection took place:	**Day 1 Start:** 10:00 hrs **Completion:** 17:30 hrs **Day 2 Start:** 09:30 hrs **Completion:** 15:30 hrs
Lead inspector:	Mary McCann
Support inspector(s):	N/A
Purpose of this inspection visit:	☐ to inform a registration/renewal decision ☒ to monitor ongoing regulatory compliance ☐ following an application to vary conditions ☐ following a notification ☐ following information received
Type of inspection	☐ **announced** ☒ **unannounced**

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 Social Services Inspectorate 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 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 16 of the 18 outcomes were inspected against. The purpose of the inspection was:

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

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

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

This monitoring inspection was unannounced and took place over two days. As part of the monitoring inspection the inspector met with residents, relatives, and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The last inspection report identified non compliance in 38 regulatory matters. The original completed action plan was forwarded to the Authority on the 5 April 2012. An update to the action plan was forwarded to the Authority on 12 June 2012. The inspector found that improvements had continued to be made in all areas and most of the actions from the previous inspection were addressed by the provider and person in charge. Actions partially completed or not addressed and further actions

required from this inspection are set out in the action plan at the end of this report. Areas requiring improvement on this inspection in addition to actions that were partially completed or not completed include access to occupational therapy, care planning, continued review of the quality of care and the quality of life of residents, safe access to the enclosed gardens and evidenced-based practice with regard to pain assessment and immediate assessment and care post falls.

Residents were complimentary of the staff stating that “they look after us well” and confirmed that they felt safe in the centre due to the continued presence of staff. They were positive in their comments regarding the care they received and voiced that there was “nothing that could make things better”. There were no complaints logged in the complaints register since the last inspection.

There is a good working relationship with the pharmacist who completes a three monthly comprehensive medication audit. Results from this audit are provided to the medical staff who in turn review the residents’ medication. Recommendations made by the pharmacist have been enacted by the medical staff resulting in positive outcomes for the residents. For examples, a decrease in the use of laxatives, better use of prescribed pain relief and a decrease in antibiotic prescribing.

The Action Plan identifies mandatory improvements in order 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*.

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 1

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

While the statement of purpose had been updated in June 2012 and described the service that was to be provided and the manner in which it was to be provided, it requires review to include date of registration, room measurements and to include arrangements for the supervision of therapeutic activities.

Outcome 2

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

References:

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

Outstanding action(s) required from previous inspection:

Agree a contract with each resident in the designated centre and for new residents, within one month of admission.

Ensure each resident's contract deals with all the fees to be charged.

Inspection findings

The response in the action plan submitted detailed that contracts of care had been made available to residents and their representatives for signature. The inspector reviewed two contracts of care. These were both signed by the relevant parties and the person in charge confirmed that these were the most recent up-to-date contracts. Fees are detailed with regard to hairdressing which residents are liable for as detailed in the statement of purpose. This is the only fee payable outside the contract of care.

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

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge has not changed since the last inspection. She is known as the director of nursing in the centre and was appointed on 12 October 2011. She is a registered nurse and holds a full-time post. She maintained her professional development and had recently attended study days in medication management (January 2012) and delegation and supervision of health care assistants in clinical practice (September 2012).

The person in charge has completed the higher diploma in was in Gerontology.

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.*

Resident's guide

Substantial compliance ☒ Improvements required * ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required * ☒

Records with regard to care planning require review.

General Records (Schedule 4)

Substantial compliance ☐ Improvements required * ☐

All general records were not checked on this inspection.

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☒ Improvements required * ☐

All mandatory policies and procedures were available.

Directory of Residents

Substantial compliance ☐ Improvements required* ☒

The directory of residents did not contain the address of the general practitioner (GP)

Staffing Records

Substantial compliance ☐ Improvements required* ☒

Four staff files were reviewed by the inspector and all of them had a self declaration in relation to certification of physical and mental fitness. This is not adequate evidence of medical fitness to work in the centre as none had been certified by a medical practitioner.

Medical Records

Substantial compliance ☒ Improvements required* ☐

There was good evidence of review by the GP.

Insurance Cover
Substantial compliance ☒ Improvements required* ☐

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

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

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector spoke with the person in charge who confirmed that she had no plans for a period of absence from the centre that would warrant notification. The person in charge confirmed that if she were absent from the centre, a staff nurse would deputise in her absence. The post of clinical nurse manager is vacant at this centre and there are no plans to fill this post. The deputising person would be reflected on the duty roster. No period of absence warranting a notification had occurred since the appointment of the person in charge.

Theme: Safe care and support
Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.
In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.
To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

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

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

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. The centre also had a policy on management of residents' finances but did not manage any of the of resident's finances at the time of this inspection.

Staff informed the inspector of the procedures to be followed in the event of an alleged incident of elder abuse and they were clear how they would report an allegation of abuse and that the welfare of the residents was their primary responsibility. Documentary evidence of attendance at adult protection, detection and prevention training was maintained for each staff member in a staff training matrix. An Garda Síochána vetting was completed for all staff.

The centre was secure. Access to the centre was controlled via key pad lock. Residents spoken to confirmed that they felt safe in the centre. They attributed this to the door being locked and "staff being readily available day and night".

The receptionist's office was situated on the right on entry. A receptionist was on-duty five days per week. A visitor's record was maintained and completion was monitored by staff.

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

Outstanding action(s) required from previous inspection:

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

Ensure 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.

Put in place an emergency plan for responding to emergencies.

Take all reasonable measures to prevent accidents to any person in the designated

centre and in the grounds of the designated centre e.g. have in place security arrangements that protect residents and staff.

Ensure hot water at the point of contact is thermostatically controlled and at point of contact it is no greater than 43 degrees C.

Policies and procedures and practice are consistent with best practise guidelines on prevention of infection and ensure staff are aware of these guidelines.

Ensure current infection control guidelines are followed.

Inspection findings

The actions required from the previous inspection were satisfactorily implemented.

The risk management officer had attended the centre and worked with the person in charge and the staff to assess risk throughout the centre and give advice and guidance on the management of risk. The inspector reviewed the risk management policy and risk assessments and was informed by the person in charge that these were completed and reviewed in consultation with the risk management officer. The last risk assessment completed was on the 21 September 2012. This related to an external environmental risk of trees which could pose a risk to the centre as a result of storm damage. Details of the risk assessment which includes a risk analysis of impact and likelihood are forwarded to the provider. The *HSE Incident Management Policy & Procedure* and *HSE serious Incident Management Policy & Procedure* are available in the centre to guide and assist staff.

A comprehensive emergency plan had been developed and staff were aware of the development and contents of this. The centre has a generator which operates automatically in case of electrical failure. Contingency arrangements with a list of staff and voluntary organisations that could/would assist should evacuation be necessary was available. The emergency plan also covered an outbreak of influenza and directed staff to the infection control polices for guidance in this area also.There was evidence available from minutes of staff meetings that the emergency plan had been discussed. It was strategically placed throughout the centre. A safety statement dated May 2012 was available.

A code lock had been installed on the front door thereby restricting access to the centre. Window restrictors were in place on all external windows.

Detailed records were maintained of all accidents and incidents. Records viewed showed a low incidence of falls in 2012. The person in charge confirmed that there had been a decrease in the level of falls. She attributed this to supervision by staff , the use of low -low beds, the change in location of the night staff, (staff are now located on the corridor area as opposed to the nurse's station, this ensures that any resident getting up unaided receives timely assistance if required) falls mats and the assessment and advice from physiotherapy services. The medication audit also supported the fact that sedative use had been decreased.

The person in charge confirmed that falls prevention management was discussed regularly at handover and staff meetings. She stated that all staff wished to minimise the risk of future falls. Where a resident had an accident which involved a head injury neurological observations were recorded, however where falls were un-witnessed there was no evidence available to demonstrate that the resident was assessed for possible head injury. The person in charge confirmed that this would commence immediately. Information recorded included factual details of the accident/incident, date and time event occurred, name and contact details of any witnesses and whether medical treatment was required.

Measures were in place to prevent accidents and facilitate residents' mobility. Handrails were provided on both sides of the corridor to promote independence. Overall fire safety was well managed but there was one area for improvement. While the person in charge confirmed to the inspector that the senior nurse in charge /Person in charge would check exits daily no record was maintained of this. If a record was maintained this would ensure that it was completed every day and where any procedural deficits existed there would be monitored and addressed. The inspector viewed the fire records which showed that fire equipment had been regularly serviced. The fire alarm system had been serviced quarterly. The inspector found that all fire exits were clear and unobstructed during the inspection.

Thermostatic control valves to reduce water temperature to a maximum of 43 degrees centigrade to prevent risk of scalding were installed.

A designated infection control nurse had been appointed in the centre. She has attended training on infection control and links in with the HSE specialist infection control services. The HSE infection control policy is available to staff. All staff have been trained on safe hand washing techniques. Infection Control is a standing item on the agenda of staff meetings. The person in charge works closely with the supervisor of the contract cleaners and meets with her regularly. Signature sheets re cleaning of toilets and bathrooms are in place.

The inspector viewed the fire training records and found that not all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire. However, fire drills were not carried out regularly to ensure the theoretical aspect of the training was put into practice.

The maintenance department have visited the centre and completed an assessment with regard to resting ramp platforms. This work has been approved but has not occurred to date.

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

Outstanding action(s) required from previous inspection:

You are required to revise your medication policy and establish good practice in the ordering, prescribing, storing and administration of medicines to residents.

You must ensure that all nurses are informed about and implement the revised practices.

You are required to submit a copy of the updated medication policy together with evidence that all nurses are familiar with the revised arrangements.

Inspection findings

The actions required from the previous inspection were satisfactorily implemented.

The inspector reviewed the updated medication management policy. Records were available to support that all nursing staff had read this policy and all nursing staff had received training on medication management in January 2012. The person in charge informed the inspector that Medication training will be delivered annually by the pharmacist to all nursing staff. The person in charge stated that she regularly observes medication administration rounds. The inspector observed a nurse administering medications and found that medication was administered in accordance with the centre's policy and An Bord Altranais guidelines. The staff nurse on the medication round was knowledgeable of the medications being administered and ensured that residents took the medication.The prescriptions reviewed did not include maximum doses for PRN (as required) medication.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection

Inspection findings

Inspectors found that all accidents and incidents were recorded in the centre and were maintained in a log. The person in charge was aware of the timescales within which notifications must be forwarded to the Authority. Notifiable incidents were notified to the Authority within the required timeframes.

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:

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.

Carry out a review of the quality and safety of care practices in regard to the ordering, prescribing, storing and administration of medications within the centre.

Improve the quality of care provided at, and the quality of life of residents in, the designated centre.

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

Inspection findings

The actions required from the previous inspection were satisfactorily completed.

A system for reviewing the quality and safety of care provided to, and the quality of life of residents has been developed. The pharmacist completes a three monthly medication audit as already mentioned in outcome 8. This audit includes a review of each resident's medication record.

A review of restraint practices and care planning had been completed. A trending report which details for example all falls, complaints, antibiotic use is completed by the person in charge every three months and forwarded to the provider.

The dietician had completed an audit of the nutritional assessments. This showed that nurses had poor understanding of completing a comprehensive nutritional risk assessment. All nursing staff have received refresher training in this area.

A new care plan system has been enacted. This provides a more comprehensive organised system to ensure. This had been audited the centre had begun to audit this procedure and found that the care plans were not person-centred and failed to link the assessment information to the care plans.

Restraint practices were audited in February 2012 and a new system to ensure compliance with the national standards in this area was implemented.

An infection control audit had been completed on the 16 March 3012.area that required attention were addressed for example one shower tray required cleaning and steam cleaning was carried out in this area.

The centre had completed a residents and relative satisfaction survey in 2012, the results of which were complimentary of the service and staff. The inspector noted that where residents had the provision of activities and exercise groups the person in charge had reviewed the activity schedule and exercise groups and a greater choice of activities and increased exercise. Residents spoken with informed the inspector that they enjoyed living in the centre.

The person in charge completes a quality monitoring and data report three monthly. A trending report is completed monthly. Both reports were made available to the inspector. The trending report shows al falls, antibiotic use and general day to day care of the residents. The quality monitoring report is a three month analysis which looks at for example falls, injuries sustained and restraint measures. Both reports atre forwarded to the clinical support manager for Mayo and the provider.

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

Outstanding action(s) required from previous inspection:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Provide a high standard of evidence-based nursing practice.

Provide appropriate medical care by a medical practitioner.

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

Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances.

Facilitate each resident's access to speech and language therapy as required by residents.

Provide opportunities for participation in purposeful and meaningful activities for residents of all levels of dependency on an ongoing basis.

There was no rehabilitative care plan to support residents who spent long periods of time in bed.

Provide suitable and sufficient care to maintain the resident's welfare and well-being having regard to the nature and extent of the resident's dependency and needs as set out in their care plan.

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

Inspection findings

The inspector found that the majority of these actions had been completed.

The inspector found that generally, a good standard of nursing care was provided. Staff promoted the residents' health by encouraging them to stay active and many of the residents had managed to maintain their mobility. A regular exercise class formed part of the activity programme.

The inspector found that while there had been improvements to the nursing assessments, clinical risk assessments and care plans since the previous inspection, but further improvements were required. A skin assessment is carried out on admission and post transfer back from the general hospital. A new care documentation system was in place. All nursing staff had received two days training on this system prior to its enactment.

The person in charge described good access to GP services and stated that a local GP attended the centre daily Monday – Thursday and as required. The inspector reviewed two medical files and found that there was good documentary evidence in medical files that residents were regularly seen by the GP. Reviews of medication were occurring at three monthly intervals and this was reflected in the audits by the pharmacist but this was not documented by the GP in the medical notes or on the medication charts.The person in charge described good links with the local pharmacy services. A chiropodist attended the service regularly. A dentist had attended the centre and carried out dental assessments on all residents. Dietician services were available and there was good evidence of regular review by the dietician. 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. Records of referrals were available

The inspector reviewed a sample of residents' care plans. There were nursing assessments and clinical risk assessments carried out for all residents. There was poor evidence of review of the care plans at three monthly intervals or with regard to changing circumstances. The inspector noted that the assessments didn't inform the care plans. For example, where a resident was assessed and seen by the dietician and recommendations made this was not reflected in the care plan. A record of the residents' health condition and treatment given which was linked to the care plan was completed on a daily basis. However, the nurses' entries were not timed which is not in line with best practice guidelines from An Bord Altranais. There was poor evidence of involvement of the residents or their representatives in the development and review of the care plan.

There were opportunities for all residents to participate in activities. A carer is allocated to the day room from 11: 00 hrs to lead on activities, Mass was said weekly, two staff had recently trained in Sonas therapy (a group session involving stimulation of all five senses particularly useful for people with cognitive impairment. This was a regular session on the activities schedule. Other activities included activity boxes, bingo, a knitting group, vintage films, card playing, art, aromatherapy, reminiscence, pet therapy planned and farmers journal. Residents had submitted poetry for the Bealtaine festival.

Residents who spent long periods of time in bed or in a chair had individual activities provided for example hand massage or aromatherapy.

However, access to some peripatetic services involved a period of waiting.The person in charge informed the inspector that a physiotherapist would be available if required but since the physiotherapy department had relocated from the centre to the primary care centre residents had to wait longer to be seen. The inspector noted that while all residents who spend long periods of time in bed or in a chair had a physiotherapy rehabilitation programme this was not reviewed since February 2012. While the occupational therapist had attended the centre in August 2012 and seen all residents who required occupational therapy review, the person in charge informed the inspector that this service was by referral only and it entailed a waiting period. One resident who had been waiting on a seating assessment to assess safe use of a new chair was waiting for six weeks for an occupational therapy review. On day one of

the inspection the inspector requested that the person in charge inform the provider that the inspector requested that he arrange an occupational therapy assessment for this lady as a matter of urgency. The provider confirmed that an occupational therapist would attend the centre two days later and review this resident. The person in charge confirmed in writing to the Authority that this lady was seen on the 5 October by the occupational therapist. All residents who required a speech and language therapy assessment were seen in May 2012. There was good evidence on files reviewed of a comprehensive assessment at this time, however, staff informed the inspector that while there was access to speech and language therapy (SALT) services, this entailed a waiting time for residents referred directly from the centre. If residents had an admission to the local acute hospital they would often be seen by SALT services if required. A nurse has been trained in dysphagia assessment.

While assessment of the requirement for pain relief was taking place there was no process in place for monitoring of the effectiveness of the analgesia administered.

A Policy on Challenging behaviour was available. There was no resident exhibiting behaviour that challenges at the time of inspection. The person in charge confirmed that they had good input from mental health services who attended the centre as requested.

Restraints in use included bedrails. The policy on restraint was based on the new national policy on promoting a restraint free environment. Two staff had completed the train the trainer course on restraint but had not trained all the staff on this policy as yet. The person in charge confirmed that she would prioritise this training. Documentation in audits reflected that the use of bedrails had decreased. The person in charge related this to the use of low-low beds and better understanding with regard to restraint practices.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Outstanding action(s) required from previous inspection:

Provide suitable communal space for residents and day service attendees for the provision of social and cultural activities appropriate to the circumstances of all in the centre.

Keep all parts of the designated centre clean.

Provide and maintain external grounds which are suitable for, and safe for use by residents with particular attention to the ramps leading to the enclosed gardens.

Provide adequate facilities for residents' clothes to be sorted and kept separately and to separate clean from dirty laundry.

Provide a suitable storage area for equipment.

Maintain the centre in a good state of repair internally and externally.

Inspection findings

The inspector found that's some of these actions were complete and some partially completed.

For the most part the location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs, However, there were areas for improvement. All communal areas were being used. The front sitting room was used mainly by day residents. Plans to enhance the communal areas was shown to the inspector. Different activities are run in both the sitting and day room. The time of commencement of the day service has been moved to 12 noon which assists with crowding in the day room. The day care residents use the sitting room prior to lunch and some of the day care residents go straight to the dining room thereby freeing the day room for residents.

The premises were bright and free from any unpleasant odours. The inspector observed a satisfactory standard of cleanliness throughout the centre. The person in charge has developed a monitoring system for cleaning requirements.

Residents interviewed stated they enjoyed living in the centre and were complimentary of the staff and their surroundings. The inspector found there was adequate personal storage space in the bedrooms and locked personal storage was provided on request.

The inspector reviewed the most recent environmental health officers report dated the 26 June 2012.This was positive apart from recommending a new bedpan washer which has been installed.

The following environmental changes have occurred since the last inspection:

1. The cleaning supervisor supplied more effective cleaning equipment.

2. Steam cleaning of toilet and bathroom areas has been undertaken.

3. A painting programme is in place.

4. All bedroom doors have been widened and replaced – this was to comply with fire safety and evacuation procedures.

5. The damaged floor covering has been replaced.

The maintenance team have attended the centre and have addressed a substantial amount of maintenance issues. Staff informed the inspector that the new system with regard to logging maintenance issues and their resolution was working well. The bedpan washer has been replaced and the rack in the sluice room has been secured to the wall.

The inspector visited the laundry. At the time of the previous inspection, the inspector was concerned that there was inadequate space in the laundry to keep clean and soiled clothes separate. As a short tem measure the centre was using a single unused bedroom to store any soiled clothes. These were stored in alginate bags and were brought to the laundry when all other clothes had been washed dried and distributed back to the residents. Plans were shown to the inspector to increase and upgrade the laundry facilities. Clothing items were discreetly marked using a button identification system with the name of the resident. The inspector spoke to the staff member in the laundry and found that she was knowledgeable about the systems in place to segregate laundry and prevent the spread of infection. Residents expressed satisfaction to the inspector regarding the laundry and the general care of their clothes and one lady told the inspector 'I never lost a bit of my laundry'.

Storage for equipment was adequate as the physiotherapy room was used to store the overflow of equipment. Improved storage facilities have been discussed with estates and this has been included in the new architectural Plans.

Insecure raised toilet seats have been removed.

A visitors' room is available for residents to meet their visitors in private.

A code pad lock was installed on the front door.

The actions that have not been addressed include:

The installation of resting platforms on the ramps into the garden has not been addressed. This has been brought to the attention of maintenance that have attended the centre and agreed to install same but no timeframe has been agreed.

The extractor fan has not been installed in the laundry. Maintenance are aware that an extractor fan is required in the laundry. The person in charge informed the inspector that this was because there were safety implications that had to be considered prior to the installation of a large fan. She stated that venting of an extractor fans in sluice (internal area) and laundry is known to maintenance and has to be discussed further with Fire compliance officer in order to establish a safe exit and method of extraction.

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

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

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

Outstanding action(s) required from previous inspection:

Document the wishes of residents and their representatives as to how they want care delivered at the end of their life.

Inspection findings

This action was partially completed.

No resident was in receipt of end-of-life care on the days of inspection. The inspector discussed end-of-life care planning with the person in charge. She confirmed that while they would know the residents' wishes and would have spoken with the family with regard to same. The person in charge informed the inspector that staff would record any known resident wishes and would try and elicit all residents end of life care wishes. The person in charge informed the inspector that they had good access to palliative care services.

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

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

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector was satisfied that residents received a nutritious and varied diet. There was one dining room. The inspector observed lunch in the dining room and assisted lunches in the day room.

Eight residents ate in their bedrooms and the inspector requested an explanation from staff as to why this occurred. Appropriate explanations were given including choice, feeling unwell, and four told the inspector that they wished to say in bed in the am. Three of these residents got up after dinner.

The menus were displayed and residents told the inspector there was always a choice of food. The menu choices on the days of inspection provided nutritious and wholesome food. Meals were well presented and hot. Residents who required their food pureed or mashed had their food presented in individual portions. Residents confirmed that they enjoyed the food.

Documentary evidence to demonstrate that residents' weights were recorded monthly was made available to the inspector. Nutritional risk assessments were used to identify residents at risk of malnutrition. A recent audit of those had been completed by the dietician who found that staff were not clear with regard to the completion of the assessment tool. The dietician had delivered further training to staff. There is a link staff nurse for nutrition in the centre. Nutritional care plans were in place. The inspector saw residents being offered drinks throughout the day and jugs of water and glasses were available in communal areas. Nursing staff and the person in charge confirmed that there were no pressure sores on the day of inspection.

Outcome 16

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

References:

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

Outstanding action(s) required from previous inspection:

Ensure that each resident is facilitated and encouraged to communicate.

Inspection findings

This action was partially completed.

Pictorial communication cards have been developed to assist with communication. These have not been implemented with residents as yet as the advocate is currently doing a set re menu choices and the plan is to introduce all communication card together so as there will be greater variety.

Residents' meetings are held every four to six weeks. The quality monitoring data report which is completed by the person in charge three monthly is available to residents at their meetings.

The inspector reviewed minutes of these meetings. The meetings were chaired by the independent advocate for the centre, between five and seven residents had attended the last two meetings. Issues discussed included outings, activities and exercise.

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

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

Outstanding action(s) required from previous inspection:

Maintain an up to date record of each resident's personal property that is signed by the resident.

Inspection findings

The action required from the previous inspection was satisfactorily implemented.

A triplicate property record book was in place. This detailed the property of the resident on admission and the record that was kept in the book was updated on regular occasions. The person in charge informed the inspector that a notebook and a sign is available in each residents wardrobe for staff to record any new items of property, the sign is to alert the relatives to inform staff if they bring in any additional property. Staff have been reminded of their responsibilities in this matter by the person in charge at staff meetings and have been requested to observe and document any new items brought in to residents.

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

Outstanding action(s) required from previous inspection:

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

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

Provider to esure that they are satisfied that procedures are in place to safely evacuate the residents at all times taking into consideration the residents specific needs and dependency levels.

Provider to complete a comprehensive assessment of staffing levels over the 24 hours using recognised assessment tools and contemporary evidence-based practice, to ensure the needs of the residents are met and the safety of the residents is not compromised.

Inspection findings

The inspector reviewed staffing rosters and discussed the staffing levels with the person in charge. She said she used the assessed dependency level of residents, resident numbers and her clinical judgment to inform her decisions on adequate staffing levels.

A registered nurse was on duty at all times. A staff handover occurred at 08:00 hrs, 16:00 hrs and 20:30 hrs .

Emergency evacuation plans were in place to assist staff with swift evacuation if required. The centre has been upgraded with regard to fire safety and new fire doors were in place.

Documentation was available to support that the residents' dependency levels are reviewed weekly or sooner if required. The person in charge was clear that she linked the staffing levels with the dependency levels. The person in charge had completed an assessment of staffing levels using various staffing assessment tools. There were two staff nurses on duty until 23:30 hrs. Post 23:30 hrs there was one staff nurse and one carer until 08:00 hrs. Where there were unplanned absences, part-time staff had been organised to work extra shifts which ensured that residents

were familiar with staff and staff were knowledgeable of residents' needs. There was an actual and planned roster available, where a nurse had retired a permanent agency nurse was in place. The bed complement had been reduced from 39 to 32. The day care house has also been reduced. The person in charge confirmed that if a resident's needs dictated a requirement for extra staff would be sanctioned to ensure the safety of all residents.

The inspector found that residents' privacy and dignity was respected by staff. The inspector observed staff knocking on the doors of occupied rooms and waiting for permission to enter. The inspector observed good interactions between staff and residents who chatted with each other in a relaxed manner. Staff spoken with were knowledgeable of residents' individual needs.

The post of clinical nurse manager is vacant at this centre, however a clinical support manager is available who works with l the person's in charge of the HSE designated centres in Co. Mayo. This is a required additional support to enable, support and advise the person in charge to ensue the delivery of safe quality care with positive outcomes to residents.

All nursing staff had the required up-to-date registration with An Bord Altranais for 2012.

The inspector reviewed the training records and found that staff had completed training:

- medication management
- infection control
- elder abuse
- nutrition, hydration and dysphagia
- dementia and behaviour that challenges
- care planning
- food hygiene
- delegation and clinical supervision.
-

Mandatory traing in safe moving and handling and adult protection was up to date, however as detailed in outcome 7 fire safety traing was not up-to-date for all staff.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Mary McCann

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

16 October 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre Name:	D'alton Community Nursing Unit
Centre ID:	0643
Date of inspection:	2 and 3 October 2012
Date of response:	31 October 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 1: Statement of purpose and quality management

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

While the Statement of Purpose had been updated in June 2012 and described the service that was to be provided and the manner in which it was to be provided it requires review to include date of registration, room measurements and to include arrangements for the supervision of therapeutic activities.

Action required:

Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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

Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Statement of purpose has been updated to October 2012. Date of registration has been included in new document. Previously, residents attending licensed aromatherapist are on a referral basis, with documentary evidence from GP of his/her approval that resident suitable for this therapy. Clarification of this referral system has now been included within the updated statement of purpose October 2012. Estates have been re-contacted to provide room measurements.	30 November 2012

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

2.The person in charge is failing to comply with a regulatory requirement in the following respect: The directory of residents did not contain the address of the GP. Four staff files were reviewed by the inspector and all of them had a self declaration in relation to certification of physical and mental fitness. This is not adequate evidence of medical fitness to work in the centre as none had been certified by a medical practitioner.
Action required: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.
Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.
Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records Regulation 24: Staffing Records

Standard 22: Recruitment Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Directory of residents now includes dr's name and address. HSE permanent staff would have been medically screened as to mental and physical fitness for the post to which appointed. Currently these records are held by HR, director of nursing is in consultation with HR on this issue. Temporary staff have been advised of the necessity of providing evidence from own GP as to mental and physical fitness.	 completed 30 November 2012 15 November 2012

Theme: Safe care and support

Outcome 7: Health and safety and risk management

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

The inspector viewed the fire training records and found that not all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire. However, fire drills were not carried out regularly to ensure the theoretical aspect of the training was put into practice.

Action required:

Provide suitable training for staff in fire prevention.

Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Reference:

Health Act, 2007
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Fire officer will attend to give further training to staff.	 January 2013

More regular fire drills will be implemented. Residents will also be included in instructions given, as to fire precautions and procedures to be taken in the event of fire.	November 2012

Outcome 8: Medication management

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

The prescriptions reviewed did not include maximum doses for PRN (as required) medication.

Action required:

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.

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: Policy addressess that the maximum doses of PRN medication in each 24 hr period must be documented. GP and pharmacy have been contacted and will include this requirement on all future charts. Nursing staff have been advised to re-read and re-sign medication management policies. Disposal/return of unused/out of date medication has been further clarified within medication management policy.	Immediately

Theme: Effective care and support

Outcome 11: Health and social care needs

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

While assessment of the requirement for pain relief was taking place there was no process in place for monitoring of the effectiveness of the analgesia administered.

Where falls were un-witnessed there was no evidence available to demonstrate that the resident was assessed for possible head injury.

Action required:

Provide a high standard of evidence-based nursing practice with regard to pain management and immediate care and assessment post falls.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Nursing staff would have been informally observing effect of analgesia. However, this will now be formalized by recording the effectiveness of analgesia on an analgesia evaluation chart.	Immediately
Glasgow Coma Scale already being implemented. Nurses would use this scale and clinical judgement wherever a resident sustaines a head injury or is found in a falls position which would indicate that the person may have sustained a head injury. However, all unwitnessed falls in future will now have the Glasgow Coma Scale implemented.	Immediately

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

The inspector reviewed a sample of residents' care plans. There was poor evidence of review of the care plans at three monthly intervals or with regard to changing circumstances. The inspector noted that the assessments didn't inform the care plans. For example, where a resident was assessed and seen by the dietician and recommendations made this was not reflected in the care plan.

There was poor evidence of involvement of the residents or their representatives in the development and review of the care plan.

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 3-monthly intervals.

Action required:

Revise each resident's care plan, after consultation with him/her.

Action required:

Notify each resident of any review of his/her care plan.

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: In the past few months a considerable amount of training and documentation was undertaken in order to progress the residents' care plans. Nursing Staff are now in a position to once again review this process. Some auditing of the plans has taken place and allocation of time for auditing purposes has been discussed further with the General Manager. Assessments and Plans are being currently reviewed in order to achieve better linkage and updating of information. Review of residents' care plans will occur in consultation with each resident.	31 January 2013

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

Access to some peripatetic services was limited. The inspector noted that while all residents who spend long periods of time in bed or in a chair had a physiotherapy rehabilitation programme this was not reviewed since February 2012.

Action required:

Facilitate each resident's access to physiotherapy, chiropody, occupational therapy, or any other services as required by each resident.

Reference:

Health Act, 2007
Regulation 9: Health Care
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence

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

Provider's response: Chiropodist visits every six weeks. Occupational therapist visited on 5 October 2012, referrals for OT have been made. Dietician visits every four to six weeks. Residents attend external SALT appointments when required,(last appointment 15 October 2012) or may be assessed if admitted to hospital. Physiotherapist attends as required (last visits August/September 2012) Request has been made to have Physiotherapist attend in order to update rehabilitation plans.	26 November 2012

Outcome 12: Safe and suitable premises

8.The provider is failing to comply with a regulatory requirement in the following respect: The extractor fan has not been installed in the laundry or the sluice area.	
Action required: Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This is part of the overall architectural plans for the unit and will be addressed as part of the structural changes to be made.	February 2013

9.The provider is failing to comply with a regulatory requirement in the following respect: The installation of resting platforms on the ramps into the garden has not been addressed. This has been brought to the attention of maintenance that have attended the centre and agreed to install same but no timeframe has been agreed.
Action required: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Resting Platforms have been viewed by Estates and will form part of the construction work planned for the unit.	February 2013

Theme: Person-centred care and support

Outcome 13: Complaints procedures

10.The person in charge is failing to comply with a regulatory requirement in the following respect: Pictorial communication cards have been developed to assist with communication. These have not been implemented with residents as yet as the advocate is currently doing a set re menu choices and the plan is to introduce all communication card together so as there will be greater variety.
Action required: Put in place practices that facilitate and encourage each resident to communicate.
Reference: Health Act, 2007 Regulation 11: Communication Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Final preparations are taking place on the communication cards These will then be implemented and made available to residents.	30 November 2012

Outcome 14: End of life care

11.The person in charge is failing to comply with a regulatory requirement in the following respect: The person in charge confirmed that while they would know the residents' wishes and would have spoken with the family with regard to same, however, the inspector found that they did not document end-of-life care wishes.

Action required: Identify and facilitate each resident's choice as to the place of death, including the option of a single room or returning home.	
Action required: In the event of the sudden death of a resident, facilitate his/her religious and cultural practices, insofar as is reasonably practicable.	
Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Nurses document all known resident's wishes for end of Life care. If resident unable to make wishes known due to cognitive difficulties, Nurses liaise with resident's representative. In some cases these wishes may not be known by the Representative either. Every effort is made to ensure that this sensitive and very personal choice is known and documented, but there are some circumstances where this cannot be verified, therefore in future rather than leaving this area of the documentation blank, Nurses will document that wherever wishes cannot be elicited, that this personal information is not available from any source policy on end of life care will guide practice. Also in order to address specific religious and cultural practices Staff have access to the HSE document *Health Services Intercultural Guide: Responding to the needs of diverse religious communities and cultures in healthcare settings."* Staff also have access to the end of life care resource folder which was developed by the HSE in partnership with the Irish Hospice foundation as part of the 'Hospice Friendly' Hospitals Programme.	31 December 2012

Any comments the provider may wish to make:

Provider's response:

We thank the inspector for her courtesy and professional approach. Every effort will be made to progress standards as highlighted within the report. Our continued objective is to ensure the provision of safe, person-centred, effective and efficient care for all residents, within the ethos of a homely and welcoming environment.

Provider's name: HSE West Mr. Michael Fahey.
Date: 31 October 2012