<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Rosenalee Care Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000277</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Poulavone, Ballincollig, Cork.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>021 4850 930</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:rosenalee@eircom.net">rosenalee@eircom.net</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Rosenalee Care Centre Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Timothy Cyril Murphy</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Shigi Chalumpattu Skaria</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Geraldine Ryan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Col Conway;</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>36</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>5</td>
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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 his/her 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
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 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, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
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<tr>
<td>11 June 2014 08:00</td>
<td>11 June 2014 17:00</td>
</tr>
<tr>
<td>12 June 2014 08:55</td>
<td>12 June 2014 15:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<tr>
<td>Outcome 02: Contract for the Provision of Services</td>
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<td>Outcome 03: Suitable Person in Charge</td>
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<td>Outcome 04: Records and documentation to be kept at a designated centre</td>
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<td>Outcome 05: Absence of the person in charge</td>
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<td>Outcome 06: Safeguarding and Safety</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Medication Management</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10: Reviewing and improving the quality and safety of care</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<td>Outcome 16: Residents Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents clothing and personal property and possessions</td>
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<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection

The purpose of this inspection was to inform a registration renewal decision and to monitor ongoing compliance with Regulations and Standards. This inspection report sets out the findings of the re-registration inspection of 11 June 2014 and 12 June 2014, in which 18 outcomes were inspected against.

This re-registration inspection was the seventh inspection carried out by the Authority in this centre. The most recent inspection was carried out on the 27 July 2013 during which 12 outcomes were inspected against. That inspection generated an action plan with 14 actions. As noted on this re-registration inspection, ten of the actions were completed and four actions were not addressed and are reissued in the
action plan at the end of this report.

As part of the monitoring inspection, inspectors met with residents, a relative and staff members. Inspectors observed practices and reviewed documentation such as the statement of purpose, the directory of residents, residents’ contracts of care, care plans, medical records, the menu, accident logs, complaints log, resident/relative satisfaction surveys, records of residents' finances and personal belongings, policies and procedures and staff files.

On the first day of inspection, the inspectors met with the provider, a director, the person in charge (PIC) and the key senior manager (KSM). Findings on this inspection identified concerns in areas such as:

- medication management practices
- infection control practices
- the premises.

The Action Plan at the end of this report identifies where a number of improvements are required 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. These were discussed with the provider at the feedback meeting at the end of the two days of inspection.
Outcome 01: Statement of Purpose

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.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The Statement of Purpose (SoP) consisted of a statement of the aims, objectives and ethos of the designated centre and a statement as to the facilities and services which were to be provided for residents.

An action generated from the most recent inspection of the 25 July 2013 related to the fact that the SOP did not contain all information as required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). This action remains outstanding. One of the directors stated that she was currently engaged in a recruitment process and gave an undertaking to update the SoP when this process was completed.

The number and sizes of the rooms as stated in the SoP did not accurately reflect all the actual rooms available.

There was evidence that the SoP was readily available for residents and staff to read.

As per the conditions of the current registration certificate, the maximum number of residents that can be accommodated in the centre is 41.

The inspector noted, on the day of the inspection, that the philosophy as described in the centre's SoP was actively promoted by the PIC and staff.

Judgement:
Non Compliant - Minor

Outcome 02: Contract for the Provision of Services

Each resident has an agreed written contract which includes details of the services to be
**Outstanding requirement(s) from previous inspection:**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector reviewed a sample of the residents' contracts of care and noted that all were signed and dated by the resident or their representative within a month of admission.

The contract described in a clear manner, the services to be provided. All fees relevant to care and accommodation were included in the contract.

Details of any additional items that incurred a charge were included in the contract.

**Judgement:**
Compliant

**Outcome 03: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
There was no change to the role of person in charge since the last inspection.

The person in charge had continued to develop her clinical knowledge since the last inspection and demonstrated an understanding of her legal responsibilities under the Regulations and Standards.

She had engaged in continuous professional development (CPD). Throughout the inspection process she showed strong commitment to delivering good quality care to residents and to improving the service delivered.

The PIC was engaged in the governance, operational management and administration of this centre on a regular and consistent basis. There was a clearly defined management structure that identified the lines of authority and accountability.
Residents were aware of who was in charge of the centre. It was evident that the PIC had in-depth knowledge of all residents and their care needs.

The PIC held frequent meetings with all staff and this was evidenced by minutes of staff meetings reviewed. Staff were aware of reporting structures and voiced their satisfaction with regard to working in the centre.

Staff stated that they felt supported by the PIC and could bring any matter to her attention and voiced their confidence that issues would be immediately addressed.

**Judgement:**
Compliant

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### Outcome 04: Records and documentation to be kept at a designated centre

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).

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
Documents to be held in respect of persons managing or working at the centre, were in place. A sample of staff files reviewed reflected compliance with the requirements of Schedule 2, Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Residents' records (Schedule 3) were recorded in the centre’s computerised system and further information regarding allied services, medical notes and transfer letters were maintained in hard copy and in a secure manner. All hard copy information was filed in a satisfactory manner and was easy to retrieve.

The centre had an up to date directory of residents (Schedule 4). General records (Schedule 4) were maintained in an organised manner.

The centre's operating policies and procedures (Schedule 5) had been reviewed by the PIC. The policies were centre-specific and reflected the care given and informed staff with regard to up to date evidenced best practice or guidelines.

Inspectors noted that information relating to the residents was up to date in the
residents’ care plans.

The PIC stated that residents could access their records and this was confirmed by residents.

Residents’ records and general records were kept for not less than 10 years after the resident to whom they relate ceased to be a resident in the centre. The centre had an up to date policy in relations to the creation of, access to, retention of and destruction of records kept in the centre.

Inspectors noted that records relating to inspections by other authorities (fire/food safety, equipment servicing) were maintained.

Staff spoken to by the inspector were aware of the centre's polices and there was evidence of copies of the policies located at the nurses’ reception desk. There was evidence that the centre’s policies were discussed at staff meetings.

There was evidence that the centre was adequately insured against accidents or injury to residents, staff and visitors. Insurance cover was in place against loss or damage to the assets and delivery of the service. The provider had a liability to each resident not exceeding €1000 against loss or damage to any one item.

The PIC was aware of the records that must be maintained by the centre. There was evidence that records were audited by the PIC, for completeness and accuracy.

Judgement:
Compliant

**Outcome 05: Absence of the person in charge**

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

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
Suitable arrangements were in place for the management of the centre in the absence of the PIC. The assistant director of nursing (KSM) was the identified person to act as PIC in the event that the PIC was absent.

**Judgement:**
Compliant
### Outcome 06: Safeguarding and Safety

*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.*

**Theme:**
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The centre had an up-to-date policy on, and procedures in place for, the prevention, detection and response to abuse which staff were trained on. Staff demonstrated their knowledge of what constituted abuse and what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to.

The PIC monitored the systems in place to protect residents and ensured that there were no any barriers to staff or residents disclosing abuse.

Residents stated that they felt safe in the centre and spoke about how caring and kind the staff were.

There had not been any incidents, allegations, suspicions of abuse recorded and there was evidence that procedures were in place to ensure that an incident was appropriately investigated and responded to in line with the centre’s policy.

There was evidence that systems were in place to safeguard residents’ property and finances. A review of a record of residents’ monies indicated that details in invoices issued concurred with the transactions history as documented in the log book and that the standing balance was accurate.

**Judgement:**
Compliant

### Outcome 07: Health and Safety and Risk Management

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The centre had an up-to-date health and safety statement.

There were procedures in place for the prevention and control of infection. Alcohol hand gels, disposable gloves and aprons were located within the centre and staff were observed availing of protective equipment (PPE) when engaging in personal care, housekeeping practices and while entering, working in and exiting the main kitchen. There was some provision of separate staff hand washing facilities and visible instructions on hand washing techniques.

There was evidence that clinical waste was collected by an approved external agency. A clinical waste container located externally, was securely locked. Containers for used sharps and needles were mostly stored in a secure manner. However, one unsecured sharps container was noted at the nurses’ reception desk and this was immediately removed to a secure location.

A housekeeping staff member ably demonstrated her knowledge in regard to procedures on cleaning residents’ bedrooms and en suites. A colour coded housekeeping system was in use for cloths. While it was evident that the floor mops were changed post completion of cleaning of each room or bathroom, colour coded mops/mop handles were not in place.

Inspectors noted that the housekeeping room located in the convalescent unit stored both the mops/buckets used by both the general housekeeping staff and by the kitchen staff. This method of storage did not promote best practice in the prevention of infection.

The timber rim on the front of the sink unit in the housekeeping room in the convalescent unit required attention.

The nursing unit had a sluice room and it was noted that mop buckets used by housekeeping, were stored, filled and emptied from the sluice room. The provider and PIC were asked to review this to ensure that best practice in infection control was promoted.

The centre’s laundry was located in a separate external building. This room contained appropriate equipment, regularly serviced by an external contractor. A staff hand washing facility was available.

Inspectors noted that the levels of cleanliness, housekeeping, décor and furnishings were of a high standard. The PIC informed the inspector that a schedule of updating décor, painting, refurbishment and deep cleaning was ongoing. There was evidence that the carpet flooring was regularly cleaned by an external contractor.

On review, the risk management policy covered:
- the identification and management of risks including the specified risks outlined in Article 31
- the measures in place to control risks
- the arrangements for identification, recording, investigation and learning from serious incidents, untoward incidents or adverse events involving residents.
There was evidence that the risk register was continually reviewed and updated by the PIC.

There were arrangements in place for investigating and learning from serious incidents/adverse events involving residents. The PIC stated that incidents were discussed at staff meetings, handover reports and the weekly management meeting. Documented audits and minutes of staff meetings reviewed supported this.

A safety committee was in place and minutes of meetings reviewed indicated that health and safety and risk were discussed.

The inspector viewed the emergency plan and noted that there were arrangements in place for responding to emergencies and a location identified for safe placement of residents, in the event of an evacuation.

The inspector noted that reasonable measures were in place to prevent accidents (handrails, grab rails, safe floor covering). A functioning call-bell was in operation.

There was evidence that staff were trained in the moving and handling of residents and this was confirmation that manual handling equipment was serviced by a suitably qualified external contractor. However, in-house checks on the standing hoist before use (i.e. checking the slings and attachments for wear and tear) required review as there was no evidence that this check was carried out before use. The PIC stated that the centre promoted each resident’s independence and throughout the two days of inspection it was evident that residents’ independence was actively encouraged.

Records reviewed by the inspector indicated that the fire alarm was serviced on a quarterly basis, fire safety equipment was serviced on an annual basis and fire drills took place on a six monthly basis. The centre had a signed certificate of fire safety compliance from an appropriate external authority. There was evidence of arrangements in place for reviewing fire precautions which included the alarm panel, the fire exits and the testing of fire equipment. Fire records were kept which included details of fire drills/fire alarm tests/ number, type and maintenance of fire-fighting equipment.

Inspectors noted that all fire exits were unobstructed. Staff spoken to by the inspector were aware of what to do in the event of a fire and were aware of the identified fire exits. A procedure for the safe evacuation of residents and staff in the event of fire was prominently displayed throughout the centre.

Two visitors’ sign in/out books were readily accessible at the front door. There was evidence that persons entering and leaving the centre signed the book.

**Judgement:**
Non Compliant - Moderate

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**Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for*
**Theme:**
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector reviewed the centre’s policy on medication management relating to the ordering, prescribing, storing and administration of medicine to residents, and noted that it was up to date. However, the centre did not have a policy to guide staff on transcribing medication. The issue of transcribing medications is addressed in more detail below.

Residents’ medications were supplied by an external pharmacy. The inspector saw evidence of secure storage of unused medication and the PIC stated that the external pharmacy supplier collected these medications on a regular basis. While records of medications returned to the pharmacy were maintained, it was not evident that the external pharmacy supplier co-signed the returned medications.

A sample of medication administration charts were reviewed and all included the resident’s name, date of birth, a photograph of the resident and details of any allergies.

A review of the medication prescription charts reflected that the nursing staff transcribed the medications for the GP to sign. The centre did not have a policy to support this process. The centre’s practices with regard to the transcription of medications did not concur with national guidelines as outlined in the An Bord Altranais Guidance to Nurses and Midwives on Medication Management:
- the medications were not signed by the transcribing nurse
- checking systems to minimise errors were not in place
- the centre did not have a policy to guide and inform staff on the transcription of medications
- one resident’s transcribed medication prescription chart noted that the resident had no known drug allergies (NKDA). However, the resident’s allergy to a particular medication was noted on the medication administration chart and in the computerised medical history note. This information had not been correctly transcribed.

Medications currently administered as crushed to residents were signed off by the resident’s GP. No resident was currently self-medicating.

There was documentary evidence indicating that residents’ medication was reviewed by the GP on a three monthly basis. There was evidence of ongoing review and audit of residents prescribed psychotropic medications.

There was a facility in place for the safe storage of scheduled controlled drugs (MDAs). The controlled drug register was reviewed with the KSM. One controlled drug was currently being administered and there was evidence that:
- the total corresponded
- two nurses signed and dated each entry
- the stock balance was checked and signed by two nurses at the change of each shift.

A locked fridge containing medication only was located in the medicines room. There was evidence that the temperature of the fridge was monitored daily.

**Judgement:**
Non Compliant - Major

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**Outcome 09: Notification of Incidents**

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

**Theme:**
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
A record of all incidents occurring in the designated centre was maintained in the centre’s computerised system. The inspector reviewed the accident/incident log and noted that the records concurred with the notifications forwarded to the Authority and within the required timeframe. A quarterly report was provided to the Authority to notify the Chief Inspector of any incident which did not involve personal injury to a resident and where there had been no such incidents a ‘nil’ return was made under Section 65 of the Health Act 2007.

**Judgement:**
Compliant

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**Outcome 10: Reviewing and improving the quality and safety of care**
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

**Theme:**
Effective Care and Support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
There was a robust system in place to review and monitor the quality and safety of care and the quality of life of residents. A range of three monthly audits included medication
management, falls, pressure care, infection control, restraint, clinical waste, food and nutrition, records, use of psychotropic medications, end of life care and pain. The inspector saw evidence of how improvements were brought about as a result of the learning from the monitoring review and noted actions identified to address non compliance.

There was evidence that a residents' group met on a regular basis. Minutes reviewed indicated that these meetings had an average of 20 attendees. Meetings were attended by the residents’ advocate. The residents’ advocate was also the co-ordinator of activities for the centre. He demonstrated in-depth knowledge of the residents and their backgrounds. It was evident that choices of activities were discussed with residents. Residents confirmed that they could influence the choice of activity.

There was evidence that any request arising from the residents’ meetings were responded to and written evidence that the residents were updated with regard to changes; for example, one resident with particularly dietary requirements expressed a desire for more choice with regard to desserts. On speaking with the head cook, it was evident that she was aware of the request and endeavoured to address it. There was evidence to indicate that the resident was happy with the outcome.

Comments in residents’ satisfaction surveys reflected an overall satisfaction with life in the centre. Elicited comments were very complementary of the gardens, the care received by residents and relatives and of PIC and staff.

**Judgement:**
Compliant

**Outcome 11: Health and Social Care Needs**

*Each residents 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 residents 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.*

**Theme:**
Effective Care and Support

**Outstanding requirement(s) from previous inspection:**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector reviewed a sample of computerised residents’ care plans and found that residents had timely access to general practitioner (GP) services and appropriate treatment and therapies. There was evidence that residents had access to allied health care services which reflected their diverse needs. Records were maintained of all
referrals, follow-up appointments and hospital discharge letters. There was evidence that processes were in place to ensure that when residents, particularly residents availing of convalescence, were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared between providers and services. Pre- admissions assessments were completed with prospective residents.

Of the care plans reviewed it was evident that the assessment, care planning processes and clinical care accorded with evidence based practice. Clinical risk assessments, using recognised tools, were carried out on all residents and there was evidence that care planning reflected the findings of updated clinical risk assessments.

It was evident that the residents’ computerised care plans were reviewed three monthly. Documented evidence indicated that this review was done in consultation with residents and/or their relatives. Care plans were made available to residents. Each resident had a personalised care plan, which detailed their individual needs and choices. There was evidence that consent to treatment was obtained from residents and the residents’ right to refuse treatment respected and documented and brought to the attention of the resident’s GP. This concurred with the centre’s policy in this regard.

A daily progress note, completed by the nursing staff, captured up to date clinical care and medical review. Care assistants were observed regularly imputing information into the computerised system regarding up-to-date care provided to the residents.

The PIC stated that efforts were ongoing to ensure that restraint was not used. Three residents availed of bedrails and it was clear that comprehensive assessments for residents on whom restraint (bedrails) was used, had been completed. The inspector reviewed the care plans and risk assessments of residents on whom restraint was used. There was documented evidence to reflect:
- when bedrails were being used at the request of the resident
- interventions in the care plan for maintaining a safe environment regarding the level of resident supervision required
- there was evidence of regular checks of residents on whom restraint was used
- signed consent was sought from the resident/ relative for the use of restraint.

There was evidence that clinical observations were recorded and that residents were weighed regularly. Any concerns regarding weight loss/gain were communicated to, and subsequently addressed by the dietician, speech and language therapist (SALT) and GP. There was evidence that residents had a malnutrition universal screening tool (MUST) assessment on admission, three monthly or when required. There was evidence that some staff completed a record of nutritional intake/output in the computerised planning system for residents.

Care plans of residents reviewed by an allied professional were updated accordingly. This information was also available in a separate folder to staff in the main kitchen.

It was evident that residents had opportunities to participate in activities that were meaningful and purposeful to them and that suited their needs interests and capacities. A range of activities were facilitated. These included newspapers, prayers, live music sessions (as observed on the second day of inspection) fit for life, bingo, Sonas
activities, hairdressing, movies and pet therapy. The centre had an in-house activity co-ordinator. Inspectors saw evidence of how the co-ordinator regularly audited the activities on and how the results of the audits were included in a comprehensive annual report authored by the co-ordinator.

The co-ordinator clearly demonstrated an understanding and knowledge of how he ensured that all residents, including residents with a cognitive impairment, had opportunities to engage in an activity of their preference. Residents informed the inspector that they enjoyed the activities and spoke with high regard of the activities co-ordinator.

Staff, spoken with by the inspector were very knowledgeable about residents’ health and social care needs.

A number of residents spoken to by the inspector voiced how they had lived in the centre for a long time and stated that they were very happy with the care they received.

The inspector noted that the centre promoted continence programmes for residents. Staff had received training on the assessment of incontinence wear to ensure that residents benefited from the correct incontinence wear.

Staff training records indicated that staff had attended training on how to manage episodes of challenging behaviour. Care plans of residents who intermittently displayed a behaviour that may challenge, gave very clear guidance to staff on how to manage the episode. While the centre had a policy on challenging behaviour, it required review to ensure that it reflected what was described in the residents' care plans.

The inspector reviewed the computerised incident log and the residents’ care plans and noted that residents who sustained a fall (witnessed or unwitnessed) were observed and reviewed and full neurological observations were carried out on residents who sustained a head injury. There was evidence that residents who sustained falls were medically reviewed in a timely manner.

Residents admitted with a wound were receiving ongoing treatment and the care plans reviewed portrayed evidence of appropriate ongoing assessment, review, treatment and progress.

It was evident to the inspector that residents who experienced dysphagia (difficulty in swallowing) had care plans tailored to their particular needs and had been assessed by the speech and language therapist and the dietician. Kitchen staff were up to date on the requirements of these residents.

No resident currently accommodated in the centre, smoked.

Judgement:
Compliant
### Outcome 12: Safe and Suitable Premises

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.

**Theme:**
Effective Care and Support

**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Rosenalee Care Centre is a two-storey building which opened in 1988, providing long-term, convalescent and respite care to older persons. It is registered for the care of 41 residents and there were 36 residents living in the centre at the time of inspection, some of whom had dementia.

The centre consisted of two units, one called the independent unit, providing convalescent care, and the other called the nursing home unit, providing long-term or short-term nursing care. The two units had their own separate key pad accessible doors on either side of a common entrance lobby.

As described in the centre’s Statement of Purpose, residential accommodation comprised 23 single and nine twin bedrooms. 21 of the 23 single bedrooms and five of nine twin bedrooms had en suite shower, wash-hand basin and toilet. The remaining two single bedrooms and four twin bedrooms had a wash hand basin.

The size of the existing single bedrooms ranged from 7.92m2 to 14.82m2. The provider was asked to put forward a plan as to how the design and layout of the undersized rooms would meet the needs of the residents accommodated.

The size of the existing twin bedrooms ranged from 11.14m2 to 19.43m2. The provider was asked to put forward a plan as to how the design and layout of the undersized rooms would meet the needs of the residents accommodated. Two of the twin rooms did not have room to accommodate two chairs for the residents accommodated in these rooms. One other twin room had a high central velux window which did not enable the residents to see out when seated. The other window (opaque and curtained) in this bedroom was located on one of the bedroom walls which backed onto the nurses’ station located on the opposite side of the wall.

Televisions were available in all bedrooms. While some televisions were wall mounted the provider was asked to review and assess the locations of the free standing televisions to ensure that they were secured in a safe manner.

The sluice room in the nursing unit was also used as a cleaner’s room. The PIC was asked to review and assess the dual functionality of this room to ensure and promote
best practices in the prevention of infection. On the first day of inspection the sluice room was notably untidy, cluttered and unclean. The PIC addressed this issue immediately and the issue was addressed in a satisfactory manner by the end of day one of inspection.

Additional assisted toilets and bathrooms were situated throughout the centre. Communal accommodation consisted of:
- two dining rooms
- three lounges
- two conservatory areas
- a visitors’ room which was also used as a quiet room. Libraries of books, magazines and papers, located throughout the centre, were readily available to residents.

The external grounds were maintained to a high standard. All windows had window flower boxes. Residents remarked how they liked looking out at the flowers. The gardens towards the rear of the centre were very well maintained. A range of seating, open and covered, was available for residents’ use. Residents remarked how they enjoyed the gardens. Residents were appropriately safeguarded from the sun by the use of protective creams and clothing. An outdoor music session was in progress on the second day of inspection.

The external garden water feature had been risk assessed and the assessment outlined the safeguards in place to ensure the safety of the residents. One of the safeguards was that no resident was to be in the external garden without ongoing supervision by staff. This safeguard was noted to be enforced on the days of inspection.

Residents with an interest in gardening had access to an external glasshouse where they could pot plants. Inspectors noted that the glass house was not secure and containers of liquid stored in the glasshouse were not maintained in a secure manner. This was immediately addressed by the provider.

Some windows on the ground floor were not restricted. This was addressed by the provider during inspection.

The centre was warm, homely and decorated to a high standard with suitable furnishings, curtaining, seating and flooring. New bedside lockers had been purchased for some residents' bedrooms.

Staff dining facilities, staff changing facilities, storage, an office for the activities coordinator, family overnight facilities and secure medication storage were accommodated on the first floor of the nursing home unit. A lockable stair gate was located at the foot of the stairs.

Ample car parking was available to the front and the rear of the building.

Judgement:
Non Compliant - Major
**Outcome 13: Complaints procedures**
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The centre had an up-to-date policy and procedure for the management of complaints.

The complaints procedure was displayed in a prominent place and a copy was included in the Resident’s Guide and in the residents’ contracts of care.

The PIC was the nominated person to ensure that all complaints were appropriately responded to. The co-ordinator of activities was the in-house advocate and a named advocate was the independent appeals person. Residents spoken with by an inspector stated that they could raise any issue or concern with the PIC or staff.

There was evidence that a record of complaints was maintained, including the details of the complaint, the results of any investigations, any actions taken and whether or not the resident was satisfied with the outcome of the complaint. The inspector reviewed the complaints and noted that all were addressed in a satisfactory manner. There was evidence that the complainant was satisfied with the outcome.

**Judgement:**
Compliant

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**Outcome 14: End of Life Care**
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.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector reviewed the centre’s policy on end of life care and noted that the policy addressed assessing the residents’ wishes for end of life care, care of the resident approaching end of life, the signs and symptoms of dying, guidance to staff following the death of a resident, a procedure for staff to follow in attending to the physical care of a deceased resident, laying out of the deceased resident, removal of the deceased resident.
from his/her room, staff attendance at funeral/sending of sympathy card and staff training.

The inspector reviewed a sample of residents care plans with regard to end of life care and noted that significant work was in progress. The 'Let Me Decide' initiative, pertinent to advanced directives capturing residents' preferences at this time, was currently being implemented. Care plans reflected up to date information.

Residents spoken to by the inspector spoke in a positive manner with regard to their care. Some residents expressed that in the event of becoming unwell, they would like to go to the acute services while other residents stated that they would prefer to stay in the centre.

Staff training records indicated that a number of staff had completed training to Further Education and Training Awards Council (FETAC) level five standard. Modules included palliative care and care at end of life. Provision of training for staff on care at end of life, was ongoing. Staff had attended training in ‘What Matters to Me’.

The PIC stated that she was familiar on the use of a syringe driver (a mechanical pump used to administer medications) in symptom management and a policy to guide staff was available.

Religious and cultural practices were facilitated. Residents had the opportunity to attend religious services held in the centre, and ministers from a range of religious denominations visited on request. The centre’s policy included comprehensive guidance to staff with regard to facilitating and engaging in cultural practices at end of life.

Family and friends were facilitated to be with the resident at end of life. A designated overnight facility with shower facilities was available to families at this time. The centre had a majority of single bedrooms with some twin bedded rooms. Tea/coffee/snacks facilities were provided for relatives. Open visiting was facilitated and this was confirmed by a resident’s relative. There was provision of private sitting spaces, conservatories, sitting rooms, and quiet rooms.

There was evidence in residents' care plans that residents had choice as to the place of death.

Residents had access to the local specialist palliative care service.

There was evidence that medication management was regularly reviewed and closely monitored by the GP.

Practical information (verbally and in writing by means of a leaflet and booklet) was available to resident’s relatives upon the death of a resident. Information included what to do following the death and information on how to access bereavement and counselling services.

There was a protocol for the return of personal possessions. On review it was evident that residents had an updated inventory of their personal belongings, signed by the
Judgement:
Compliant

Outcome 15: Food and Nutrition
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.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The centre had up to date policies on food and nutrition.

A record of staff training indicated that staff had access to a range of ongoing training pertinent to food and nutrition, dysphagia (a difficulty in swallowing), food consistency and basic food hygiene.

Inspectors observed mealtimes including mid morning refreshments and lunch.

The PIC stated that residents had the option of having their breakfast served in bed, in the dining rooms or at their bedside and at a time of their choosing. Snacks, hot and cold drinks including juices and fresh drinking water were readily available throughout the day. The inspector noted that staff levels were adequate to meet the needs of the residents during mealtimes. Residents having their meals were appropriately assisted and received their meal in a timely manner.

Assistive cutlery or crockery required for a resident with reduced dexterity was available. There was evidence that residents were reviewed by an occupational therapist.

An inspector met with the cook, who worked part-time. The cook demonstrated thorough understanding of residents’ dietary requirements likes and dislikes. There was evidence that menus, food choices and preferences, residents experiencing weight loss/gain were communicated to kitchen staff. A daily, seasonal, menu was in operation and all produce was locally sourced. An up to date folder of diets, dietary requirements to guide staff, was available in the kitchen.

There was evidence that ample choice was available to residents for breakfast, lunch and evening tea. The breakfast choice included a variety of hot and cold cereals, breads, juices and fruits. Residents confirmed that a staff member came around daily informing them what was on the menu and confirmed that they had a choice in the menu. There was ample evidence that the kitchen staff regularly sought feedback from the residents.
with regard to the meals served. A meal satisfaction survey was carried out in 2014.

A sample of medication administration charts reviewed evidenced that nutritional supplements prescribed by the general practitioner were administered accordingly.

Lunch was served between 12:10 hrs and 13:30 hrs. Residents’ dining rooms were bright and spacious and the inspector noted that the dining experience was a relaxed social occasion, with low volume background music playing in one of the dining rooms. The dining tables were adorned with tablecloths, centrepieces, glassware and serviettes. The ambience of the dining rooms was enhanced by the furniture and decor.

An inspector noted that lunch, in sufficient portions, was plated and presented in an appetizing manner. Gravies/sauces were served to the residents who chose gravy. Staff informed the inspector that residents could choose to have their meal in the dining room or in their room. On the days of the inspection, most residents dined in the dining rooms while some residents chose to dine in their bedroom. Residents voiced how the food choices were varied and that the lunch was appetizing and hot. Choices of desserts were attractively displayed on a trolley. Staff were observed assisting residents, particularly residents with a cognitive impairment, in a sensitive and discreet manner. Staff were observed using the mealtimes as an opportunity to communicate with residents. Staff were noted describing the meal to residents, asking residents if they wished to wear protective attire and offering residents the opportunity to use the bathroom before their meal.

Judgement:
Compliant

### Outcome 16: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each residents 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.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
There was evidence that residents were consulted about how the centre was run. Residents meetings were held on a regular basis. There was evidence that suggestions emanating from these meetings were actioned by the PIC; for example, a request for more choice in desserts from a resident with particularly dietary requirement. The cook, on discussion with the inspector, was aware of this request.

The PIC stated that she met with residents and relatives on a daily basis. The inspector
observed the PIC and staff interacting with residents. Residents received care in a dignified way that respected their privacy at all times. Residents had access to a public telephone facility. Internet access was available in the centre. Televisions were located in all bedrooms and in some sitting rooms. Quiet sitting rooms/ with a library were available. Information on local events was evident. A notice informing residents and visitors that there were no restrictions on visits except when requested by the resident or when the visit or timing of the visit was deemed to pose a risk.

Residents’ political, civil and religious rights were supported. Residents had been offered the opportunity to vote at the most recent elections. Some residents confirmed that they could attend religious service monthly and attended a daily prayer group. The PIC stated that residents from all religious denominations were accommodated.

Judgement:
Compliant

<table>
<thead>
<tr>
<th>Outcome 17: Residents clothing and personal property and possessions</th>
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<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The centre had a policy on residents’ personal property and possessions. It included a reference that inventories of residents' personal belongings be recorded on admission. A sample of residents' inventories of personal belongings were reviewed and it was evident that inventories were completed and signed on admission and updated on an annual basis. With residents’ permission, inspectors visited some residents’ bedrooms. Bedrooms were individualised with residents’ own personal effects. An inspector reviewed the laundry system and found that adequate measures were in place to ensure that residents’ clothing was being cared for appropriately. The staff member in the laundry was knowledgeable with regard to knowledge of infection control precautions. Systems were in place to ensure that residents’ own clothes were returned to them.

Judgement:
Compliant
**Outcome 18: Suitable Staffing**  
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.

<table>
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<tr>
<th>Theme:</th>
<th>Workforce</th>
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**Outstanding requirement(s) from previous inspection:**  
No actions were required from the previous inspection.

**Findings:**  
An inspector reviewed a sample of staff files and observed that the requirements of Schedule 2 had been met.

On the days of inspection, there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times.  
On the days of inspection, the residents’ assessed dependency level were as follows:  
- maximum dependency, five residents  
- high dependency, three residents  
- medium dependency, 11 residents  
- low dependency, 15 residents  
- independent, two residents.

There was an actual and planned staff rota which indicated that staff nurses were on duty at all times. However, the staff complement did not concur with the Statement of Purpose. The provider stated that he was currently engaged in a recruitment process and gave an undertaking to update the staffing in the centre’s Statement of Purpose.

Records reviewed indicated that staff had attended mandatory training. Staff had access to a broad range of education and training. The inspector noted evidence of opportunities for further training advertised in the centre.

Staff, spoken to by the inspector, were aware of policies and procedures related to the general welfare and protection of residents. They were also aware of the Regulations and Standards and were supervised appropriate to their role.

**Judgement:**  
Compliant
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Geraldine Ryan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name</th>
<th>Rosenalee Care Centre</th>
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<tbody>
<tr>
<td>Centre ID</td>
<td>ORG-0000277</td>
</tr>
<tr>
<td>Date of inspection</td>
<td>11/06/2014</td>
</tr>
<tr>
<td>Date of response</td>
<td>29/07/2014</td>
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</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

Theme:
Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not consist 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).

Action Required:
Under Regulation 5 (1) (c) you are required to: 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).

Please state the actions you have taken or are planning to take:
The whole time equivalent was calculated incorrectly and has since been rectified on

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
It was understated in our statement of purpose to the number of rooms available and has been rectified on 12/06/2014.

**Proposed Timescale:** 12/06/2014

**Outcome 07: Health and Safety and Risk Management**

**Theme:**
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not having in place written operational policies and procedures relating to the health and safety of residents, staff and visitors with particular regard to the current practices of the:
- non use of colour coded mops/mop handles for housekeeping
- the dual usage of the sluice room as a cleaner's room
- the dual usage of a cleaner's room by both the kitchen staff and general housekeeping
- the timber rim on the front of the sink unit in the housekeeping room in the convalescent unit required review.

**Action Required:**
Under Regulation 30 you are required to: Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

Please state the actions you have taken or are planning to take:
We have been in consultation with the food hygiene company who is responsible for doing our audits in that area. This has been reviewed and policy put in place 29/07/2014.

**Proposed Timescale:** 29/07/2014

**Outcome 08: Medication Management**

**Theme:**
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not having in place appropriate and suitable practices and written operational policies relating to the transcription of medications and ensuring that staff were familiar with such policies and procedures.

**Action Required:**
Under Regulation 33 (1) you are required to: 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.

Please state the actions you have taken or are planning to take: This was reviewed on day of inspection, a policy was put in place and staff made aware of it.

Proposed Timescale: 11/06/2014

Outcome 12: Safe and Suitable Premises

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not ensuring that the physical design and layout of a single bedroom and of three twin bedded rooms, met the needs of each resident, having regard to the number and needs of the residents.

Action Required:
Under Regulation 19 (3) (a) you are required to: 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.

Please state the actions you have taken or are planning to take:
- bedrooms 2 and 3 become single bedrooms with immediate effect
- bedroom 17 (single room) will become vacant once a date for the installation of the lift is determined (estimated end of October 2014)
- lift company contacted to review installation of lift to access the first floor of the nursing home side of the NH
- when bedrooms 18,19, 20 and 21 on the first floor are reinstated the provider will be in a position to close room 4

Proposed Timescale: 01/07/2015

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not ensuring that the size and layout of rooms occupied or used by residents are suitable for their needs.

Action Required:
Under Regulation 19 (3) (f) you are required to: Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

Please state the actions you have taken or are planning to take:
- bedrooms 2 and 3 become single bedrooms with immediate effect
- bedroom 17 (single room) will become vacant once a date for the installation of the lift is determined (estimated end of October 2014)
- lift company contacted to review installation of lift to access the first floor of the nursing home side of the NH
- when bedrooms 18, 19, 20 and 21 on the first floor are reinstated the provider will be in a position to close room 4

Proposed Timescale: 01/07/2015