



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# National Quality Standards for Residential Care Settings for Older People in Ireland

17 February 2009





## About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which has been established to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** — Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services).
- **Monitoring Healthcare Quality** — Monitoring standards of quality and safety in our health services and implementing continuous quality assurance programmes to promote improvements in quality and safety standards in health. As deemed necessary, undertaking investigations into suspected serious service failure in healthcare.
- **Health Technology Assessment** — Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.
- **Health Information** — Advising on the collection and sharing of information across the services, evaluating information and publishing information about the delivery and performance of Ireland's health and social care services.
- **Social Services Inspectorate** — Registration and inspection of residential homes for children, older people and people with disabilities. Monitoring day- and pre-school facilities and children's detention centres; inspecting foster care services.

The Authority's approach to the development of standards for health and social care services is informed by the following key principles:

- **Openness and transparency**, to ensure that the general public is informed of the development of standards and the decision-making process
- **A focus on outcomes**, to ensure that the implementation of standards will result in real, meaningful and tangible improvements in services
- **Person-centredness**, to ensure that all stakeholders, including service users and those who deliver health and social services, are involved in the development of standards
- **Evidence-based practice**, to ensure that the standards are underpinned by up to date, peer reviewed national and international research.



## Foreword

I am delighted to present the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

The Health Information and Quality Authority is the independent Authority established to drive high quality and safe care for people using our health and social services. These Standards are a key component in ensuring the quality and safety of residential care for our older population in the years to come.

The demographic make-up of Irish society is rapidly changing and it is important that we plan for the future. With the demise of the traditional extended family, more and more people are moving into residential care settings, such as nursing homes, as they get older. There is widespread recognition of the need to protect the rights of residents living in residential care settings and of the need for service providers to be supported in providing excellent quality care.

The set of Standards contained within this report will provide the template for the provision of care for the foreseeable future. The Standards provide a baseline for those with the responsibility for providing care to assess the quality of care planning, strategically develop appropriate and sustainable resources, and provide continuity and stability to the lives of those in their care.

They also provide very clear guidelines for residents, their families and/or representatives as to the rights of a resident living in a residential care setting. Every resident should expect to live as full and as independent a life as possible and to direct, together with the care provider, their own care.

The Authority's inspectors will carry out inspections across the public, private and voluntary sectors to ensure that the Standards detailed in this report are being met and that residents are receiving the highest quality of care.

The Health Information and Quality Authority acknowledges and greatly appreciates the work and commitment that has underpinned the development of these Standards by its own staff, the advisory working group and those individuals and many organisations who took the time to contribute to their development.

**Dr Tracey Cooper**

*Chief Executive*

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# 1. Introduction

## 1.1 Development of the Standards

It is widely recognised that Ireland is at a crossroads in the way we, as a society, care for our older people. In times past, the extended family meant that as people grew older they remained in the family home cared for by their relatives. This is no longer the norm, with more and more people moving into residential care settings as they grow older. This raises challenges in terms of how we protect the rights of older people who live in residential care settings and ensure that they are able to lead as full lives as possible in a caring, respectful environment.

In response to this challenge, the *National Quality Standards for Residential Care Settings for Older People* have been developed by the Health Information and Quality Authority (the Authority). They set out what a quality, safe service for an older person living in a residential care setting should be. For service providers, these Standards provide a road map of continuous improvement to support the continued development and provision of person-centred, accountable care.

The delivery of quality services to older people is a shared priority. In developing these Standards it was important that those using the services, as well as those providing services, were involved in their development. A working group was set up by the Authority which included service users, providers, advocacy groups, and others (see Appendix C for a full list of members). This working group ensured a shared vision across all stakeholders as to what should be contained in the National Quality Standards published in this document.

The terms of reference of the working group were to:

- » review and develop the draft Standards developed by the Department of Health and Children
- » establish a process for targeted and public consultation
- » oversee the public consultation process
- » consider feedback from the public consultation process
- » finalise the draft Standards for publication.

The working group reviewed the initial Draft National Quality Standards for Residential Care Settings for Older People published by the Minister for Health and Children on 25 January 2007. This review involved consideration of international standards in other countries, appropriate legislation and best practice. Subsequently, the revised draft Standards were published in August 2007 by the Authority which then engaged in a public consultation, resulting in the publication in March 2008 of the Authority's revised draft standards.

As part of this consultation process a number of workshops were held with service providers and health and social care professionals involved in the care and treatment of older people. Focus groups were also held to canvas the views of prospective and current residents, their relatives and carers and interviews with people with dementia were also undertaken. In addition, advertisements were placed in the national press inviting contributions from the general public and informing people of how to make their views known.

The Authority, and the working group, gave careful consideration to the comments, observations and suggestions that came out of this consultation process and these have informed this final set of *National Quality Standards for Residential Care Settings for Older People*.

The Authority would like to express its sincere thanks to the members of the working group who committed significant amounts of time to the development of these Standards. We would also like to thank all those who participated in our consultation process and to other professionals who contributed to our work through the provision of expert advice.

The Social Services Inspectorate within the Health Information and Quality Authority will inspect providers of residential care settings for older people to ensure that these Quality Standards are being met. It will also register new providers of residential care settings for older people, once they meet these quality standards.

Exempted from inspection and registration by the Authority are those institutions registered by the Mental Health Commission and that are part of an institution in which the majority of people being cared for are being treated for “acute” illnesses or provided with palliative care.

## 1.2 Inspection of Residential Care Settings

The Health Act 2007 introduced a significant change to how residential care settings for older people are inspected and registered. Prior to this, only nursing homes operated by private and voluntary providers were inspected by the Health Service Executive (HSE).

The new Health Act requires that all “designated centres”, including residential care settings for older people, must be inspected and registered, whether run by the HSE, private providers or voluntary organisations.

This ensures equity of treatment across the whole sector and supports the aim of delivering consistent standards of service to residents regardless of the provider of the service.

Once the necessary regulation is in place, the Authority will inspect the service provided to all residents of the residential care setting, irrespective of their reason for admission. This includes services provided to younger residents with specific needs who have been placed in residential care settings for older people.

When applying for registration, the service provider must state accurately the service that is to be provided in the residential care setting and the manner in which it is to be provided. This statement, known as “a statement of purpose and function” sets out the number of residents, the type of care provided, the level of need that is accommodated, and the services and facilities available in the centre. During inspections, inspectors will assess the centre’s compliance with its statement of purpose and function.

### 1.3 Standards and Criteria

The *National Quality Standards for Residential Care Settings for Older People* have been developed based on legislation, standards in other jurisdictions, research findings and best practice.

There are 32 Standards which are made up of standard statements and criteria. The standard statements set out what is expected in terms of the service provided to the resident. The criteria are the supporting statements that set out how a service can be judged as to whether the standard is being met or not.

The Standards are grouped into seven sections to reflect the dimensions of a quality service. Thus, there are sections on the rights of older people, on protection, health and social care needs, quality of life, staffing, the care environment and management and governance.

In addition, the proposed Standards include supplementary criteria that apply to units that specialise in the care of people with dementia.

### 1.4 Registration

Some of these Standards are linked to regulations. Regulations differ from Standards. They are based on primary legislation and are designed to give effect to it. A regulation, in essence, spells out the detail of what the legislation intends. All residential care settings must be registered to operate within the law. In order to be registered, the residential care setting must comply with the regulations. If the setting is not in compliance with the regulations it may fail to achieve registration status or it may lose the registration status.

In the case of those Standards which are not regulatory Standards, or Standards linked to regulations, failure to comply will not in themselves lead to failure to be registered or loss of registration, but they are designed to encourage continuous improvement.

## 1.5 Supporting Service Development

International best practice in residential care settings for older people is moving away from institutional “hospital” type care to more intimate home-style settings, which enable residents to live full lives that reflect, as far as possible the lives they led prior to their admission.

The *National Quality Standards for Residential Care Settings for Older People* will not, by themselves, bring about a transformation from institutional to more person-centred models of care. This will require a significant cultural shift in our society. It will require a concerted effort on the part of all relevant national, regional and local healthcare agencies; courageous and imaginative leadership on the part of the owners and managers of residential care settings and the support of staff willing to be directed in their work by the expressed needs and preferences of residents. It will require that staff are encouraged and are valued by their organisations and by society for their contribution to the wellbeing of older people living in residential care settings in Ireland.

The National Quality Standards do, however, provide an important road map for both service providers and users, for the development of person-centred models of care which are driven by a respect for the rights of older people and are focused on quality of life measures meaningful to individual residents.

The Health Information and Quality Authority will make every effort to reconcile its responsibility for ensuring compliance with these Standards with support for those who seek to transform residential facilities for older people into home-like environments, where the holistic needs of the resident take precedence.



## 2. The Standards

The Standards reflect relevant legislation and are informed by existing standards and guidelines, research findings and best practice. They are set out below.

Section 1: Rights	
Standard 1:	Information: <i>Each resident has access to information, in an accessible format, appropriate to his/her individual needs, to assist in decision making.</i>
Standard 2:	Consultation and Participation: <i>Each resident's rights to consultation and participation in the organisation of the residential care setting, and his/her life within it, are reflected in all policies and practices.</i>
Standard 3:	Consent: <i>Each resident's consent to treatment and care is obtained in accordance with legislation and current best practice guidelines.</i>
Standard 4:	Privacy and Dignity: <i>Each resident's right to privacy and dignity is respected</i>
Standard 5:	Civil, Political and Religious Rights: <i>Each resident is facilitated to exercise his/her civil, political and religious rights in accordance with his/her wishes.</i>
Standard 6:	Complaints: <i>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.</i>
Standard 7:	Contract/Statement of Terms and Conditions: <i>Each resident has a written contract/ statement of terms and conditions with the registered provider of the residential care setting.</i>

Section 2: Protection	
Standard 8:	Protection: <i>Each resident is protected from all forms of abuse.</i>
Standard 9:	The Resident's Finances: <i>Each resident's finances are safeguarded.</i>

### Section 3: Health and Social Care Needs

Standard 10:	Assessment: <i>Each resident has his/her needs assessed prior to moving into the residential care setting, a full assessment upon admission, and subsequently as required to reflect changes in need and circumstances during his/her period in residence.</i>
Standard 11:	The Resident's Care Plan: <i>The arrangements to meet each resident's assessed needs are set out in an individual care plan, developed and agreed with each resident, or in the case of a resident with cognitive impairment with his/her representative.</i>
Standard 12:	Health Promotion: <i>Each resident benefits from policies and practices that promote his/her health, rehabilitation and wellbeing.</i>
Standard 13:	Healthcare: <i>Each resident's assessed health needs are reviewed and met on an ongoing basis in consultation with the resident.</i>
Standard 14:	Medication Management: <i>Each resident is protected by the residential care setting's policies and procedures for medication management and, where appropriate, is responsible for his/her own medication.</i>
Standard 15:	Medication Monitoring and Review: <i>Each resident benefits from his/her medication to increase the quality or duration of his/her life. He/she does not suffer unnecessarily from illness caused by the excessive, inappropriate or inadequate consumption of medicines.</i>
Standard 16:	End of Life Care: <i>Each resident continues to receive 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.</i>

### Section 4: Quality of Life

Standard 17:	Autonomy and Independence: <i>Each resident can exercise choice and control over his/her life and is encouraged and enabled to maximise independence in accordance with his/her wishes.</i>
Standard 18:	Routines and Expectations: <i>Each resident has a lifestyle in the residential care setting that is consistent with his/her previous routines, expectations and preferences, and satisfies his/her social, cultural, language, religious, and recreational interests and needs.</i>
Standard 19:	Meals and Mealtimes: <i>Each resident receives a nutritious and varied diet in pleasant surroundings at times convenient to them.</i>
Standard 20:	Social Contacts: <i>Each resident maintains contact with his/her family, friends, representatives and the local community according to his/her wishes.</i>
Standard 21:	Responding to Behaviour that is Challenging: <i>The needs of each resident with behaviour that is challenging, including behaviour that poses a high risk to him/herself or others, are managed and responded to effectively in an environment that promotes wellbeing and has the least restrictions.</i>

### Section 5: Staffing

Standard 22:	Recruitment: <i>Staff are recruited in accordance with best human resource management practices.</i>
Standard 23:	Staffing Levels and Qualifications: <i>There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these Standards and the needs of the residents.</i>
Standard 24:	Training and Supervision: <i>Staff receive induction and continued professional development and appropriate supervision.</i>

## Section 6: The Care Environment

Standard 25:	Physical Environment: <i>The location, design and layout of the residential care setting are suitable for its stated purpose. It is accessible, safe, hygienic, spacious and well maintained and meets residents' individual and collective needs in a comfortable and homely way.</i>
Standard 26:	Health and Safety: <i>The health and safety of the resident, staff and visitor to the residential care setting is promoted and protected.</i>

## Section 7: Governance and Management

Standard 27:	Operational Management: <i>The residential care setting is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.</i>
Standard 28:	Purpose and Function: <i>There is a written statement of purpose and function that accurately describes the service that is provided in the residential care setting and the manner in which it is provided. Implementation of the statement of purpose and function is clearly demonstrated.</i>
Standard 29:	Management Systems: <i>Effective management systems are in place that support and promote the delivery of quality care services.</i>
Standard 30:	Quality Assurance and Continuous Improvement: <i>The quality of care and experience of the residents are monitored and developed on an ongoing basis.</i>
Standard 31:	Financial Procedures: <i>The continued viability of the residential care setting is assured through suitable accounting and financial procedures.</i>
Standard 32:	Register and Residents' Records: <i>Each resident is safeguarded by the residential care setting's record-keeping policies and procedures.</i>

## 3. Standards and Criteria

### Section 1: Rights

#### Standard 1: Information

**Each resident has access to information, in an accessible format, appropriate to his/her individual needs, to assist in decision making.**

#### Criteria

- 1.1 There is a guide for residents clearly written and made available in an accessible format to each resident and each prospective resident. It includes a description of:
  - » the residential care setting's statement of Purpose and Function (see Standard 28: Purpose and Function)
  - » the services and facilities (including external facilities) provided
  - » the programme of activities provided, including those that are available in the local community
  - » the individual accommodation and communal space provided
  - » the name of the person in charge and the general staffing arrangements
  - » the number of places provided and any special needs or interests catered for
  - » the arrangements for inspection of the residential care setting and details of how to access the Office of the Chief Inspector and inspection reports
  - » local Health Service Executive contact details
  - » an outline of the residential care setting's complaints procedure
  - » arrangements for visiting
  - » the name of the registered provider
  - » contact details of organisations providing advocacy services
- 1.2 The residential care setting ensures that information is available to the resident in a format and language that suits his/her communication requirements.
- 1.3 The prospective resident and/or his/her family or representative are informed of all fees payable including charges for activities and services that may have additional costs.
- 1.4 The person in charge ensures that the prospective resident and/or his/her family or representative is invited to visit the residential care setting before he/she makes a decision to stay. Emergency admissions are avoided where possible. The opportunity to meet with other residents during a visit is facilitated.

- 1.5 The prospective resident is given the opportunity to have an appointed member of staff meet him/her in his/her own home or current accommodation, to further discuss and plan for the transition into long-term care.
- 1.6 In emergency admissions, the person in charge or delegate informs the resident as soon as possible and no later than 24 hours about key aspects of the service.

## Standard 2: Consultation and Participation

**Each resident's rights to consultation and participation in the organisation of the residential care setting, and his/her life within it, are reflected in all policies and practices.**

### Criteria

- 2.1 Where the resident has been admitted to the residential care setting in an emergency, he/she is given time, information and, if necessary, access to an advocate, in order to decide whether or not to remain in the residential care setting on a long-term basis. (See Standard 3: Consent)
- 2.2 The resident is consulted on what information is provided to his/her relatives or representative in relation to his/her care and to whom this is provided.
- 2.3 The resident contributes ideas to and participates in the day-to-day activities of the residential care setting.
- 2.4 The person in charge facilitates the establishment of an in-house residents' representative group for feedback, consultation and improvement on all matters affecting the residents. At least one nominated person acts as an advocate for people with dementia/cognitive impairment. Issues raised by the residents' representative group are acknowledged, responded to and recorded, including the actions taken in response to issues raised.
- 2.5 Feedback is actively sought from the resident on an ongoing basis on the services provided. The residential care setting clearly demonstrates how the impact of the resident's feedback informs reviews and future planning.

## Standard 3: Consent

**Each resident's consent to treatment and care is obtained in accordance with legislation and current best practice guidelines.**

### Criteria

- 3.1 The resident is presumed to be capable of making informed decisions in the absence of evidence to the contrary.
- 3.2 The residential care setting has a policy that outlines the procedure for seeking consent from the resident prior to any treatment or care-giving or, in the case of emergency, in accordance with best practice. The policy addresses when the resident does not wish to consent and when the resident lacks the capacity to consent. The policy is consistent with Health Service Executive policy and any guidance issued by professional regulatory bodies.
- 3.3 The information provided to the resident or his/her representative, for the purpose of informing choices, is given at the earliest opportunity and in a manner that he/she can understand in order to ensure, as far as possible, that he/she has sufficient time to consider the information given and his/her options.
- 3.4 Clear explanations in a format and language suitable for the resident, and/or appropriate communication and visual aids are used to assist the resident, where necessary, in decision making, and in keeping with the principle of maximising autonomy.
- 3.5 The resident is facilitated to access an advocate/advocacy services when making decisions relating to consent to treatment or care, if necessary and in accordance with his/her wishes.
- 3.6 The resident's wishes and choices relating to treatment and care are discussed and documented, and as far as possible, implemented and reviewed regularly with him/her.
- 3.7 The resident or his/her representative is provided with the information required to make an informed choice about any proposed medical intervention or treatment. The information outlines the advantages and disadvantages of the proposed action, including any likely side effects.
- 3.8 The resident's lack of capacity to give informed consent on one occasion is not assumed to be the case on another occasion. Where there is any doubt as to the resident's capacity to decide on any medical treatment or intervention, his/her capacity to make the decision in question is assessed by a suitably qualified professional using evidence-based best practice.
- 3.9 Where the resident is deemed to lack the capacity to give or withhold consent, account is taken of his/her past and present wishes; the wishes of the family or representative; the resident's needs and preferences, where they are ascertainable, and his/her general wellbeing and cultural and religious convictions.
- 3.10 Where written consent is required, forms are maintained within individual case records.

## Standard 4: Privacy and Dignity

**Each resident's right to privacy and dignity is respected.**

### Criteria

- 4.1** Care practices are personalised to respond to the resident's individual needs and preferences.
- 4.2** Arrangements are in place to ensure that the resident's privacy, dignity and modesty are respected at all times, and with particular regard to:
- » maintaining social contacts to the extent to which he/she wishes to do so
  - » spending time alone, in accordance with his/her wishes
  - » expressions of intimacy and sexuality
  - » wearing his/her own clothing
  - » dressing and undressing
  - » being assisted to eat and drink
  - » consultations with advocates, social care and other professionals
  - » examinations by healthcare professionals
  - » personal care-giving
  - » circumstances where confidential and/or sensitive information is being discussed (including details of medical condition or treatment)
  - » entering bedrooms, toilets and bathrooms
  - » care received prior to and at the time of death.
- 4.3** The resident receives enhanced support at times of acute distress in a manner that takes account of his/her particular needs and preferences.
- 4.4** Staff demonstrate their respect for the dignity, modesty and privacy of the resident:
- » through their general demeanour
  - » through the manner in which they address and communicate with the resident
  - » through their appearance and dress
  - » by avoiding ageist, racist, sexist or other inappropriate comments or jokes
  - » through discretion when discussing the resident's medical condition or treatment needs.

It is understood that lapses are unacceptable, even when staff are working under pressure.

- 4.5 The resident has access to a telephone for use in private. Any circumstances in which restrictions on the use of the telephone are imposed are agreed with the resident and recorded.
- 4.6 The resident receives his/her mail promptly. The resident's privacy is respected in relation to his/her mail.
- 4.7 Where the resident shares a room, the screening ensures that his/her privacy is not compromised when personal care is being given.
- 4.8 The resident's permission is sought before any person enters his/her room.

## Standard 5: Civil, Political and Religious Rights

**Each resident is facilitated to exercise his/her civil, political and religious rights in accordance with his/her wishes.**

### Criteria

- 5.1 The residential care setting has a policy that acknowledges the rights of the resident. The policy sets out the manner in which the resident is informed of and facilitated in the exercise of his/her rights.
- 5.2 The resident has access to citizen's information and advocacy services. (See Standard 3: Consent)
- 5.3 The resident has equitable and timely access to healthcare services. Where medical care is not provided by the residential care setting team, the resident has access to a general practitioner of his/her choice. (See Standard 13: Healthcare)
- 5.4 The resident is facilitated to participate in the political process.
- 5.5 The resident is facilitated to access legal advice.
- 5.6 The resident is facilitated to access community-based facilities. (See Standard 18: Routines and Expectations)
- 5.7 The resident's decision to participate in activities involving personal risk is respected, and when necessary is documented.
- 5.8 The resident is facilitated to observe or abstain from religious practice in accordance with his/her wishes. (See Standard 18: Routines and Expectations)

## Standard 6: Complaints

**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.**

### Criteria

- 6.1** The residential care setting provides an environment that is conducive to residents, staff, family, advocates or representatives, and visitors being able to raise issues and make suggestions and complaints (verbally or in writing) in a spirit of openness and partnership and without fear of adverse consequences.
- 6.2** In the first instance, issues of concern to the resident, his/her family and/or representative are addressed immediately at local level and without recourse to the formal complaints procedure, unless the complainant wishes otherwise.
- 6.3** The person in charge ensures that there is a clear complaints procedure in an accessible format and prominently displayed that outlines:
- » how to make a complaint and to whom
  - » how to obtain assistance making a complaint, including how to access an advocate
  - » the stages and timescales of the process
  - » the process for providing feedback to the complainant
  - » how the complainant can appeal a decision if they are unhappy with the outcome
  - » how to refer a complaint to the Health Service Executive, the Chief Inspector and the Office of the Ombudsman at any stage, should the complainant wish to do so.
- 6.4** The complaints procedure takes account of the requirements of legislation, relevant regulations and national guidelines.
- 6.5** A register of complaints is maintained that includes details of investigation and any action taken.
- 6.6** The person in charge ensures that complaints and comments are raised at team meetings for feedback and future learning. Measures required for improvement are put in place.

## Standard 7: Contract/Statement of Terms and Conditions

**Each resident has a written contract/ statement of terms and conditions with the registered provider of the residential care setting.**

### Criteria

- 7.1 Each resident or his/her representative is provided with a contract, specifying the terms and conditions within one month of admission. The resident and/or his/her representative are involved in discussing the contract and it is signed by the resident and/or his/her representative and the registered provider. Where the resident or his/her representative is unable or chooses not to sign, this is recorded. The contract is provided to the resident or his/her representative.
- 7.2 The contract includes (where applicable):
- » the room to be occupied. Once a room is allocated (single or multiple-occupancy) the resident is not moved from the room, unless at his/her request or for medical reasons or an identified assessed risk in the case of a resident with dementia/cognitive impairment, without his/her consent or the agreement of his/her representative. This also applies to residents who are absent from the residential care setting for acute hospital admission. The reason for moving a resident to another room is documented
  - » the overall care and services covered by the fee, and additional health, personal and social care services to be paid for over and above those included in the fee
  - » the fees payable and by whom (the resident or his/her representative, the Health Service Executive, or other)
  - » the rights, obligations and liability of the resident and/or his/her representative, where relevant, and the registered provider
  - » the terms and conditions relating to the period of occupancy including the period of notice to leave
  - » the circumstances under which the resident can be discharged or the contract terminated
  - » a clear outline of the policy on absences by the resident from the residential care setting.



## Section 2: Protection

### Standard 8: Protection

**Each resident is protected from all forms of abuse.**

#### Criteria

- 8.1** There is a policy on the prevention, detection and response to abuse within the residential care setting. The policy outlines procedures for:
- » the prevention of abuse
  - » responding to suspicion, allegation or evidence of abuse or neglect
  - » reporting concerns and/or allegations of abuse, to the Health Service Executive, the Garda Síochána and the Chief Inspector.
- These procedures take account of the recommendations of relevant reports, best practice initiatives and guidelines. The implementation of the policy is reviewed annually.
- 8.2** The person in charge takes steps to ensure that the resident is safe from physical or sexual abuse, psychological abuse, financial or material abuse, neglect or acts of omission, or discriminatory abuse, through deliberate intent, negligence or ignorance by others within the residential care setting. All allegations of any such incidents are fully and promptly investigated in accordance with the policies and procedures.
- 8.3** There is a policy and procedures on “whistle blowing” and protected disclosure. Staff are aware of who they report concerns to and can do so without fear of adverse consequences to themselves.
- 8.4** All staff receive induction and ongoing training in:
- » prevention of abuse
  - » protection from abuse
  - » indicators of abuse
  - » responding to suspected, alleged or actual abuse
  - » reporting suspected, alleged or actual abuse
  - » procedures for protecting residents with particular vulnerabilities.

## Standard 9: The Resident's Finances

**Each resident's finances are safeguarded.**

### Criteria

- 9.1 The residential care setting has a clear policy and procedures on the management of residents' accounts and personal property in accordance with national guidelines.
- 9.2 Procedures are in place to protect the interests of the resident, including residents with advanced cognitive impairment.
- 9.3 Where any money belonging to the resident is handled by staff within the residential care setting, signed records and receipts are kept. Where possible, they are signed by the resident or his/her representative.
- 9.4 The registered provider or delegate is appointed by the resident as his/her agent only where no other suitable person is available. In this case, the registered provider ensures that:
  - » the Chief Inspector is notified at the time of inspection
  - » records are kept of all incoming and outgoing payments
  - » the Department of Social and Family Affairs is given notice at the time of the appointment.
- 9.5 Secure facilities are provided for the safe-keeping of money and valuables by the resident and on behalf of the resident.
- 9.6 The residential care setting keeps signed records and receipts of possessions handed over for safekeeping at admission and subsequent to admission, including withdrawals of possessions.

## Section 3:

# Health and Social Care Needs

### Standard 10: Assessment

**Each resident has his/her needs assessed prior to moving into the residential care setting, a full assessment upon admission, and subsequently as required to reflect changes in need and circumstances during his/her period in residence.**

#### Criteria

##### Pre-admission

- 10.1** All necessary information relating to the resident's health, personal and social care needs is obtained prior to admission. In the case of emergency admissions, this information is obtained as soon as possible after admission and no later than 72 hours.
- 10.2** There are protocols in place to ensure appropriate continuity of care. These ensure that information concerning the resident's circumstances, medication, treatment and/or ongoing support by medical and other professionals is provided to the person in charge.
- 10.3** The resident is admitted to the residential care setting following a comprehensive assessment of his/her health, personal and social care needs, undertaken by appropriate professionals trained to do so. This includes any prospective resident making private arrangements for admission to the residential care setting. The resident participates in and contributes to the assessment, with the support of a family member or representative in accordance with his/her wishes.

##### On and subsequent to admission

- 10.4** A general risk assessment is carried out and recorded upon admission to the residential care setting and as indicated by the resident's changing needs or circumstances and no less frequently than at three-monthly intervals.
- 10.5** A comprehensive assessment of the resident's health, personal and social care needs, using a minimum data set tool, is completed within seven days of his/her admission or sooner if the risk assessment indicates. This assessment is reviewed as indicated by the resident's changing needs or circumstances and no less frequently than at three-monthly intervals. See Appendix A: Supplementary Guidance for the Choice and Use of a Minimum Data Set Tool
- 10.6** Assessment findings are communicated to the resident or representative and to his/her family in accordance with his/her wishes.

## Prior to discharge

- 10.7 Notwithstanding the resident's freedom to discharge him/herself from the residential care setting, discharge decisions are based on assessment and are in accordance with the resident's care plan. The resident is discharged from the residential care setting in a planned manner and the discharge is discussed, planned for and agreed with the resident or his/her representative.
- 10.8 To ensure continuity of care, information concerning the resident's circumstances, medication, treatment and/or ongoing support by medical and other professionals is provided by the person in charge to the subsequent care provider, as appropriate.

## Standard 11: The Resident's Care Plan

**The arrangements to meet each resident's assessed needs are set out in an individual care plan, developed and agreed with each resident, or in the case of a resident with cognitive impairment with his/her representative.**

### Criteria

- 11.1 The resident's care plan is commenced within 48 hours of admission, or earlier if indicated by the general risk assessment, from the comprehensive assessment drawn up with the resident. (See Standard 10: Assessment)
- 11.2 The care plan reflects the assessment findings and sets out in detail the action to be taken by staff, to ensure that all aspects of the health, personal and social care needs of the resident are met. Residents, including those with dementia/cognitive impairment, are actively encouraged to participate in this process.
- 11.3 The care plan meets clinical guidelines produced by professional bodies concerned with the care of older people. It is updated regularly to reflect daily changing needs and best practice.
- 11.4 The resident or his/her representative has access to the care plan and is kept informed of care changes.
- 11.5 The care plan is discussed, agreed and drawn up with the involvement of the resident and/or his/her representative. If the resident is unable or unwilling to participate, this is documented.
- 11.6 The care plan is formally evaluated by staff in consultation with the resident and/or his/her representative. It is updated as indicated by the resident's changing needs and circumstances and current objectives for health, personal and social care and no less frequently than at three-monthly intervals.

## Standard 12: Health Promotion

**Each resident benefits from policies and practices that promote his/her health, rehabilitation and wellbeing.**

### Criteria

- 12.1 The residential care setting has a health promotion policy devised in consultation with the residents.
- 12.2 The residential care setting provides opportunities for the resident to pursue healthy lifestyle choices and recreational activities.
- 12.3 The resident's general physical and mental health is promoted through the provision of social contact and appropriate health promoting interventions, devised and reviewed by allied health professionals.
- 12.4 Opportunities are provided for indoor and outdoor exercise and physical activity, personal development, communication and other psychosocial development.

## Standard 13: Healthcare

**Each resident's assessed health needs are reviewed and met on an ongoing basis in consultation with the resident.**

### Criteria

- 13.1 Policies and procedures, including rehabilitation policies, based on current best practice are developed, implemented and reviewed annually. See Appendix B: Healthcare Policies and Procedures
- 13.2 The resident is referred to healthcare services including primary care, secondary care, specialist services, allied health professionals, and has access to assistive devices to meet his/her assessed needs, irrespective of geographical location or place of residence. A record is maintained of all referrals and follow-up.
- 13.3 Where medical care is not provided by the residential care setting team, the resident receives a high standard of service from the general practitioner with whom he/she is registered (or a suitably qualified appointed deputy) including regular and timely consultations and an out-of-hours service that is responsive to his/her needs.

## Standard 14: Medication Management

**Each resident is protected by the residential care setting's policies and procedures for medication management and, where appropriate, is responsible for his/her own medication.**

### Criteria

- 14.1** Medicines in the custody of the registered provider are handled according to the legislative requirements<sup>1</sup> and any subsequent legislation or guidance.
- 14.2** Nursing staff abide by the Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais, 2000) and are familiar with the Nurse Prescribing Regulations, the Guidance to Nurses and Midwives on Medication Management (2007) (An Bord Altranais), the Health Act 2007 and any subsequent revisions to the above and any other subsequent legislation or guidance including the HSE Dispose of Unused Medicines Properly Campaign for Disposal of Medicinal Products.
- 14.3** The person in charge ensures that there is a medication management policy and procedures that accord with legislation and professional regulatory requirements or guidance. The medication management policy includes procedures on the management and administration of:
- » medications via percutaneous endoscopically-guided gastrostomy (PEG) tube
  - » medications for respite clients/emergency admissions/re-admissions
  - » subcutaneous and intravenous drugs
  - » eye drops, ear drops, suppositories, pessaries, inhalers, nebulisers and PRN (as required) medications.
- (This list is not intended to be exhaustive.)
- 14.4** Staff adhere to procedures for the safe administration of medication, for the prescription, supply, receipt, self-administration by residents, recording, storage, handling, and disposal of medicines that accord with legislation and professional regulatory requirements or guidance. Only prescribed medicines which are in date and are properly stored in accordance with the manufacturer's instructions should be administered to residents.
- 14.5** All medication errors, suspected adverse reactions and incidents are recorded, reported and analysed within an open culture of reporting. Learning is fed back to improve patient safety and prevent reoccurrence.
- 14.6** Records are kept to account for all medicines. This includes all medicines received, administered to residents, given to residents on leaving the residential care setting and returned to the pharmacy. A medicines administration chart is maintained for each resident that:

- » distinguishes between routine and once-off medicines
  - » records any allergies to any medicines
  - » clearly marks the date of medicine initiation and discontinuation
  - » charts medicines according to their generic name
  - » notes the need for periodic, routine tests to monitor certain medicines
  - » records the dates of such tests.
- 14.7** All medicines, including scheduled controlled drugs (except those for self-medication) are administered by a registered nurse or medical practitioner.
- 14.8** The receipt, administration, management and disposal of controlled drugs are recorded in accordance with An Bord Altranais guidelines and the relevant legislative requirements<sup>1</sup>.
- 14.9** Scheduled controlled drugs (including those for self-medication) are secured in a manner that meets legislative requirements as set out by the Misuse of Drugs Regulations, 1988 and 1993.
- 14.10** The resident may self-administer medications, where the risks have been assessed and his/her competence to self-administer is confirmed. Any change to the initial risk assessment is recorded and arrangements for self-administering medicines are kept under review.
- 14.11** Staff actively promote the resident's understanding of his/her health needs relating to medication. Residents are advised as appropriate about the side effects of prescribed medicines and are given access if they request it, to the patient information leaflet provided with medicines. The residents should be afforded the opportunity to consult the pharmacist or other appropriate independent healthcare professional about medicines prescribed as appropriate. The resident should be advised about these rights.
- 14.12** There are mechanisms to ensure that the use of non-prescribed medicinal products by the resident are brought to the attention of the medical officer and/or general practitioner and noted where appropriate.
- 14.13** In the case of a post-mortem following the death of a resident, all medication (including non-prescription items) is retained until the results of the post-mortem are known.

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(1) Medicines in the custody of the registered provider are handled according to the requirements of the Irish Medicines Board Miscellaneous Provisions Act, 2006 Medicinal Products (Prescription and Control of Supply) Regulations, 2003 (S.I. 540 of 2003) Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations (S.I. No. 201 of 2007), Regulations entitled Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations, Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) Order 2007 (S.I. No 194 of 2007) Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) (No. 2) Order 2007 (S.I. No 543 of 2007), Nurses Act 1985 and Nurses Rules, 2007 (Made under the Nurses Act 1985, Misuse of Drugs Act 1977 and 1984 and the Misuse of Drugs (Amendment) Regulations 2007 (S.I. No. 200 Of 2007) which authorise the nurse to possess and supply medicinal products.

## Standard 15: Medication Monitoring and Review

**Each resident benefits from his/her medication to increase the quality or duration of his/her life. He/she does not suffer unnecessarily from illness caused by the excessive, inappropriate or inadequate consumption of medicines.**

### Criteria

- 15.1** Staff have access to comprehensive, up-to-date information on all aspects of medication management. The residential care setting has policies and procedures in place relating to working arrangements with the pharmacist. Evidence of continuing education is documented and registered nurses attend the relevant updates on medicines management at least annually.
- 15.2** The condition of the resident on medication is monitored and subject to review at three-monthly intervals or more frequently where there is a significant change in the resident's care or condition. All medication will be prescribed and administered according to best practice as individually clinically indicated to increase the quality or duration of each resident's life. (See also Standard 10: Assessment)
- 15.3** In the event of the resident being treated as an inpatient in an acute general hospital, any change to his/her medication must be directly communicated, both verbally and evidenced in writing to the pharmacist, the general practitioner and the residential care setting within six hours of discharge.
- 15.4** Suspected adverse reactions observed or notified in association with medicines are documented and discussed with the medical officer or general practitioner, to facilitate consideration of the need for any treatment alterations. Suspected adverse reactions are reported to the Irish Medicines Board (IMB).
- 15.5** Before initiating prescribing, or changing a resident's medication, due attention should be given to the possibility of the patient's behaviour resulting from other causes for example, urinary tract infection, tooth ache, ear ache, constipation, need for change of incontinence pads, leg cramps or other precipitating pain, discomfort, need or stimulus.

- 15.6** Each resident on long-term medication is reviewed by his/her medical practitioner at least on a three-monthly basis, in conjunction with nursing staff and the pharmacist. Special consideration is given to the use of:
- » antipsychotic medication
  - » sleeping tablets and other sedating medication
  - » anticonvulsant medication
  - » medication for the management of depression
  - » analgesic medications (pain management)
  - » medication for the management of constipation
  - » anti-platelet and anticoagulant medication (prevention of stroke)
  - » influenza and pneumococcal vaccines
  - » non-steroidal anti-inflammatory drugs
  - » different medications and their potential interactions.

## Standard 16: End of Life Care

**Each resident continues to receive 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.**

### Criteria

- 16.1** The resident's palliative care needs are assessed, documented and regularly reviewed. The information derived from these assessments is explained to, and options discussed at regular intervals with the resident, his/her family or representative, in accordance with the resident's wishes.
- 16.2** The resident's wishes and choices regarding end of life care are discussed and documented, and, in as far as possible, implemented and reviewed regularly with the resident. This includes his/her preferred religious, spiritual and cultural practices and the extent to which his/her family are involved in the decision-making process. Where the resident can no longer make decisions on such matters, due to an absence of capacity, his/her representative is consulted. (See Standard 3: Consent)
- 16.3** In accordance with the resident's assessed needs, referrals are made to specialist palliative care services so that an integrated multidisciplinary approach to end of life care is provided.
- 16.4** Staff are provided with training and guidance in end of life care as appropriate to their role.
- 16.5** The residential care setting has facilities in place to support end of life care so that the resident is not unnecessarily transferred to an acute setting except for specific medical reasons, and in accordance with his/her wishes.
- 16.6** Every effort is made to ensure that the resident's choice as to the place of death, including the option of a single room or returning home, is identified and respected.
- 16.7** The resident's family and friends are facilitated to be with the resident when he/she is very ill or dying and overnight facilities are available for their use. Upon the death of the resident, time and privacy are allowed for his/her family, friends and carers. An atmosphere of peace and calm is maintained at all times.
- 16.8** There is a procedure for staff to follow after the death of a resident in relation to the verification and certification of death.
- 16.9** The deceased resident's body is treated with respect and dignity in accordance with his/her wishes, if stated, or in accordance with the wishes of his/her family or representative, and in accordance with the resident's cultural and religious beliefs and best practice.

- 16.10** Upon the death of a resident, his/her family or representatives are offered practical information (verbally and in writing) on what to do following the death and on understanding loss and bereavement. This includes information on how to access bereavement care services and how to register the death.
- 16.11** Procedures are in place for the return of the resident's personal possessions in accordance with the resident's wishes, in a timely and respectful fashion following his/her death. The return of personal effects is formally documented and signed.
- 16.12** Following the death of a resident, support is provided to other residents and staff. Where residents would like to have a remembrance event, this is facilitated.
- 16.13** Following the death of a resident, notification of the date, time and certified cause of death is communicated to the local Coroner's Office, as stipulated by that Office and subject to amendment. Notice is also sent to the Health Service Executive as stipulated in Health Service Executive guidelines.



## Section 4: Quality of Life

### Standard 17: Autonomy and Independence

**Each resident can exercise choice and control over his/her life and is encouraged and enabled to maximise independence in accordance with his/her wishes.**

#### Criteria

- 17.1** Care practices reflect a person-centred approach to care. They encourage individuality and self-sufficiency, and promote the resident as an equal partner in his/her own care.
- 17.2** There is a policy that promotes, maintains and maximises independence.
- 17.3** The person in charge manages the residential care setting in a manner that maximises the resident's capacity to exercise personal autonomy and choice. Where the resident's choice is restricted, the reason for this is explained and documented and appropriate support is provided. (See Standard 3: Consent)
- 17.4** There are clear communication and information processes in place to facilitate the resident exercising choice.
- 17.5** The resident is given a choice to participate in individual and/or communal recreational activities.
- 17.6** The resident's individual choices relating to his/her preferred term of address are respected. (See Standard 4: Privacy and Dignity)
- 17.7** Practices enable and protect the autonomy of each resident. Staff engagement with residents actively promotes opportunities for self-expression.
- 17.8** The resident handles his/her own financial affairs for as long as he/she wishes and has the capacity to do so. (See Standard 9: The Resident's Finances)
- 17.9** The resident is entitled to bring personal possessions with him/her, the extent of which is agreed prior to admission.

## Standard 18: Routines and Expectations

**Each resident has a lifestyle in the residential care setting that is consistent with his/her previous routines, expectations and preferences, and satisfies his/her social, cultural, language, religious, and recreational interests and needs.**

### Criteria

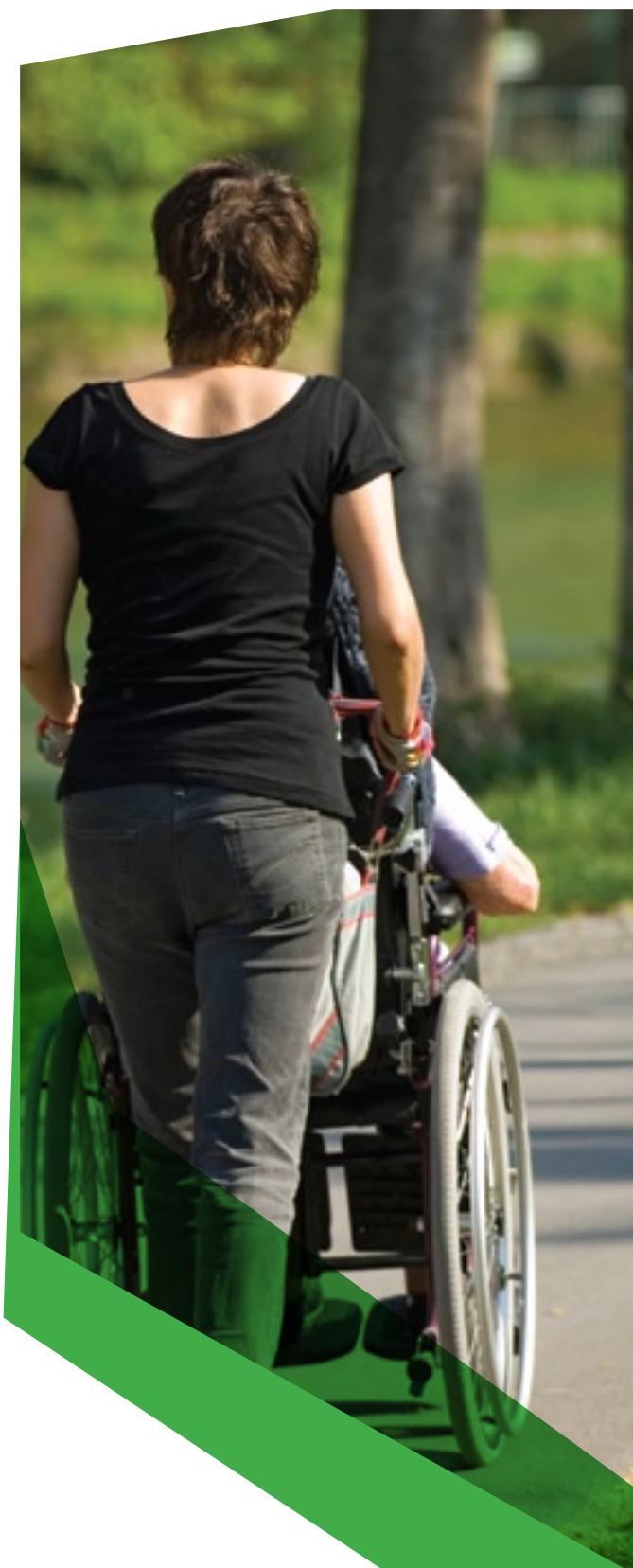
- 18.1** The routines of daily life and activities are flexible and vary to suit the resident's expectations, preferences, previous interests and capacities, as outlined in his/her care plan. They are reviewed at three-monthly intervals in consultation with the resident as part of his/her care plan review. (See Standard 11: The Resident's Care Plan)
- 18.2** The resident is given opportunities for participation in meaningful and purposeful activity, occupation or leisure activities, both inside and outside the residential care setting, that suit his/her needs, preferences and capacities. Particular consideration is given to residents with dementia and other cognitive impairments, residents with visual, hearing or dual sensory impairments, residents with communication difficulties and residents with physical or learning disabilities.
- 18.3** The resident is enabled to live in a manner akin to his/her own home and the daily routines of the residential care setting, including meal times and bed times, are not solely dictated by staffing rotas.
- 18.4** The resident's social, religious and cultural beliefs and values are respected and accommodated within the routines of daily living.
- 18.5** The person in charge ensures that staff can communicate effectively with residents and that the residential care setting is conducive to staff interaction and engagement with residents.
- 18.6** Up-to-date information on activities is circulated to each resident or his/her representative, in formats suited to his/her capacities.

## Standard 19: Meals and Mealtimes

**Each resident receives a nutritious and varied diet in pleasant surroundings at times convenient to them.**

### Criteria

- 19.1** The resident is provided with a nutritious and varied diet, which meets his/ her individual and dietary needs and preferences.
- 19.2** The menu offers the resident a choice of meal at each mealtime. A choice is also available to residents on specific diets.
- 19.3** The resident is offered three full meals each day at conventional meal times. Hot and cold drinks and nutritious snacks are available at all times and offered regularly. Drinking water is readily accessible.
- 19.4** Food, including therapeutic and modified consistency diets, is presented in a manner which is attractive and appealing in terms of texture, flavour and appearance, in order to maintain appetite and nutrition.
- 19.5** Special therapeutic diets are provided when advised by healthcare and dietetic staff.
- 19.6** The resident's religious or cultural dietary needs are catered for as agreed on admission and menus provided for special occasions.
- 19.7** The daily menu is displayed in a suitable format and in an appropriate location so that the resident or his/her representative knows what is available at each mealtime.



- 19.8** Independent dining is encouraged. There is a sufficient number of staff present when meals are served to offer assistance when necessary. Assistance is offered discreetly, sensitively and individually.
- 19.9** Meals are unhurried social occasions and staff are encouraged to participate in and view mealtimes as an opportunity to communicate, engage and interact with the residents.
- 19.10** Opportunities are provided for the resident's family and friends to dine with him/her on special occasions.
- 19.11** The resident's family and friends are facilitated to assist him/her at mealtimes with due regard to the privacy of other residents.
- 19.12** Staff receive training in safe food handling as appropriate to their role and are compliant with safe food handling.

## Standard 20: Social Contacts

**Each resident maintains contact with his/her family, friends, representatives and the local community according to his/her wishes.**

### Criteria

- 20.1** The resident's links with family members including children, and friends, are encouraged and facilitated.
- 20.2** Links with and involvement of local community groups and/or volunteers in the residential care setting are encouraged and maintained in accordance with residents' preferences and with appropriate protective measures.
- 20.3** The resident can receive visitors in private. The resident chooses who he/she sees and does not see and his/her wishes are respected and recorded.
- 20.4** The person in charge ensures that there are no restrictions on visits except when requested to do so by the resident or when the visit or the timing of the visit is deemed to pose a risk.
- 20.5** The resident has access to radio and television programmes, newspapers, magazines, information via computer (for email and internet access) and a notice board displaying information on local events.

## Standard 21: Responding to Behaviour that is Challenging

**The needs of each resident with behaviour that is challenging, including behaviour that poses a high risk to him/herself or others, are managed and responded to effectively in an environment that promotes wellbeing and has the least restrictions.**

### Criteria

- 21.1** The residential care setting's procedures for managing and responding to behaviour that is challenging, promote positive outcomes for the resident. They are based on staff knowing and understanding the resident's usual conduct, behaviour and means of communication, and having an awareness of and ability to adapt the environment in response to behaviours that are challenging.
- 21.2** There is a policy that sets out the residential care setting's response to behaviour that is challenging. It provides guidance on understanding, investigating the cause(s) of, assessing and responding to behaviour that is challenging. It outlines interventions based on best practice evidence and interventions that are prohibited in the residential care setting.
- 21.3** Where a resident's behaviour presents a risk to him/herself or others, his/her care plan sets out a plan of care that meets his/her individual assessed needs. The plan is reviewed regularly to assess its effectiveness and reflect the resident's changing needs. Records of review meetings and/or case conferences, including named responsibility and timescales for actions and arrangements for review, are recorded and distributed to the resident and those in attendance at the meeting.
- 21.4** All staff have up-to-date knowledge and skills, appropriate to their role, to enable them to manage and respond to behaviour that is challenging. There are arrangements in place to obtain advice, training and support from key professionals with the required expertise.
- 21.5** The person in charge ensures that all interventions in response to behaviour that is challenging are reviewed regularly, demonstrably inform learning and practice development. Reviews take place in a spirit of staff support.
- 21.6** Positive (non-restrictive and non-pharmacological) interventions are the preferred method of providing support to the resident experiencing behavioural disturbances.
- 21.7** A standardised assessment tool is used to assess behaviour that is challenging, with symptoms objectively documented and qualified. There is documented evidence that the symptoms are persistent, preventable causes have been ruled out, and the risks and benefits of the use of physical restraint or medication in relation to the level of distress or potential harm without such interventions have been evaluated.
- 21.8** Expert advice is sought where necessary on a behaviour management and activity plan before commencing psychotropic medication (anti-psychotic, atypical anti-psychotic, antidepressant or anxiolytic) or ongoing use of physical restraint.

### Use of Psychotropic Medication (Criteria 21.9 – 21.13)

- 21.9** The medication being used as a restrictive practice to manage behaviour that is challenging is used under strictly controlled conditions that promote the wellbeing and interests of the resident.
- 21.10** Where the use of psychotropic medication is indicated, there is evidence that the appropriate drug is selected with reference to evidence-based practice, started at the lowest dosage possible, and increased slowly until either there is a therapeutic effect, side effects emerge, or the maximum recommended dose is reached. Pharmaceutical advice is accessible where needed.
- 21.11** The resident taking psychotropic medication is assessed for potential hypotension, risk of falls, drug-related cognitive/behavioural function and drug-related discomfort. The resident's psychotropic medication is subject to an initial review and then there is ongoing monitoring and review for potential side effects, as indicated by the resident's changing needs and circumstances, but no less frequently than at three-monthly intervals.
- 21.12** Where such drugs are prescribed on an "as required basis" there should be documented clinical indications identified that may trigger the use of such medication and, the indications for giving or withholding the medication, and its effects, are documented.
- 21.13** This standard is implemented in conjunction with Standard 14: Medication Management, and Standard 15: Medication Monitoring and Review.

### Use of Physical Restraint (Criteria 21.14 – 21.23)

- 21.14** The residential care setting has a policy on the use of physical restraint that is evidence-based and adheres to regulations and national guidelines. Compliance with policy and regulatory requirements is clearly demonstrated.
- 21.15** The requirements of this standard take precedence over requests, or the approval of the resident's family, representative or general practitioner, for the use of physical restraint.
- 21.16** The resident is free from any physical restraint imposed for the purpose of discipline or convenience that is not required to treat his/her specific medical symptom(s).
- 21.17** Physical restraint is not used in response to the following behavioural symptoms:
- » wandering behaviour
  - » risk of falls, unless the risk of falling is immediate, as in severe imbalance
  - » removal of a medical device, unless the resident requires emergency care and physical restraint is used for a brief period to permit medical treatment to proceed.

- 21.18** Assessment must be documented prior to the initiation of physical restraint. At a minimum, assessment must identify and consider:
- » the specific medical symptom to be treated by the use of physical restraint
  - » the steps taken to identify the underlying physical and/or psychological causes of the medical symptom
  - » the alternative measures that have been taken, for how long, how recently, and with what results
  - » the evidence that a physical restraint will benefit the symptom
  - » the risks involved in using the physical restraint
  - » the specific circumstances under which physical restraint is being considered
  - » the type of physical restraint; period of physical restraint; and location of physical restraint.
- 21.19** Where a resident's unanticipated behaviour places him/her or others in imminent danger, short-term, proportionate and non-dangerous physical restraint measures may be taken by staff without prior formal assessment. Precipitating factors and behaviours, and the actions taken are clearly recorded in a restraint register.
- 21.20** The resident is not restrained without his/her informed consent. The resident is informed of the potential negative outcomes and hazards of physical restraint use. Where the resident is judged to lack the capacity to consent, physical restraint is not used if he/she expresses a clear and consistent preference not to be restrained. The single exception is the physical restraint of the resident as an emergency measure when his/her unanticipated behaviour places him/her in imminent danger of serious physical harm. In such circumstances the use of the physical restraint does not exceed beyond an immediate episode.
- 21.21** Except in rare, time-limited emergencies, or for brief provision of essential care, no physical restraint is used that causes the resident distress, discomfort, anger, agitation, pleas for release, calls for help or constant attempts to untie or release him/ herself.
- 21.22** Routine or "as needed" or indefinite orders for physical restraint are not used.
- 21.23** Any use of physical restraint is for the shortest possible duration. Where physical restraint is used there is documented evidence that:
- » in an emergency situation or during periods of extreme behaviour the resident is continuously observed
  - » the resident is checked regularly at intervals defined in his/her care plan
  - » an opportunity for motion and exercise is provided for a period of not less than 10 minutes during each two hour period in which the resident is awake.

## Section 5: Staffing

### Standard 22: Recruitment

**Staff are recruited in accordance with best human resource management practices.**

#### Criteria

- 22.1** Recruitment and human resource policies and procedures are based on current legislation and best practice.
- 22.2** All new staff are only confirmed in post following:
- » satisfactory Garda vetting (including vetting from other jurisdictions as appropriate)
  - » the receipt of two references (including a reference from the last place of employment)
  - » confirmation of identity
  - » confirmation of registration/validation of status, where applicable
  - » verification of all qualifications (for nurses this includes verification of registration on the active register of An Bord Altranais)
  - » exploration of gaps in employment.
- 22.3** There is a comprehensive contract between the registered provider and any registered/ licensed staffing agency used that sets out the agency's responsibilities in relation to the:
- » vetting of staff including Garda vetting and references and vetting from other jurisdictions as appropriate
  - » confirmation of registration/validation of status (where applicable)
  - » confirmation of identity
  - » professional indemnity
  - » arrangements for responding to concerns/complaints.
- 22.4** All staff have written job descriptions and a written copy of their terms and conditions of employment prior to commencing post.
- 22.5** The person in charge is satisfied that all new staff are competent to communicate effectively with residents, including those with communication difficulties, in particular in relation to speaking, listening, reading and writing.
- 22.6** Volunteers' roles and responsibilities are set out in a written agreement between the residential care setting and the individual. They receive supervision and support and are vetted appropriate to their role and level of involvement in the residential care setting.

## Standard 23: Staffing Levels and Qualifications

**There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these Standards and the needs of the residents.**

### Criteria

- 23.1** There are sufficient staff employed in the residential care setting to ensure continuity of care for the residents. Agency staff and overtime are only used for unforeseen contingencies such as unexpectedly high levels of sick leave.
- 23.2** A contemporaneous and accurate personnel file is kept for all staff and trainees of the:
- » full name
  - » date of birth
  - » curriculum vitae
  - » references
  - » Garda vetting
  - » qualifications
  - » record of previous employment
  - » training undertaken and completed
  - » relevant registration status with professional bodies in respect of nursing and other health and social care professionals employed in the residential care setting.
- 23.3** At any point in time, the number and skill mix of staff on duty is determined and provided according to a transparently applied, nationally validated, assessment tool, to plan for and meet the needs of the residents. This is subject to regular review.
- 23.4** The staffing numbers and skill mix of qualified/unqualified staff are at all times appropriate to the assessed needs of the residents and the size, layout and purpose of the residential care setting.
- 23.5** A planned and actual staff rota, showing staff on duty at any time during the day and night, is maintained.
- 23.6** At all times care is supervised by a registered nurse on duty. The number of registered nurses required is determined by the assessment tool.
- 23.7** The number of staff on duty at night time takes into account fire safety requirements to ensure the safety of residents in the event of fire.
- 23.8** The staffing calculations do not take into account individuals working in a supernumerary capacity i.e. individuals there for educational purposes alone.
- 23.9** Catering, cleaning, ancillary and administrative staff are employed to ensure that Standards relating to food and meals, infection control, transport, administration, laundry, cleaning and maintenance of the premises are fully met.

## Standard 24: Training and Supervision

### Staff receive induction and continued professional development and appropriate supervision.

#### Criteria

- 24.1 All nursing staff are, where possible, facilitated to undertake a relevant post-registration qualification in the nursing and care of older people.
- 24.2 All newly recruited care staff and those in post less than one year commence training to FETAC Level 5 or equivalent within two years of taking up employment. Long standing care staff have their competency and skills assessed to determine their need for further training and suitable arrangements are put in place to meet their identified training needs.
- 24.3 There is a staff training and development programme that maintains the skills of the workforce and ensures staff:
  - » meet the changing needs of residents
  - » fulfil the aims and philosophies of the residential care setting
  - » understand and adhere to the policies and procedures of the residential care setting and those of their regulatory body
  - » are suitably competent to carry out their role.
- 24.4 All staff receive induction training on commencement of employment, including acculturation training where appropriate.
- 24.5 The person in charge ensures that minimum mandatory training requirements for all staff are met and updated on an ongoing basis.
- 24.6 A record of all completed staff training and development is maintained.
- 24.7 A staff development and appraisal policy is established and key staff are trained in its implementation. Each staff member is informed of his/her progress and strengths and has an opportunity to develop his/her capabilities and strengths.
- 24.8 As part of the management process all staff are supervised on a regular basis pertinent to their role.

## Section 6: The Care Environment

### Standard 25: Physical Environment

**The location, design and layout of the residential care setting are suitable for its stated purpose. It is accessible, safe, hygienic, spacious and well maintained and meets residents' individual and collective needs in a comfortable and homely way.**

#### A: Criteria applying to all designated centres

- 25.1 The registered provider demonstrates that the premises and facilities comply with relevant statutory provisions and these Standards.
- 25.2 The building complies with the requirements of fire safety legislation and relevant building regulations.<sup>2</sup>
- 25.3 The registered provider demonstrates that equipment is provided and adaptations made that address the assessed needs of the resident.
- 25.4 A programme of routine maintenance and renewal of the fabric and decoration of the premises is produced and implemented and records are maintained.
- 25.5 The building and contents are insured and the registered provider has a valid insurance certificate.
- 25.6 Where close circuit television cameras are used, they do not intrude on the privacy of the resident.
- 25.7 Current infection control guidelines are followed.
- 25.8 The residential care setting is creatively designed in a manner that safely accommodates residents' mobility, audio and visual needs. The design and layout encourages and aids independence including appropriate signage and use of colours.
- 25.9 The residential care setting provides safe areas for walking and has regularly spaced seating areas and areas of interest and diversion.
- 25.10 The residential care setting provides a light and tranquil environment through the use of appropriate colours and furnishings.
- 25.11 Communal rooms and bedrooms are domestic in character and suitable for the range of interests and activities preferred by residents.
- 25.12 There is suitable and sufficient heating with a minimum temperature of 18 °C (65°F) in bedroom areas and 21°C (70°F) in day areas and in bedrooms where residents sit out during the day.

(2) The building complies with the requirements of fire safety legislation and relevant building regulations, including but not limited to Building Control Acts 1990 and 2007, the Fire Services Acts 1981 and 2003, the Department of the Environment, Heritage, and Local Government Building Regulations, Technical Guidance Document F – Ventilation and the Department of the Environment, Heritage, and Local Government Building Regulations, Technical Guidance Document G – Hygiene.

- 25.13** Rooms are individually and naturally ventilated with windows conforming to recognised standards. The height of the window enables residents to see out when seated.
- 25.14** The lighting in communal rooms is adaptable and suits the needs of residents and caregivers. It is sufficiently bright and positioned to facilitate reading and other activities.
- 25.15** Rooms are centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. Heating can be safely controlled in the resident's own room, in compliance with health and safety guidance and building regulations.
- 25.16** Hot water is stored at a temperature of at least 60°C and distributed at 50°C minimum, to prevent risks from legionella. To prevent risks from scalding, pre-set valves of a type unaffected by changes in water pressure and which have fail safe devices are fitted locally to provide water to a maximum temperature of 43°C.
- 25.17** Adequate storage space is provided to ensure that equipment and assistive devices are stored in a discreet and safe manner.
- 25.18** The residential care setting provides accommodation for each resident that is furnished and equipped to assure comfort and privacy, and meets the assessed needs of the resident.
- 25.19** The resident is encouraged to personalise his/her own room and may choose to provide his/her own furnishings. Furnishings supplied by the registered provider are in accordance with the comfort, safety and assessed needs of the resident.
- 25.20** The door to the resident's private accommodation is fitted with locks suited to his/her capabilities; it is accessible to staff in defined circumstances and meets fire safety regulations. The resident is able to secure his/her own personal accommodation, however, in defined circumstances staff are able to access it.
- 25.21** Each resident has a lockable storage space.
- 25.22** Screening is provided in rooms with more than one occupant to ensure privacy for personal care.

### Adaptations and Equipment

- 25.23** There is appropriate accommodation to facilitate the services of allied health professionals.
- 25.24** Specialist medical devices and equipment are made available to meet the resident's needs in accordance with his/her care plan.
- 25.25** There is a policy on the provision, management, maintenance, cleaning and decontamination, and repair of medical devices and equipment. An identified person has responsibility for medical devices and equipment management including staff training and safety assurance.

- 25.26** The resident, including those with a physical, sensory, mental health, dementia or other cognitive impairment, has access to relevant communal areas, through the provision of, where required:
- » ramps and passenger lifts
  - » stair/chair lifts
  - » grab rails, hoists and other aids
  - » appropriate signage and colour schemes to assist safe mobility.
- 25.27** The doorways into communal areas, residents' rooms, bathing and toilet facilities and other spaces to which wheelchair users, power wheelchair users and those requiring the use of hoists have access, are of sufficient width to allow adequate access. In all newly built residential care settings, new extensions and first time registrations, the doorways into areas into which wheelchair users, power wheelchair users and those requiring the use of hoists have access comply with the relevant design criteria and specifications required for access by people with a disability.
- 25.28** Call systems with an accessible alarm facility are provided in every room normally used by residents and for every bed with due regard to the resident's safety.
- 25.29** The person in charge facilitates the use of assistive living technology to maximise the independence of the resident.



## B: Criteria for existing designated centres

Set out below are the minimum facilities to be provided in existing residential care settings<sup>3</sup>.

### Outdoor space

**25.30** The existing residential care setting provides, where possible, a safe outdoor space with seating, accessible to all residents, including residents with mobility impairments and those using wheelchairs. The grounds are kept safe, tidy and attractive. In residential care settings that accommodate people with dementia, there is a secure perimeter. Where outdoor space is not available, the resident has access to a programme of outdoor activities.

### Communal space

**25.31** In the existing residential care setting communal space comprises separate sitting and dining rooms, and recreational space. It excludes residents' private accommodation, corridors, and entrance halls of corridor width and amounts to at least 3.4 m<sup>2</sup> for each resident. It includes:

- » rooms in which a variety of social, cultural and religious activities can take place
- » dining room(s) to cater for all residents
- » sitting rooms, at least one of which provides for quiet space
- » a separate room(s) where residents can meet visitors in private
- » where there is a separate designated smoking room for residents, it is ventilated to the external air by natural and mechanical ventilation. It is located and designed to facilitate continuous supervision of smokers with due regard to "duty of care" and health and safety legislation. The residential care setting has a documented smoking policy
- » where a hairdressing room is provided it contains a hairdressing sink and a separate wash basin, a continuous supply of hot and cold water, and adequate ventilation to the external air.

### Treatment Room(s)

**25.32** The existing residential care setting has a separate dedicated room(s) with facilities in place for clinical examinations and therapy, if required and as appropriate to the size of the residential care setting.

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(3) These criteria apply to existing designated centres including existing designated centres seeking re-registration after change of ownership. The six-year timeframe, applicable to existing designated centres, commences on the implementation of the Standards.

## Kitchens

- 25.33** The existing residential care setting has kitchens and, where appropriate ward serveries and associated areas, which are adequate in size and of suitable layout to cater for the residents' needs and comply with food safety legislation.

## Lift

- 25.34** In order to ensure safe access and egress, premises with more than one floor, or located on upper floors, have a lift or chair lift to facilitate the transfer of residents between floors. Where there is no lift or chair lift residents who are not independently mobile are not accommodated on upper floors.

## Cleaning Rooms

- 25.35** The existing residential care setting has separate cleaning rooms appropriate to the size of the residential care setting. The cleaning rooms are ventilated to the external air and contain a sluice sink, wash hand basin, and lockable safe storage for cleaning chemicals. There are separate cleaning rooms for catering and non-catering areas. All new/replacement sinks are of stainless steel.

## Sluice Room(s)

- 25.36** The existing residential care setting has sluicing facilities appropriate to the size of the residential care setting and easily accessible from all areas of the building. It is ventilated to the external air. At a minimum it contains:
- » a sluice sink sufficiently large to avoid spillage, directly connected to the foul drainage system
  - » a bedpan washer and/or macerator
  - » hand-washing facilities
  - » a suitably sized sink
  - » adequate racking/storage for bedpans/urinals
  - » lockable cupboards for safe storage of cleaning chemicals
  - » all new/replacement sinks are of stainless steel.

## Laundry

- 25.37** The existing residential care setting has a laundry ventilated to the external air that adequately caters for the size of the residential care setting. At a minimum it contains:
- » a sink with double drainer, serviced with an instant supply of hot and cold water
  - » a wash-hand basin
  - » suitable and sufficient worktops and racking for sorting, drying and storage of laundry
  - » space to separate clean and dirty laundry
  - » an adequate number of washing machines of industrial standard (with appropriate disinfection temperatures for washing soiled laundry) and dryers
  - » an ironing facility
  - » All new/replacement sinks are of stainless steel.

## Office(s)

- 25.38** The existing residential care setting has a dedicated office(s) appropriate to the size of the residential care setting. It contains suitable and safe storage for medical files and records, and seating and desk(s). It is ventilated to the external air and equipped to facilitate management and staff in the performance of their duties.

## Bedrooms

- 25.39** The existing residential care setting provides a minimum of 9.3 m<sup>2</sup> usable floor space (excluding en-suite facilities) in all single rooms. Where the residential care setting provides less than 9.3 m<sup>2</sup> usable floor space, it must be provided within six years\* of the implementation of these Standards.
- 25.40** Existing bedrooms which are currently shared have at least 7.4 m<sup>2</sup> per resident. Within six years\* of implementation of these Standards, there are no more than two residents per room except in a high dependency room where up to six highly dependent residents, in need of 24-hour high support nursing care, or who are in transition from hospital to nursing home care, can be accommodated together.

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*\* "Where written, explicit costed plans with timescales are agreed with the Chief Inspector, at the discretion of the Chief Inspector, the period for meeting the criteria at 25.39 and 25.40 may be extended on a case by case basis. The Chief Inspector may impose appropriate conditions of registration, in respect of any such setting, relating to the agreed plans."*

## Toilets and Washing Facilities

- 25.41** The existing residential care setting provides toilet, washing and bathing facilities that meet the needs of residents. Toilets are accessible, clearly marked and within close proximity to bedrooms and communal areas.
- 25.42** The existing residential care setting has:
- » at least one toilet to every six residents (residents with en-suites are not included in this calculation)
  - » communal toilets located in close proximity to day areas and dining areas
  - » additional toilet facilities that are wheelchair accessible identified for use by visitors
  - » one hand basin per bedroom with a minimum of one hand basin for every two residents or one for every three residents of a high dependency room
  - » at least one assisted toilet per floor.
- 25.43** The existing residential care setting provides:
- » at least one assisted bath (or assisted showers provided this meets residents' needs) to 11 residents. Where suitably adapted en-suite bathing/shower facilities are provided in residents' rooms, these residents can be excluded from this calculation
  - » where existing residential care settings provide less than one assisted bath (or assisted showers) to 11 residents, this must be provided within six years\* of the implementation of these Standards. Where new assisted bathrooms are provided in existing buildings the minimum floor space for a communal bathroom is 9.3 m<sup>2</sup>
  - » assisted baths/showers are suitably located in close proximity to bedrooms.

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*\*"Where written, explicit costed plans with time scales are agreed with the Chief Inspector, at the discretion of the Chief Inspector, the period for meeting the criteria at 25.39 and 25.40 may be extended on a case by case basis. The Chief Inspector may impose appropriate conditions of registration, in respect of any such setting, relating to the agreed plans."*

## C: Criteria for newly built designated centres, new extensions and first time registrations

Set out below are the minimum facilities to be provided in newly built residential care settings, new extensions or first time registrations.

### Outdoor space

**25.44** The newly built residential care setting, new extension or first time registration, provides a safe outdoor space with seating, accessible to all residents including those who use wheelchairs or who have other mobility problems. The grounds are kept safe, tidy and attractive. They are designed to meet the needs of residents including those with physical, sensory and cognitive impairments. In residential care settings registered to accommodate people with dementia, there is a secure perimeter.

### Communal Space

**25.45** In the newly built residential care setting, new extension or first time registration, communal space comprises separate sitting and dining rooms, and recreational space. It excludes residents' private accommodation, corridors, and entrance halls of corridor width, and amounts to at least 4 m<sup>2</sup> for each resident. It includes:

- » rooms in which a variety of social, cultural and religious activities can take place
- » dining room(s) to cater for all residents
- » sitting rooms, at least one of which provides for quiet space
- » a separate room(s) where residents can meet visitors in private with a minimum floor space of 9.3 m<sup>2</sup>
- » where there is a separate designated smoking room for residents, it is ventilated to the external air by natural and mechanical ventilation. It is located and designed to facilitate continuous supervision of smokers with due regard to "duty of care" and health and safety legislation. The residential care setting has a documented smoking policy
- » where a hairdressing room is provided, it contains a hairdressing sink and a separate wash basin, a continuous supply of hot and cold water, and ventilation to the external air

### Treatment Room

**25.46** The newly built residential care setting, new extension or first time registration has a separate dedicated room or rooms, as appropriate to the size of the residential care setting, with facilities in place for clinical examinations and therapy, if required. It has a minimum 16 m<sup>2</sup> floor space.

## Kitchens

- 25.47** The newly built residential care setting, new extension or first time registration has kitchens and, where appropriate, ward serveries and associated areas, which are adequate in size and of suitable layout to cater for the residents' needs and comply with food safety legislation.

## Lift

- 25.48** The newly built residential care setting, new extension or first time registration with more than one floor, or located on upper floors, has a lift to facilitate the transfer of residents between floors. The lift is sufficiently large to facilitate the transfer of a resident by ambulance trolley or stretcher to the ground floor with due regard to the resident's dignity.

## Cleaning Rooms

- 25.49** The newly built residential care setting, new extension or first time registration has separate cleaning rooms appropriate to the size of the residential care setting. The cleaning rooms are ventilated to the external air, contain a stainless steel sluice sink, wash-hand basin, and lockable safe storage for cleaning chemicals. There are separate cleaning rooms for catering and non-catering areas.

## Sluice Room(s)

- 25.50** The newly built residential care setting, new extension or first time registration has a sluicing facility/facilities appropriate to its use and easily accessible from all areas of the building. At a minimum it contains:
- » a sluice sink sufficiently large to avoid spillage, directly connected to the foul drainage system
  - » a bedpan washer and/or a macerator
  - » washing facilities
  - » a suitable sized sink
  - » racking/storage for bedpans/urinals
  - » lockable cupboards for safe storage of cleaning chemicals.



## Laundry

**25.51** The newly built residential care setting, new extension or first time registration has a laundry ventilated to the external air that adequately caters for the size of the residential care setting and the amount of laundry done in it. At a minimum it contains:

- » a stainless steel sink with double drainer, serviced with an instant supply of hot and cold water
- » a wash-hand basin
- » suitable and sufficient worktops and racking for sorting, drying and storage of laundry
- » adequate space to separate clean and dirty laundry
- » an adequate number of washing machines of industrial standard (with disinfection temperatures for washing soiled laundry) and dryers
- » an ironing facility.

Where laundry is done externally, there is a storage room with direct external access for the storage and collection of materials and waste.

## Office(s)

**25.52** The newly built residential care setting, new extension or first time registration, has a dedicated office(s) appropriate to the size of the residential care setting. It contains suitable and safe storage for medical files and records, and seating and desk(s). It is ventilated to the external air and equipped to facilitate management and staff in the performance of their duties.



## Bedrooms

- 25.53** All single rooms, in the newly built residential care setting, new extension or first time registration, have a minimum of 12.5 m<sup>2</sup> usable floor space (excluding en-suite facilities). Room dimensions and layout options provide for space on either side of the bed, to enable access for carers and any equipment needed.
- 25.54** The newly built residential care setting, new extension or first time registration:
- » has a minimum of 80% of residents accommodated in single rooms
  - » shared rooms have at least 20 m<sup>2</sup> of usable space (excluding en-suites) and are occupied by no more than two residents
  - » a room to accommodate up to six highly dependent residents together is used only where the resident needs 24-hour high support nursing care or is in transition from hospital to nursing home care.

## Toilets and Washing Facilities

- 25.55** The newly built residential care setting, new extension or first time registration, provides toilet, washing and bathing facilities to meet the needs of residents.
- » toilets are accessible and clearly marked
  - » a sufficient number are close to day and dining areas
  - » additional toilet facilities that are wheelchair accessible are identified for use by visitors
  - » there is at least one assisted toilet per floor.
- 25.56** The newly built residential care setting, new extension or first time registration, provides en-suite facilities (at minimum a toilet and hand-basin) in all bedrooms. Communal toilets are located in close proximity to day areas and dining areas. Additional toilet facilities are identified for use by visitors and are wheelchair accessible.
- 25.57** The newly built residential care setting, new extension or first time registration, provides for a totality of one assisted bath (or assisted showers provided this meets residents' needs) to eight residents. Where suitably adapted en-suite bathing/shower facilities are provided in residents' rooms, these residents can be excluded from this calculation.
- 25.58** The newly built residential care setting, new extension or first time registration, has communal bathrooms and shower rooms that have a minimum floor area of 10 m<sup>2</sup>. Toilets are a minimum of 4 m<sup>2</sup> and are at least 2 m long. Toilets designed for assisted use have a floor space of at least 5.5m<sup>2</sup>.

## Standard 26: Health and Safety

**The health and safety of the resident, staff and visitor to the residential care setting is promoted and protected.**

### Criteria

- 26.1** The registered provider ensures compliance with all relevant health and safety legislation.
- 26.2** There are policies and procedures that comply with health and safety legislation for providing and maintaining:
- » a safe and healthy place of work with safe access to and egress from it
  - » working practices that minimise risks to health or welfare
  - » a healthy work environment.
- 26.3** The person in charge, in accordance with relevant legislation, promotes healthy and safe working practices through the provision of information, training, supervision and monitoring of staff under the following broad headings:
- » a safe and healthy working environment with safe systems of work
  - » a safe place of work with safe access to it and egress from it
  - » fire safety
  - » infection control
  - » moving and handling
  - » falls management
  - » first aid
  - » food safety
  - » maintenance of all equipment and machinery
  - » personal safety at work in compliance with Safety, Health and Welfare at Work Act, 2005.
- 26.4** There is a safety statement for each residential care setting and each staff member understands his/her responsibility for the safety of residents and other staff members. Staff safety representatives are facilitated to discharge their responsibilities.
- 26.5** There are arrangements in place to ensure the person in charge receives appropriate information and can access support and the necessary resources to ensure a safe and healthy workplace.

- 26.6** Publicly displayed health and safety procedures are in formats that are easily understood and take account of the special communication needs of people using the building. All staff are familiar with the health and safety arrangements for the building.
- 26.7** The person in charge ensures that risk assessments are carried out for every area of work and associated work activities. The findings of the risk assessment and the action taken to manage identified risks are recorded. All staff are aware of any hazards identified and the current control measures in place. The risk assessments are reviewed on a regular basis and updated as required.
- 26.8** There is a clear procedure in place setting out the action to be taken including reporting requirements where there is an unanticipated absence of a resident from the residential care setting.
- 26.9** The person in charge ensures that all significant events including accidents, injuries, dangerous occurrences and incidents of fire are recorded. Where a significant event involves a resident, the next of kin is notified as soon as possible. This information is audited and feedback and education are provided.
- 26.10** Staff use appropriate protective clothing and equipment suitable for the job to prevent risk of harm or injury to themselves or others.
- 26.11** Vehicles are roadworthy, insured and are only driven by staff with a full driving licence which entitles him/her to drive the particular vehicle. A record is kept of maintenance checks. All incidents are reported as per an Incident Report Policy.
- 26.12** Lifts are inspected and certified by a competent person.
- 26.13** There is an emergency plan in place.



## Fire Safety

- 26.14** The registered provider ensures that adequate precautions are taken against the risk of fire, including effective means of escape and evacuation, arrangements for detecting, containing and extinguishing fires and maintenance of fire fighting equipment.
- 26.15** The residential care setting has a fire safety policy and procedure which is communicated to all staff on commencement of employment and at least annually thereafter.
- 26.16** There is an up-to-date fire management plan (including management of fire safety equipment and conducting fire drills) that is revised and actioned when necessary and whenever the fire risk changes. This includes the maintenance and checking of physical fire precautions in accordance with relevant legislation and manufacturers and installers guidance.
- 26.17** Each staff on commencing employment, and at least once a year thereafter, undertakes training in fire safety and evacuation. Where evacuation sheets or other equipment for the evacuation of immobile residents are provided, staff are trained in the use of such equipment as appropriate to their role. A record of fire safety and evacuation training is maintained.
- 26.18** Arrangements are in place to ensure that all staff and as far as possible, all residents know the procedure to be followed in the case of fire. Fire drills take place at least twice a year.
- 26.19** The registered provider ensures that emergency lighting is provided and that materials contained in bedding and internal furnishings have adequate fire retardancy properties and have low levels of toxicity when on fire.
- 26.20** The registered provider has written confirmation that all statutory requirements relating to fire safety and these Standards have been complied with.

## Hygiene and Control of Infection

- 26.21** Responsibility for infection prevention and control is clearly defined and there are clear lines of accountability for infection prevention and control throughout the residential care setting.
- 26.22** Policies and procedures consistent with current national guidelines on infection prevention and control systems are used by staff on a daily basis. These include the safe handling and disposal of healthcare risk waste, dealing with spillages, provision of protective clothing, raising awareness of residents and their visitors, hand washing, linen handling, covering of cuts and abrasions and cleaning of equipment in order to prevent cross contamination. At all times, the premises is clean, hygienic and free from offensive odours.

- 26.23** All staff receive education and training and regular updates (at least annually) on the risks of infection, that are commensurate with their work activities and responsibilities and their role in preventing and managing infection.
- 26.24** Alcohol rub and hand-washing facilities are prominently sited throughout the residential care setting in accordance with current infection control guidelines. They are available with a separate hand-washing sink in areas where infected material and/or clinical waste are handled.
- 26.25** Clearly documented systems are in place for detecting and responding to an outbreak of infection.
- 26.26** Changing, shower and toilet facilities are provided for staff in accordance with best practice for infection control and prevention. Separate changing facilities are provided for catering and non-catering staff.
- 26.27** The laundry floor finishes and those in sluice and cleaning rooms are impermeable. Floor and wall finishes are washable, anti-slip and easily cleaned when wet. Wall-floor junctions are coved. Laundry facilities are sited so that soiled articles, clothing and infected linen are not carried through areas where food is stored, prepared, cooked or eaten. There are separate areas for clean and dirty laundry and washing machines have the specified programming ability to meet disinfection Standards. There is an adequately sized linen storage area on each floor or wing depending on the design of the building.
- 26.28** The person in charge ensures compliance with food safety legislation and that staff receive training in relation to it.



## Section 7:

# Governance and Management

### Standard 27: Operational Management

**The residential care setting is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.**

#### Criteria

- 27.1** The person in charge is qualified, competent and experienced to manage the residential care setting and meet its stated purpose, aims and objectives. He/ she:
- » is a registered nurse
  - » has at least three years experience nursing older people in the last six years
  - » has a minimum of two years management experience
  - » has engaged in continuous professional development
  - » has an in-depth knowledge of the ageing process.
- 27.2** Within five years of the implementation of these Standards each newly-appointed person in charge will have:
- a post-registration qualification in nursing of the older person
  - three years experience in a management capacity
  - a post-registration qualification in healthcare management or equivalent.
- 27.3** The job description of the person in charge enables him/ her to have authority and take responsibility for fulfilling his/her duties.
- 27.4** Where the size of the residential care setting dictates there is an appropriate management structure to support the work of the person in charge.
- 27.5** Where an organisation provides multiple designated centres, there is a named manager to whom each person in charge reports.
- 27.6** The named manager carries out the responsibilities and duties of the registered provider.
- 27.7** The Chief Inspector is notified in writing of any change to the registered provider or person in charge, prior to or at the time of the change.

## Standard 28: Purpose and Function

**There is a written statement of purpose and function that accurately describes the service that is provided in the residential care setting and the manner in which it is provided. Implementation of the statement of purpose and function is clearly demonstrated.**

### Criteria

- 28.1** The statement of purpose and function includes:
- » the aims, objectives and ethos of care, including practices that are directly determined by the residential care setting's ethos
  - » the number of residents, categories of care provided, and level of needs that can be accommodated
  - » the services and facilities provided
  - » the terms and conditions of the contract of care (See Standard 7: Contract/Statement of Terms and Conditions)
  - » the physical facilities of the premises
  - » a list of key policies that inform practice in the residential care setting.
- 28.2** The day-to-day operation of the residential care setting reflects the statement of purpose and function.
- 28.3** Before any changes are made which affect the purpose and function of the residential care setting, notification is made to the Chief Inspector to vary the conditions of registration.
- 28.4** The statement is available in a format that is accessible to the resident and the prospective resident, his/her family and/or representative. The statement is kept under review and updated when necessary. (See Standard 1: Information)
- 28.5** The purchaser of beds and the relevant registered providers have Service Level Agreements which are implemented and monitored.
- 28.6** Service delivery plans are resident-focused and promote continuity in service delivery. Where progress is less than expected, or where difficulties or risks are encountered, the service responds to this and initiates changes to the service delivery plan.

## Standard 29: Management Systems

**Effective management systems are in place that support and promote the delivery of quality care services.**

### Criteria

- 29.1** There is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for areas of activity including support services, such as maintenance.
- 29.2** The organisational structure and systems support the registered provider, the person in charge and the management team to create a transparent, positive and inclusive environment.
- 29.3** The person in charge ensures that professional development plans are in place that are supported by training and education programmes.
- 29.4** The person in charge ensures that staff receive training in, are familiar with, and implement all policies and procedures within the residential care setting. There is clear evidence in this regard.
- 29.5** The person in charge ensures that applicable legislation, regulatory requirements, best practice and relevant codes of practice are met.
- 29.6** The residential care setting has systems in place to effectively manage risk, including a designated person(s) to contact in an emergency. Policies and procedures are implemented effectively with due consideration of the needs and wishes of the resident.
- 29.7** The person in charge ensures that all legally required certificates and licences are kept up to date and are displayed where required.
- 29.8** Policies, procedures and practices are regularly reviewed in light of changing legislation, alert directions, quality monitoring, residents' views and best practice. They are subsequently amended and implemented as required. There is clear evidence in this regard.

## Standard 30: Quality Assurance and Continuous Improvement

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

### Criteria

- 30.1** An annual review of systems and practices against these Standards takes place. Improvements are clearly demonstrated and a corrective action plan, where required, addressing areas requiring improvement, is developed and implemented.
- 30.2** The person in charge, for the purposes of ongoing quality monitoring and continuous improvement collects data on:
- » residents given influenza vaccination during the flu season
  - » residents assessed for and given pneumococcal vaccination
  - » residents who have had moderate to severe pain within the previous week
  - » residents who have pressure sores
  - » residents who have been physically restrained within the previous week
  - » residents who have received psychotropic drugs (including sleeping tablets) within the last week
  - » residents who have an indwelling catheter
  - » residents who spent most of their time in bed or in a chair within the last week
  - » residents who have fallen within the last month
  - » residents who experienced significant weight loss over the last three months
  - » complaints
  - » unexplained absences of residents
  - » significant events.

(This list is not intended to be exhaustive.)

The person in charge ensures that appropriate action is taken in response to any findings of concern arising from the above.

- 30.3** The person in charge or management delegate, for the purposes of monitoring, reviews care plans at least three monthly intervals to ensure that the care planning process is conducted in accordance with guidelines and procedures. If conducted by a management delegate, the person in charge is informed of his/her findings.
- 30.4** Research, quality assurance and audit is carried out by the residential care setting in accordance with best practice and ethical principles.

## Standard 31: Financial Procedures

**The continued viability of the residential care setting is assured through suitable accounting and financial procedures.**

### Criteria

- 31.1** Accounting, budgetary and financial procedures are implemented to manage and demonstrate the continued viability of the residential care setting, as evidenced by a letter from the residential care setting's accountant.
- 31.2** Insurance cover is put in place against loss or damage to the assets and delivery of the service. The registered provider ensures that out-sourced providers are appropriately insured.



## Standard 32: Register and Residents' Records

**Each resident is safeguarded by the residential care setting's record-keeping policies and procedures.**

### Criteria

- 32.1** All residents' records are secure, up to date, in good order and are constructed, maintained and used in accordance with the Data Protection Act 1988 and 2003, the Freedom of Information Act (1997/2003) and national guidelines. They are accessible to the resident and available for monitoring purposes. There is an appropriate system for recording the interventions of visiting healthcare professionals.
- 32.2** Records required for the effective and efficient running of the residential care setting are maintained, up to date and accurate at all times. The register (electronic or hard copy) includes the following information in respect of each resident:
- » the first name(s), surname, address, date of birth, marital status and religious denomination
  - » the name, address and telephone number of the person the resident has nominated to be notified in the event of a change in his/her health or circumstances and to act on his/her behalf
  - » the name, address and telephone number of the resident's medical practitioner
  - » the date the resident was last admitted to the residential care setting
  - » where the resident left the residential care setting, the date on which he/she left and a forwarding address
  - » where the resident is admitted to hospital the date of and reasons for the admission and the name of the hospital
  - » where the resident dies in the residential care setting, the date, time and certified cause of death as soon as it is made available.
- 32.3** The resident's record includes:
- » a summary of the assessment of the level of dependency of the resident on admission and on review
  - » a copy of the contract between the residential care setting and the resident;
  - » a record of the resident's assessed physical and mental health and social needs at the time of admission
  - » the resident's care plan

- » an appropriate record of nursing interventions, based on assessed needs, completed at a minimum on a daily basis, and preferably at the end of each shift and signed and dated by the nurse on duty
  - » a medical record with details of every assessment undertaken by a doctor, investigations made, diagnosis and treatment given, and a record of all drugs and medicines prescribed, signed and dated as appropriate
  - » a record of drugs and medicines administered giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by the nurse administering the drug or medicine
  - » a record of any incident involving the resident
  - » a record of any occasion on which physical or chemical restraint is used, the nature of the restraint and its duration
  - » a record of any substantial complaint made by the resident or his/her representative and the outcome of the investigation
  - » the resident's personal preferences including their preferred communication method
  - » the records of any allied health professionals.
- 32.4** There is a policy for the retention and destruction of records in compliance with the Data Protection Act, 1988 and 2003.
- 32.5** The resident has access to his/her record and information about him/her held by the registered service provider. He/she has opportunities to help maintain his/her personal records, in accordance with the Data Protection Act 1988 and 2003 and Freedom of Information Act (1997).

## 4. Supplementary Criteria for Dementia-specific Residential Care Units for Older People

The following are supplementary criteria for dementia-specific residential care settings for older people. They do not replace but should be read in conjunction with the *National Quality Standards for Residential Care Settings for Older People*. These supplementary criteria apply to:

- » residential care settings that exclusively care for the needs of people with dementia, and
- » residential care settings that care for people with dementia and people without dementia on a physically segregated basis, in separate units within the same care setting.

### These criteria must be read in conjunction with Standard 10: Assessment, and Standard 11: The Resident's Care Plan

- 10.9 Prior to entering the dementia-specific residential care unit, each resident has a specific diagnosis of dementia made by a suitably qualified medical practitioner.
- 11.7 The diagnosis, assessment and care planning process aids the understanding of any changes to memory, behaviour and personality and aids the resident and his/her family to better understand the progressive nature of dementia.

### These criteria must be read in conjunction with Standard 17: Autonomy and Independence, and Standard 18: Routines and Expectations

- 17.10 The culture, practice and procedures of the dementia-specific residential care unit reflect a person-centred approach that provides the additional time needed to enable independence and functioning to the resident's highest possible level.
- 18.7 The dementia-specific residential care unit has a policy on the development and use of appropriate therapies as a basis in designing activity focused care. This is clearly demonstrated in practice.
- 18.8 The dementia-specific residential care unit actively uses personal items, appropriate therapies and activities to promote quality of life and wellbeing for each resident.
- 18.9 Staff are trained in and understand the communication difficulties that residents experience and are trained in and make every effort to support and facilitate residents' communication (verbal and non-verbal) needs in an individualised manner. Person-centred communication is encouraged in all interactions, in consultation with relevant healthcare professionals.

- 18.10** The dementia-specific residential care unit provides evidence that, where appropriate, techniques such as life stories, reminiscence, reality orientation, validation, sensory equipment and music are used to enhance communication.
- 18.11** Meaningful self-expression is facilitated by occupational, recreational, physical and sensory stimulation.
- 18.12** The needs of the resident during any periods of change or transfer in and out of the unit are recognised, recorded and responded to effectively.

**These criteria must be read in conjunction with Standard 28: Purpose and Function**

- 28.7** The statement of purpose and function indicates clearly how the dementia-specific residential care unit meets the needs of people with dementia, including a consideration of the progressive aspects of the illness.
- 28.8** The location, lay-out and model of the dementia-specific residential care unit is specific to its stated purpose and adheres to evidenced-based principles on dementia care and design.
- 28.9** The dementia care provided reflects the dementia-specific residential care unit's stated approach to care delivery.



**These criteria must be read in conjunction with Standard 23: Staffing Levels and Qualifications; Standard 24: Training and Supervision; and Standard 27: Operational Management**

- 23.10** Staffing arrangements, supports and working conditions, take cognizance of the complex cognitive, physical, psychological and social needs of residents with dementia.
- 24.9** There is an active practice development policy in place that incorporates evidence-based principles on dementia care, best practice findings and new learning.
- 27.8** Within 5 years of the implementation of these Standards any newly-appointed person in charge of a dementia-specific residential care unit will hold a post-registration qualification in nursing people with dementia.

**These criteria must be read in conjunction with Standard 25: Physical Environment**

- 25.59** All newly built dementia-specific residential care units are configured in such a way that residents are cared for in groups of no more than 10.
- 25.60** All newly built dementia-specific residential care units are divided into areas that resemble rooms found in an average domestic dwelling, with separate rooms for separate functions.
- 25.61** All newly built dementia-specific residential care units have a room with some of the features of a domestic kitchen to facilitate orientation and provide therapeutic activities.
- 25.62** All newly built dementia-specific residential care units including those with more than one storey have a secure garden that is safe, accessible and provides multi-sensory stimulation.
- 25.63** The dementia-specific residential care unit uses landmarks, cueing or highly distinctive visually unique elements to help to orient residents with dementia.
- 25.64** Internal exit points are positioned and designed according to best practice for dementia care.
- 25.65** The dementia-specific residential care unit provides safe areas for walking that have regularly spaced sitting areas and areas of interest and diversion.
- 25.66** The dementia-specific residential care unit has a design and layout that encourages and aids independence including appropriate signage and use of colours and lighting in line with best practice dementia care principles.
- 25.67** The dementia-specific residential care unit uses appropriate contrasting colours to create a light and tranquil environment and assist with perceptual difficulties.
- 25.68** The dementia-specific residential care unit pays particular attention to minimising excessive external and internal noise.
- 25.69** The dementia-specific residential care unit has fixtures and fittings that aid and promote reminiscence practice.

## 5. Conclusions

These standards focus on the key areas that most affect the quality of life experienced by service users, as well as the physical environment in which they live. The standards are aimed at ensuring respect for and protection of the rights of older people who live in residential care settings.

Each standard is a statement of the intended outcome for service users to be achieved by the service provider. While the standards are qualitative – they provide a means of judging the quality of life of residents – they are also measurable.

The standards can be evidenced by discussions with service users and their family members, and with managers and staff; by observations of daily life in the residential care setting; by the policies and procedures that inform practice in the residential care setting; by the extent to which individuals' changing needs continue to be met; by how the residential care setting works with other services and professionals to ensure each individual's inclusion in the life of the community; and by the service providers' commitment to continuous improvement.

# Appendices



## Appendix A

### ***Supplementary Guidance for the Choice and Use of a Minimum Data Set Tool (See Standard 10: Assessment)***

The following is supplementary guidance for assessment of older people on and subsequent to admission and in particular regarding the choice and use of a Minimum Data Set Tool for these purposes.

**Minimum Data Set Tool:** A structured assessment tool covering a range of domains (cognitive patterns, communication/hearing patterns, vision patterns, psychosocial wellbeing, mobility and activities of living, and so on), appropriate for assessing the needs of older people. The resident's care plan is based on this comprehensive assessment.

1. Residential care settings including dementia specific settings should use a Minimum Data Set Tool, which incorporates a general risk assessment for use on admission, as well as a subsequent comprehensive assessment to be completed within seven days, as outlined in criteria 10.4 and 10.5.
2. The Minimum Data Set Tool used should have the following qualities:
  - » reliability: *inter- and intra-rater reliability have been shown to be acceptable*
  - » validity: *the scale has been shown to measure that which it set out to measure*
  - » fit for purpose: *the scale is of proven value in extended care settings*
  - » international comparability: *benchmarking with international practice is possible.*
3. The Minimum Data Set Tool should cover the following domains of need necessary for assessing the needs of vulnerable older people in residential care settings and for developing appropriate care plans to meet these needs:
  - » identification and background information, to include demographic information as well as their usual routine prior to admission
  - » cognitive ability/patterns including performance related to decision-making ability and organisation of self-care activities
  - » communication, hearing and understanding ability/patterns
  - » visual abilities and limitations
  - » mood and behaviour patterns
  - » psychosocial wellbeing, including emotional adjustment to the home, attitude and adaptation to surroundings and changing relationships
  - » mobility and activities of living
  - » continence and elimination patterns

- » disease diagnosis relative to current condition, treatments, monitoring needs or risk of death
  - » health conditions, including specific problems or symptoms affecting the resident's health/functional status as well as identification of risk factors for illness, accident and functional decline
  - » oral/nutritional status specific to nutritional needs/problems
  - » oral/dental status specific to oral/dental disease
  - » skin condition, including the presence, stage and type of ulcers, other skin conditions and foot problems
  - » interest and activity pursuit patterns
  - » current medication use
  - » special treatment, therapies and/or treatment programmes
  - » discharge potential.
4. Where as, the Minimum Data Set Tool should act as a comprehensive assessment tool to identify actual/potential needs and problems, it should either incorporate or be supplemented with specific assessment protocols or assessment scales to allow a more detailed assessment of actual/potential needs and problems identified by the comprehensive assessment.
  5. The Minimum Data Set Tool should facilitate a person-centred assessment that acknowledges the importance of the role of relatives/carers.
  6. The Minimum Data Set Tool should make the views and participation of the resident to the assessment process explicit and/or the views and contribution of carers/relatives as appropriate.
  7. The Minimum Data Set Tool should facilitate assessment focused on the resident's abilities, wishes and expectations.
  8. Assessment scales used for assessment either as part of, or in conjunction with the Minimum Data Set Tool should be valid and reliable, and should support rather than replace professional judgement.
  9. The assessment process and use of the Minimum Data Set Tool, including subsequent care planning activities, should comply with current professional and legislative requirements regarding consent and confidentiality.
  10. The Minimum Data Set Tool should map onto standard international classifications of diseases.

## Appendix B:

### *Healthcare Policies and Procedures*

The following is a non-exhaustive list of policies and procedures based on current best practice that should be developed, implemented and reviewed annually (See Criterion 13.1).

- » **Cognitive impairment**
- » **Activities of daily living (ADL) function**
- » **Rehabilitation**
- » **Communication (including regular checks on hearing and vision)**
- » **Swallowing**
- » **Nutritional status (including management of feeding tubes)**
- » **Hydration/fluid maintenance**
- » **Skin care (including pressure sore prevention and wound management)**
- » **Behavioural symptoms**
- » **Falls**
- » **Dysphasia**
- » **Infection control and prevention  
(including use of influenza and pneumococcal vaccines)**
- » **Continence promotion (including management of indwelling catheters)**
- » **Dental care**
- » **Pain management**
- » **Mood disorders**
- » **Psychotropic drug use**
- » **Physical restraint use**

## Appendix C:

### **Membership of the Working Group on the National Quality Standards for Residential Care Settings for Older People**

<b>Robin</b>	<b>Webster</b>	<i>Age Action Ireland</i>
<b>Maurice</b>	<b>O'Connell</b>	<i>Alzheimer Society of Ireland</i>
<b>Kathy</b>	<b>Murphy</b>	<i>An Bord Altranais</i>
<b>Emma</b>	<b>Benton</b>	<i>Association of Occupational Therapists of Ireland</i>
<b>Brigid</b>	<b>Barron</b>	<i>Caring for Carers Ireland</i>
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<b>Ann</b>	<b>Ryan</b>	<i>Health Information and Quality Authority</i>
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<b>Peter</b>	<b>Ryan</b>	<i>Health Service Executive, Assistant National Director of Estates</i>
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<b>Michael</b>	<b>Boland</b>	<i>Irish College of General Practitioners</i>
<b>Michael</b>	<b>O'Halloran</b>	<i>Irish Senior Citizens' Parliament</i>
<b>Marian</b>	<b>Glynn</b>	<i>Irish Society of Chartered Physiotherapists</i>
<b>Shaun</b>	<b>O'Keeffe</b>	<i>Irish Society of Physicians in Geriatric Medicine</i>
<b>Bob</b>	<b>Carroll</b>	<i>National Council on Ageing and Older People</i>
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<b>Aisling</b>	<b>Denihan</b>	<i>Psychiatry of Old Age Services</i>
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## 7. Glossary of Terms

**Abuse:** a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person or violates their human or civil rights.

- **Physical abuse**, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions.
- **Sexual abuse**, including rape and sexual assault or sexual acts to which the person has not consented, or could not consent, or into which he or she was compelled to consent.
- **Psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.
- **Financial or material abuse**, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
- **Neglect and acts of omission**, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

- **Discriminatory abuse**, including racism, sexism that is based on a person's disability, and other forms of harassment, slurs or similar treatment.

**Access:** the ability of a resident to obtain a service, when needed within an appropriate time.

**Accessible Format:** the presentation of print and online information on individual residential care facilities in plain English in a manner suited to older people and those with sensory disabilities; information provided in formats appropriate to anticipated clientele, including large print, audio and Braille.

**Advocacy:** a process of empowerment of the individual which takes many forms; includes taking action to help people say what they want, secure their rights, represent their interests or obtain the services they need; it can be undertaken by older people themselves, by their friends and relations, by peers and those who have had similar experiences, and/or by trained volunteers and professionals.

**Advocate:** a person independent of any aspect of the service or any of the statutory agencies involved in purchasing or providing the service, who acts on behalf of, and in the interests of, the person using the service. In the context of residential care settings for older people, an advocate facilitates a resident, insofar as possible, to make informed choices regarding health care, social care and quality of life.

**Assessment:** a process by which the resident's needs are evaluated and determined so that they can be addressed.

**Assistive Living Technology:** a generic term that includes assistive, adaptive, and rehabilitative devices and the process used in selecting, locating, and using them. Assistive Living Technology promotes greater independence for people by enabling them to perform tasks that they were formerly unable to accomplish, or had difficulty accomplishing.

**Autonomy:** the perceived ability to control, cope with and make personal decisions about how one lives on a day-to-day basis, according to one's own rules and references.

**Care Plan:** a plan, generated from the assessment, developed by the residential care setting for older people with the resident and his or her relatives/representatives. The resident's care plan should cover all aspects of health and personal care, and show how these will be met in terms of daily living and longer term outcomes.

**Cognitive Impairment:** a cognitive decline greater than expected for an individual's age and educational level. Cognition is the mental acquisition of knowledge through thought, experience and the senses.

**Complaint:** an expression of dissatisfaction with any aspect of a service.

**Complaints procedures:** a set of clearly defined steps for the resolution of complaints.

**Contract:** written agreement between the resident and the residential care setting, that sets out the terms and conditions and rights and responsibilities of both parties.

**Dementia:** a syndrome due to disease of the brain, usually of a chronic or progressive nature in which there is a disturbance of multiple higher cortical function including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. The impairments of cognitive function are commonly accompanied and occasionally preceded by deterioration in emotional control, social behaviour or motivation. (ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines. World Health Organisation, Geneva. 1992)

**Emergency Admission:** an admission that is unplanned, unprepared or not consented to in advance.

**Emergency plan:** a plan to address failure of mains power, heating system failure, water supply interruption, communications failure and other identified emergency situations.

**Garda Vetting:** the practice whereby employers obtain information from An Garda Síochána as to whether or not a prospective or existing employee or volunteer has a criminal conviction.

**Governance:** the function of determining the services' direction, setting objectives and developing policy to guide the service in achieving its stated purpose.

**Hazard:** anything that can cause harm, injury, ill-health or damage.

**Health Promoting Interventions:**

programmes, initiatives or measures aimed at promoting the participation, security and health of residents, assisting residents optimise their personal, physical, cognitive or social wellbeing, or maximising the independence and quality of life of residents.

**Infection control:** programmes of disease surveillance, generally within healthcare facilities designed to investigate, prevent and control the spread of infections and the micro-organisms that cause them.

**Mandatory training:** training that employers have a statutory duty to provide under the Safety, Health and Welfare at Work Act, 2005 and the Safety, Health and Welfare at Work (General Application) Regulations, 2007

**Meaningful and purposeful activity:** individually facilitated or group occupation provided on the basis of consultation with residents and awareness of their present or former interests, hobbies and pastimes; therapeutic activities designed to assist residents regain or maintain optimal functioning.

**Minimum Data Set tool:** a structured assessment tool covering a range of domains (cognitive patterns, communication/hearing patterns, vision patterns, psychosocial wellbeing, mobility and activities of daily living, and so on), appropriate for assessing the needs of older people. The resident's care plan is based on this comprehensive assessment.

**Multidisciplinary working:**

a group of professionals from various disciplines who work as part of a team. Ideally members of a multidisciplinary team share expertise in order to deliver a holistic service.

**Palliative care:** the specialised care of people with life-limiting illness.

**Person centred:** a term applied to the ethos adopted by facilities which seek to tailor their services to the particular needs of individual residents. It also describes an open, listening and empathetic communication approach which fosters wellbeing, rehabilitation and healing.

**Person in charge\*:** the person whose name is entered on the register as being in charge of or managing the residential care setting.

**Pharmacist:** a pharmacist registered with the Pharmaceutical Society of Ireland

**Physical restraint:** any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove that restricts freedom of movement or normal access to one's body.

**Policy:** a written operational statement of intent which helps staff make sound decisions and take actions that are legal, consistent with the aims of the home, and in the best interests of residents.

**Procedure:** a written set of instructions that describe the approved steps to be taken to fulfil a policy.

\* Definitions that are subject to regulation

**Register\*:** the register of residential care settings established under Part 7, Section 41, of the Health Act 2007.

**Registered Provider\*:** the person whose name is entered on the register as the person carrying on the business of the residential care setting.

**Representative:** a person acting on behalf of a resident, who may be a relative or friend.

**Resident\*:** a person living in and provided with services by a residential care setting for older people.

**Residential care setting\*:** public, private and voluntary services providing some or all of the following for older people: long-term care, respite, rehabilitation and convalescence.

**Risk:** the chance or possibility of danger, loss or injury. For service providers this may relate to the health and wellbeing of residents, staff and visitors to the residential care setting.

**Risk management:** the culture, processes and structures that are directed towards identifying and minimising actual or potential risk.

**Self-determination:** the ability of a resident to fashion his/her own life and make decisions in keeping with his/her own values and preferences, taking into account the interests of other residents.

**Service level agreement:** a contract between the provider of a service and the funding authority (HSE) that specifies the level of service that is expected during the term of the agreement.

**Social Services Inspectorate:** the Inspectorate, within the Health Information and Quality Authority, headed by the Chief Inspector for Social Services who holds the statutory responsibility for the inspection and registration of designated services as outlined in Part 7, Section 40, of the Health Act 2007.

**Standards and criteria:** a standard is a measure by which quality is judged. It sets out an expected or desired level of performance. The criteria are the supporting statements that set out how a service can be judged to meet the standard.

**Unit:** a unit within a residential care setting is a part of it that is to some degree self-contained and provides an opportunity for residents to live in a smaller living environment. A single residential care setting may be divided into several such units, some of which may have a specialised function, for example, a unit for residents suffering from dementia.

**Usable Floor Space:** space which is accessible to the resident for furniture, possessions and daily living, with attention to room shape, positioning of doors, windows or en-suite facilities, and headroom.

**Whistleblowing:** the protected disclosure by an employee (or professional) of information which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace, that places residents at risk.

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