

Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act
2007



Centre name:	Elm Green Nursing Home
Centre ID:	0133
Centre address:	New Dunsink Lane
	Castleknock
	Dublin 15
Telephone number:	01 8113900
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Email address:	info@elmgreen.ie
Type of centre:	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public
Registered provider:	MNMS Developments
Person authorised to act on behalf of the provider:	Martin O'Dowd
Person in charge:	Geraldine Donohoe
Date of inspection:	21 and 22 June 2011
Time inspection took place:	Start: 09.20hrs Completion: 16.30hrs Start: 09.40hrs Completion: 15.45hrs
Lead inspector:	Leone Ewings
Support inspector(s):	Sheila McKevitt
Type of inspection:	<input checked="" type="checkbox"/> Registration <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced

About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Elm Green is located on New Dunsink Lane, off the Navan Road, beside Elm Green Golf Club. It is a modern purpose-built centre laid out at ground and first floor level. The third floor of the main building provides private accommodation for staff.

There are 96 beds available, consisting of 88 single bedrooms with a further four twin rooms; all rooms have en suite shower and toilet facilities. The centre is divided into two separate units – Oak and Laurel.

Oak unit has 36 en suite single rooms on the ground and first floor. Corridors are wide and each floor has bedrooms and day dining space overlooking an internal courtyard. This unit mainly accommodates residents with a primary diagnosis of dementia. The remaining 60 beds on Laurel Unit accommodate older people and are located on the ground and first floor. Laurel has 52 en suite single rooms and 4 twin rooms.

There are two private visitors' rooms, one in each unit. There are three separate dining rooms. There are two sitting rooms on each of the two floors, a library, a relaxation room and an oratory. The main kitchen is on the ground floor with a mini kitchenette on each floor of Laurel and Oak.

In a separate adjacent complex there are 27 independent living apartments. The people living there access the centre's communal areas through a secure corridor.

The building is set in landscaped gardens with ample parking, and an electronic access gate. The grounds are well maintained, and a further internal courtyard garden is wheelchair accessible and visible from the main dining room.

Date centre was first established:			2008	
Number of residents on the date of inspection:			94	
Number of vacancies on the date of inspection:			2	
Dependency level of current residents:	Max	High	Medium	Low
Number of residents	9	34	38	13
Gender of residents			Male (✓)	Female (✓)
			✓	✓

Management structure

Elm Green Nursing Home is owned and operated by MNMS Developments, a partnership with four partners. The provider's representative is Martin O'Dowd. He is also involved with the management of three other designated centres.

The person in charge, Geraldine Mary Donohoe is supported in her role by a full time assistant director of nursing, Martina Brennan. Three clinical nurse managers are in place, one is based on Oak Unit, 18.5 whole time equivalent staff nurses, and 51.5 care assistants are employed. Care staff report to the nurse allocated to their area of work, who in turn reports to the clinical nurse manager on duty. All other staff including maintenance, catering and household staff report to the person in charge.

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

This report sets out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007.

Inspectors met with residents, relatives, and staff members over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. A fit person interview was carried out with the provider, who had completed the fit person self-assessment document in advance of the inspection. The person in charge had completed a satisfactory fit person interview in 2010 on appointment to her role as director of nursing. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation. The provider and the person in charge needed to establish formal operational management systems outlining roles and responsibilities as a team, to ensure that the legislative requirements are met on an ongoing basis. Improvements are required, particularly relating to complaints handling, documentation and notification of incidents to the Authority.

Inspectors found substantial compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the National Quality Standards for Residential Care Settings for Older People in Ireland. This was reflected in the observed positive outcomes for residents throughout the inspection and also confirmed by speaking with residents and relatives. Overall, inspectors found that residents' wellbeing was central to service provision. The services and facilities outlined in the centre's statement of purpose were reflected in practice and served to meet the diverse needs of residents, including those residents with a cognitive impairment. However, all matters and requirements of the statement of purpose outlined in schedule one were not included.

Overall care practices were found to be person-centred and the feedback received from residents and relatives on the 22 questionnaires returned were positive. Daily life in the centre maximised the residents' capacity to exercise choice and personal autonomy and their views were sought and listened to.

Residents received dignified and respectful care and received a high standard of evidence-based nursing care and medical and allied health care. There were appropriate staff numbers and skill mix to the assessed needs of residents, and to the size and layout of the designated centre. Improvements following the last inspections by the Authority were found to have been maintained relating to staffing on Oak unit.

The centre was in compliance with the fire regulations and the premises internally and externally was suitable for purpose, well maintained and clean and fit for purpose. Practices in relation to the health and safety of residents and the management of risk promoted, and ensured the safety of residents and visitors. However, staff were observed compromising their safety, and the safety of residents by poor manual handling practices on one unit.

Some improvements were required to documentation of residents' assessment, care plans and the access and use of the electronic record keeping system.

Section 50 (1) (b) of the Health Act 2007

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

1. Statement of purpose and quality management

Outcome 1

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

References:

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

Inspection findings

Inspectors reviewed the statement of purpose submitted with the application to registration and found it did not contain all the requirements of Schedule 1. The statement of purpose had not been fully reviewed by the provider following the last follow-up inspection on 22 June 2010 to include the actual numbers of beds, and the range of needs that the centre is designed to meet.

Updated details about recent changes at the centre, when the two units were renamed as Oak and Laurel units were not included in the statement of purpose. The arrangements in place for dealing with complaints required more clarity and detail around the process to ensure it is in line with legislative requirements. The provider, MNMS partnership, was not named on the statement of purpose.

Outcome 2

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

References:

Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

The provider had put a system in place to audit the number and type of accident/incidents on a monthly basis. The inspector reviewed the accidents/incidents since the last inspection in June 2010 together with the notifications received by the Authority and found that all required notifications had been received by the Authority. The monthly audit identified the number of accidents/incidents, those involved and category of accidents/incidents. Some improvements were noted in the quality of the record keeping since the last inspection, further work was required to meet this outcome in full.

There was a detailed process in place to review other areas of clinical practice such as hand hygiene and nursing documentation. Complaints were not found to be subject to audit. A computerised system of nursing documentation was in place. No audit had been carried since its introduction to determine if staff were using it appropriately. Inspectors found staff unable to access certain files on request, for example, old care plans.

Overall, the medication management practices were found to be safe and nursing staff were administering as per An Bord Altranais guidelines. However, medication management was found to be audited only by the pharmacy provider. Inspectors reviewed the audit records for each resident and found none were dated or signed by the pharmacist. Following the last inspection the person in charge undertook to set up "in-depth auditing documents which identified all accident and incidences i.e. verbal/physical/drug error/thefts and other situations which may occur". The drug error reporting form was not found to have been implemented or linked to the medication management policies and procedures in place.

Residents and relatives meetings took place regularly, and inspectors saw a comments box at the front reception desk. However, there was no formal mechanism to audit residents' quality of life in the centre, or receive feedback on a regular basis.

Outcome 3

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.

References:

Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

Inspectors reviewed the complaints management policy and procedures, some improvements were required to meet legislative requirements. The complaints procedure outlined in the statement of purpose required improvement as outlined in outcome 1. The person in charge was identified as the complaints officer. She described her role and explained records were held on each unit of any issues or complaints raised, and the appeals process. Inspectors reviewed the records of complaints held since the last inspection, eight records were reviewed and details of the complaints discussed with the person in charge. One complaints record was found to be fully documented with the results of the investigation, actions taken, and whether or not the resident / complainant were satisfied with the outcome of the complaint. The remaining seven records were not found to be fully documented in line with legislative requirements. The person in charge told inspectors that all complaints had been addressed in full. However, there was no documentary evidence to support this.

There was no evidence of senior staff working at the centre having received any formal training relating to complaints management including how to handle and receive a complaint. However, relatives and residents confirmed to inspectors that if they spoke to the person in charge then their issues and complaints were addressed in a prompt and appropriate manner by the person in charge and her deputy. The provider also confirmed he made himself available to meet residents or relatives if requested to do so.

There was no group or individual advocacy service established or available to residents and relatives. However, the person in charge had made enquiries and was due to meet an independent advocate the following week with a view introducing advocacy services to the residents living at the centre.

2. Safeguarding and safety**Outcome 4**

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

References:

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

Inspection findings

Measures were found to be in place to protect residents from being harmed or suffering abuse.

Further to the last inspection on 22 June 2010, all staff had received training on identifying and responding to elder abuse. A centre-specific policy was available. The person in charge and a number of staff spoken with displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Residents spoken with confirmed to inspectors that they felt safe in the centre. They primarily attributed this to the staff being available to them if they had a concern and to the fact that they received a high standard of care. Both staff and residents spoken with confirmed that the person in charge was available to them on a regular basis and the assistant director of nursing was accessible to them also. Inspectors observed the person in charges' office was open and accessible to both residents' and staff on the ground floor near the entrance to the centre.

At the time of inspection there had been a recorded incident/allegation of abuse, the incident reported was between two residents, no staff were involved; the Authority had been notified of the incident. Inspectors reviewed the investigation of both incidents and were satisfied that appropriate action was put in place to protect residents. However, following the incident the person in charge had not completed the report to the Authority within the required three day time frame. This lapse in reporting requirements is also discussed in outcome 17. The provider and the person in charge undertook to ensure that all staff working at the centre were aware of their reporting obligations following a report / allegation of abuse. Inspectors found the staff on duty at the time whilst safeguarding the resident did not fully follow the policy for responding to allegations of elder abuse in place at the time of the incident. This policy has been reviewed by the person in charge and the assistant director of nursing following a reflective review of the incident. The revised policy was reviewed by inspectors and found be adequate.

Inspectors examined records of residents' finances managed by the centre. These were clear, concise and reflected sums of cash held.

Outcome 5

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

References:

Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

The provider and person in charge promoted good practice in relation to health and safety and the management of risk. All staff had received manual handling training. However, a small number of staff on one unit were observed by inspectors demonstrating poor manual handling techniques. This was not addressed by the supervising nurse who also witnessed the practices. This was discussed with the management and the clinical nurse manager who confirmed they would address this issue immediately.

Measures were in place to control and prevent infection, including arrangements in place for the segregation and disposal of waste, including clinical waste. Staff had received training in infection control. They had access to supplies of gloves, disposable aprons, facilities to wash and dry their hands at each wash hand sink and they were observed using the alcohol hand gels which were available throughout the centre.

Measures were in place to prevent accidents and facilitate residents' mobility, including safe and appropriate floor covering, a lift to each floor and hand rails which were provided on both sides of the corridor to promote independence. Residents were observed moving around the building during the day using the handrails for support.

The provider had developed a risk management policy to inform practice and there was an up to date health and safety statement in place, dated February 2011.

There was an emergency plan in the centre. This gave clear direction to staff on what to do if the in the event of any emergency residents' needed to be evacuated from the centre.

Fire safety and evacuation training took place on an annual basis. All staff had attended the training. Inspectors were informed that fire drills were held 6 monthly, records of fire drills were maintained. Key staff had been trained as fire safety wardens in case of fire or evacuation. In the last week prior to the inspection five separate sessions of fire safety and drill were completed with training for 75 staff working at the centre.

A review of fire records showed that all fire safety equipment, including the fire alarm and emergency lighting had been serviced at appropriate intervals, and written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with had been received by the Authority on application for registration.

Outcome 6

Each resident is protected by the designated centres' policies and procedures for medication management.

References:

Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings

There was a medication policy with procedures for prescribing, administering, recording and storing of medication. Review of records and observation of practice indicated that these procedures were implemented. However, the policy lacked evidence base and omitted detail in line with the requirements of An Bord Altranais Guidance to Nurses and Midwives on Medication Management (July 2007).

Controlled drugs were stored safely in a double locked cupboard and stock levels were recorded at the end of each shift and recorded in a register in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1982. There were appropriate procedures for the handling and disposal for unused and out of date medicines. However, some improvements around the documentation and audit of medication practice by the person in charge were identified.

As stated in Outcome 2 the practices outlined above was further to the local pharmacist's monthly review. However, the records were not maintained to an adequate standard as outlined in outcome 2.

No medication errors or omissions were documented, and staff were unaware of how to document an error or omission other than on a standard incident form. However, following a review of the complaints documented a number of issues were found to have related to medication practice and management. A full review had not taken place with regard to the issues raised, in order to inform nursing staff to prevent recurrence.

There was no centre specific policy or procedure for the self administration of medication at the centre, should a resident request this responsibility as part of maintaining their independence. The maximum daily dosage of the as required medication was not stated on the medication prescription charts in all cases.

3. Health and social care needs

Outcome 7

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:

Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

Overall, care practices observed by inspectors were found to be of a high standard. Residents and relatives described "an ethos of genuine care" and a high level of satisfaction with staff and information provided to them. Some improvements were required with regard to documentation of care delivery and medication reviews.

Residents were assessed prior to admission by the person in charge or her deputy. The centre had sufficient general practitioner (GP) cover, and the GPs provided an on call service at weekends. Residents had the option to retain their own GP, but where this was not possible the person in charge assisted them to transfer to the GP covering the centre. Review of residents' medical notes showed that GPs visited the centre regularly and the person in charge informed inspectors that the GPs were available by phone any time to offer advice to staff. The sample of medical records reviewed also confirmed that the health needs of residents were being monitored on an ongoing basis and no less frequently than at three-monthly intervals. However, GP involvement in medication review since January 2011 was not fully documented in all residents' records reviewed by inspectors, which had been the practice previously.

Residents had access to a range of other health services, including dietetic, chiropody, physiotherapy, occupational therapy, ophthalmology, speech and language therapy, hearing and dental services both in the public and private basis.

The community liaison team from Connolly Hospital has links with residents who have been referred or visited the accident and emergency department for follow up if necessary.

Inspectors were satisfied that care delivery was of an overall high standard. However, documentation of the care and residents assessments did not accurately reflect or record the care delivered by those responsible for its implementation. Inspectors examined a sample of residents' assessments and care plans and found the care plans were person-centered to varying degrees. Recognised evidence-based assessment tools were used to assess and promote health, and address health issues. These included assessments for risk of pressure ulcers, malnutrition, and falls risk and appropriate measures were put in place to manage and prevent risk. There was an emphasis on social care, with prescribed interventions within care plans to promote residents' social care needs, based on residents assessed preferences, interests and capacities. Three-monthly assessment and care plan reviews were completed, dated, and documented by staff on the electronic record keeping system. Some residents and relatives spoken with confirmed that they had been involved in the initial assessment and ongoing care plan reviews.

All of the residents spoken with commented on the various activities available to them, including walks, exercise classes, bingo, prayers and importantly, the quiet of their own rooms to relax. Feedback received by residents and relatives had been acted on and new activities had been added which residents who are male may enjoy, for example western films and sports.

Of particular note to inspectors was the manner in which residents with a cognitive impairment were encouraged to take part in activities, or where this was not possible, their attention was regularly brought to the activity, so that they could enjoy moments observing the enjoyment of others. For those residents with dementia there was evidence of activity focussed care, the use of reminiscence, and music to enhance interaction and communication. Inspectors observed a dedicated activities person communicating with residents and encouraging participation in activities and the day to day at the centre. A beautician was also observed offering hand massage in a quiet day room to residents and chatting quietly with residents. Inspectors observed staff taking the time to reassure residents with dementia, speaking slowly, clearly and sensitively, and repeating the information to residents to ensure that the resident understood what was being said to them.

The centres' policy on the use of restraint included a direction to consider all other alternative interventions. Risk assessments were undertaken before any form of restraint was used. The sample of residents' records reviewed provided adequate detail on the reason for the use of restraint and the duration of its use.

Outcome 8

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

References:

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

Inspection findings

The centre was found to be substantially compliant with this outcome. There was a detailed end of life policy available. A review showed it included all aspects of end of life care. Residents' care plans included their end of life preferences including their religious and spiritual needs. There was no resident receiving end of life care during the inspection. A spacious oratory was available for personal quiet time. Residents had the option to attend religious services on Sundays and / or group prayers / rosary held regularly.

The person in charge told inspectors that they accommodated residents receiving end of life care in a single bedroom, unless a move from the twin room was not appropriate or against the resident's wish.

Residents were referred to the local palliative care team to advise on and support symptom management. They visited residents in the centre on an individual basis and worked with nursing and medical staff to meet any palliative care needs.

Outcome 9

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

References:

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

Inspection findings

Residents received a nutritious and varied diet that offered choice. Mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff. Four separate dining rooms were available to residents spaced around the two units. Overall, the mealtime experience was very good with some smaller improvements were required to become more person centred and promote independence at mealtimes.

Residents could choose where they had their daily meal. Staff were available to assist those who required assistance with their lunch. Inspectors saw staff sitting

with these residents and assisting them respectfully in the dining rooms. Table settings were pleasant and included condiments and cutlery for each resident around small circular tables. It was a pleasant, unrushed occasion. Staff members chatted with residents and encouraged discussion amongst them. The main course was plated by staff in the kitchen. Staff asked residents if they were satisfied with their meal and offered them tea or coffee afterwards. Staff were observed bringing some residents their meal in their bedroom. These residents were served their meal on a tray which was set appropriately.

The inspector recommends some improvements could be made to the place-settings and table coverings. In addition, the use of clothing protection at mealtimes needs review, some residents did not get a choice of having clothing protectors put on or not, this practice was found not to be person-centred.

A water cooler and a variety of juices were available in the dining room and throughout the centre. Staff regularly offered drinks and snacks to residents throughout the day. Residents told inspectors that they could have tea or coffee and snacks any time. They expressed complete satisfaction with the food served to them and all those spoken with confirmed the food was always good. Twenty two questionnaires were received from residents and relatives, and all were complimentary about the "high quality food" served at mealtimes and during the day.

The weight records examined showed that residents' weights were checked monthly, or more regularly if required. Nutrition assessments were used to identify residents at risk of malnutrition and those at risk were reviewed by their general practitioner and when required by a dietician. The person in charge confirmed that for the residents who required dietetic assessment or follow up in the acute setting or community setting could be facilitated to get appointments both on a public and private basis.

4. Respecting and involving residents

Outcome 10

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

References:

Regulation 28: Contract for the Provision of Services

Standard 1: Information

Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

A sample of the written contracts were reviewed by inspectors. Contracts of care were agreed with and provided to residents within a month of admission. They set out the overall care and services provided to the residents and the fees charged.

Outcome 11

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

References:

Regulation 10: Residents' Rights, Dignity and Consultation

Regulation 11: Communication

Regulation 12: Visits

Standard 2: Consultation and Participation

Standard 4: Privacy and Dignity

Standard 5: Civil, Political, Religious Rights

Standard 17: Autonomy and Independence

Standard 18: Routines and Expectations

Standard 20: Social Contacts

Inspection findings

Inspectors found that residents received care in a respectful and dignified manner. Their capacity to exercise personal choice and autonomy was maximised and their views were sought and listened to.

The interaction between all disciplines of staff and residents was good. Staff were observed taking time to sit and chat to residents. Residents stated that they could talk to staff at any time and that they were approachable. There was at least one member of staff available to residents at all times in the communal sitting rooms. Residents had access to call bells in all areas of the centre. Inspectors saw staff answer resident call bells without delay and attending to their requests in a prompt manner. Daily newspapers were sought and delivered to some individuals at their request, additional copies were observed in the communal areas. Residents told inspectors they had their post hand delivered daily.

All residents interviewed indicated that they had privacy in all aspects of personal care which was observed by inspectors. The manner in which residents were addressed by staff was appropriate and respectful. Staff knocked before entering residents' bedrooms, and waited for permission before entering. Privacy locks were found in place on the doors of all toilets and assisted bathrooms.

Daily life in the centre maximised the residents' capacity to exercise choice and personal autonomy. Residents told inspectors that they could decide whether to attend communal or individual activities, whether to eat in their bedroom or the dining room they were facilitated in their choice. They confirmed that living in the centre did not restrict their preferred daily routine.

Contact with family members was encouraged and residents could meet with their visitors in the privacy of their own rooms or in the visitor's room. There were no

restrictions on visits. The person in charge explained to inspectors that this was not necessary as family members and other visitors were sensitive to and respectful of residents' wishes and needs. If the need arose, relatives were facilitated to stay overnight.

The local parish priest and chaplain visited residents in the centre. Other religious denominations were visited by their ministers, as required. One resident told inspectors that she enjoyed visiting the oratory to say a quiet prayer alone.

Residents told inspectors that all activities are displayed on their notice board and if they have something special going on that will be on the notice board, one resident gave the example of the date of their next residents' meetings. The activities coordinator explained how she worked with individuals and groups. She tried to meet the individual needs of each resident to maximise each resident's quality of life. Residents spoken with confirmed satisfaction with the wide choice of activities available to them.

The residents and relatives committee were active. The summer barbecue was planned for and inputs were sought from residents and relatives for this and other occasions held at the centre.

Outcome 12

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

References:

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

Inspection findings

Some improvements were required to record keeping around personal property and possessions.

Residents were encouraged to personalise their bedrooms. They showed inspectors their family photos and personal items. All residents had adequate storage space for their personal items. However, some residents did not have keys to the lockable storage areas in their rooms, or had to request access to the key if required.

There was a well organised laundry system in place. The laundry room was well equipped, with a separate ironing room. The laundry staff told inspectors about the different processes for different categories of laundry, and demonstrated their knowledge of infection control in doing so. Clothing was marked discreetly on admission and all residents' clothes were folded and returned to the resident's storage in their rooms by the laundry staff.

Residents and relatives expressed satisfaction with the service provided and confirmed the safe return of their clothes to them. However, some relatives retained the preference of taking the laundry home to wash and iron.

There was a policy in place for Residents' Personal Property and Possessions. However, practice did not follow the policy, inspectors noted all residents did not have an up to date list of personal possessions in their file. The person in charge confirmed, keeping residents' personal possessions updated was not completed for all residents. The list of personal possessions was not filled out in all cases on admission of the resident to the centre on the electronic record keeping system. The person in charge told inspectors they would address this immediately.

5. Suitable staffing

Outcome 13

The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings

The post of person in charge was full time and held by a registered nurse with the required experience in the area of nursing of older people. The assistant director of nursing employed fulltime also is responsible for the day to day running of Elm Green Nursing Home. The assistant director of nursing confirmed that she was supported in her role.

The person in charge was working towards a Masters qualification in Dementia Care. Inspectors observed that she had good leadership skills. All members of the team, spoken with were clear about their areas of responsibility and reporting structures and the management structure ensured sufficient monitoring of and accountability for practice. The person in charge's knowledge of the regulations and standards and her statutory responsibilities was sufficiently demonstrated to inspectors. However, improvements were required with regard to recognising and responding to safeguarding issues, and notification of same to the Authority.

Overall inspectors found that clinical leadership was good. The person in charge and assistant director of nursing had kept their clinical knowledge up to date and demonstrated an improved level of clinical audit. Both had established a process for auditing information to identify trends to improve the quality of service and safety of residents. However, as outlined in outcome 2 further training was required in complaints management for senior staff.

Improvements were required relating to the management meetings held between the provider and the person in charge. There were no formal records of any management meetings held between the provider and the person in charge.

Outcome 14

There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff has up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:

Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

Inspectors found that the levels and skills mix of staff were sufficient to meet the needs of residents on the day of inspection and a review of staffing rotas indicated that these were the usual arrangements.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice, the staff files were kept to a very high standard and included all the relevant documents required as outlined in schedule 2 of the regulations.

There was an induction programme in place for all newly recruited staff. New staff worked alongside existing staff, observing procedures and practices and reading policies. An assessment form was available for completion during the induction period to ensure staff reached an acceptable level of competency at the end of their induction. The assistant director of nursing confirmed that interviews were held with staff during their probationary period.

Overall, staff training records reflected inspection findings of good practice particularly in relation to nutritional assessment, end-of-life care; elder abuse; caring for residents with dementia and infection prevention and control. However, there was no record of any pressure ulcer prevention and management training for staff nurses and care assistants. Some practices observed by inspectors were not evidence based and in line with best practice and policy of the centre. For example, the use of continence sheets over pressure relieving mattresses and continence assessments incomplete on admission of a resident. Staff mandatory training and practices are also discussed in outcome 5.

Staff working at the centre on a regular basis, for example the hairdresser confirmed she had completed garda vetting. A written agreement was in place for volunteer workers visiting the centre and appropriate vetting procedures were found to be in place.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

The modern three storey building was purpose built and completed in 2008. The environment was bright, clean and well maintained throughout. Residents reported that the centre offered a homely comfortable environment and told inspectors that they enjoyed the lifestyle provided. Communal areas such as the day-rooms had a variety of pleasant furnishings and comfortable seating. The use of colours and signage was in line with best practice dementia care principles.

The units had recently been renamed as Oak and Laurel. Oak was the smaller unit which mainly specialises in dementia care, corridors were found to be wide, and access to outdoor space on the ground floor was promoted. Space was available for group and individual activity. The outdoor space was level, easily accessed and pleasantly landscaped.

Bedrooms were spread over the ground and first floor, 18 beds on each. Residents' bedrooms were spacious, comfortable and personalised. There were ample communal toilets accessible to residents over both floors. There was an assisted bathroom and an assisted shower room on each floor.

The centre had a secure mature landscaped garden with ample garden furniture for residents and visitors use. Residents told inspectors that they enjoyed spending time in the garden during fine weather. The areas around the front entrance were often populated by residents getting fresh air, and taking walks around the building.

The kitchen was found to be well-organised and equipped with sufficient storage facilities. Inspectors observed a plentiful supply of fresh and frozen food. The kitchen facilities had recently been inspected by the environmental health officer from the Health Service Executive and the report was made available to inspectors. The kitchen cleaning area was small and did not contain separate hand washing facilities.

Inspectors noted that the water temperature in the laundry and kitchen area was found to be higher than 43 degrees Celsius, the provider undertook to address this risk of scalding to staff immediately. Water temperatures for hand washing sinks accessible to residents were thermostatically controlled at a safe temperature.

There was appropriate assistive equipment available such as profiling beds, mobile hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. The wide corridors enabled easy accessibility for residents in wheelchairs or those with mobility aids. Hand rails were available to promote independence. Hoists and other equipment had been maintained and service records were up-to-date.

Storage of items in the sluice room was noted as this is not in line with best practice infection prevention and control and may increase the risk of cross infection. The bed pan washer on the ground floor of Laurel was out of order and was awaiting parts to repair the equipment from the service provider. Inspectors found that the cleaning rooms on each of the floors were not fully equipped as per the requirements of the Standards. There was no hand washing sink in the clinical room used by nursing staff to prepare medications.

7. Records and documentation to kept at a designated centre

Outcome 16

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:

Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings

** Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's guide

Substantial compliance

Improvements required*

Records in relation to residents (Schedule 3)

Substantial compliance

Improvements required*

Records were maintained on an electronic record keeping system. This system was found to be slow when access to records were required, and took time to retrieve each piece of information. Improvements and repairs to the system had taken place since the last inspection, including repair to the touch pad terminal which was out of order.

General records (Schedule 4)

Substantial compliance

Improvements required*

Operating policies and procedures (Schedule 5)

Substantial compliance

Improvements required*

Directory of residents

Substantial compliance

Improvements required*

Staffing records

Substantial compliance

Improvements required*

Medical records

Substantial compliance

Improvements required*

Insurance cover

Substantial compliance

Improvements required*

The insurance document was reviewed and the document showed the name of the nursing home with "Ltd" after the name, this was discussed with the provider and

was amended during the inspection by the provider in consultation with his insurance provider. A copy of the amended document was reviewed during the inspection and found to be satisfactory.

Outcome 17

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

References:

Regulation 36: Notification of Incidents

Standard 29: Management Systems

Standard 30: Quality Assurance and Continuous Improvement

Standard 32: Register and Residents' Records

Inspection findings

Inspectors reviewed a record of all incidents that had occurred in the designated centre since the previous inspection and cross referenced these with the notifications received from the centre.

A new incident and accident form has been developed and completed forms are audited by the assistant director of nursing. Improvements were noted in the quality of the reporting and the management of accidents and incidents further to the last inspection.

Inspectors noted that one incident involving an allegation of abuse of a resident had not been identified and reported to the Authority within the required three working days. The immediate response and management of the incident did not follow the centres' policy in place with regard to reporting to management and the Authority. The incident was notified to the statutory authorities and fully investigated. The details of the incident were subsequently properly notified to the Authority on 5 January 2011. The management and documentation of the incident was reviewed by inspectors during the inspection. Inspectors found reasonable measures were taken to ensure all residents living at the centre were safeguarded.

Outcome 18

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

References:

Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre

Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre

Standard 27: Operational Management

Inspection findings

There were appropriate arrangements in place for the absence of the person in charge.

The experienced assistant director of nursing deputises for the person in charge. Three clinical nurse managers are also employed. The provider told inspectors that he is also available to assist for non-nursing management duties. Inspectors were informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Leone Ewings

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

30 August 2011

Provider's response to inspection report*

Centre:	Elm Green Nursing Home
Centre ID:	0133
Date of inspection:	21 and 22 June 2011
Date of response:	14 September 2011 and 27 September 2011

Requirements

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

Outcome 1: Statement of purpose and quality management

<p>1. The provider is failing to comply with a regulatory requirement in the following respect: The statement of purpose did not include all the details listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).</p>
<p>Action required: Review the Statement of Purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).</p>
<p>Reference: Health Act 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function</p>

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>This has been completed and sent to the inspector for comment before finalising.</p>	<p>Submitted to the Authority 3 August 2011</p>

Outcome 2: Reviewing and improving the quality and safety of care

<p>2. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The provider has not evidenced compliance with the regulation with regard to quality of life at the designated centre.</p> <p>There was no formal method found to be in place to receive feedback from residents and relatives on a regular basis.</p>	
<p>Action required:</p> <p>Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.</p> <p>Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.</p> <p>Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.</p> <p>Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 35: Review of Quality and safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:

<p>Provider's response:</p> <p>A questionnaire has been drawn on quality of life in Elmgreen and was circulated to all residents. 28 responses from a circulation of 96.</p> <p>A review audit on resident's quality of life will be carried out 3 monthly.</p> <p>A report will be compiled and disseminated to relevant personnel through the monthly management and staff meetings and any changes that are required, put into place and reviewed monthly at management meetings.</p> <p>The report will be presented to residents and relatives at their monthly forums and feed back encouraged. Any person requesting a copy of the report will be given one. To ensure that all residents, relatives and staff are aware of the report, a notice will be placed through out the nursing home to inform them of its availability and given to them on request.</p>	<p>First audit completed and will be reviewed 3 monthly</p>
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Outcome 3: Complaints procedures

<p>3. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The record keeping of each complaint received was not found to have been complete and of a poor standard, and did not include details of any investigation, actions taken, or whether the resident or relative was satisfied with the outcome of the complaint.</p>	
<p>Action required:</p> <p>Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.</p> <p>Ensure the person in charge and key management staff receive training on complaint's handling.</p>	
<p>Action required:</p> <p>Inform complainants promptly of the outcome of their complaints and details of the appeals process.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 39: Complaint's Procedures Standard 6: Complaint's</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>

<p>Provider's response:</p> <p>The complaints recording documentation has been changed to reflect the outcome and satisfaction of the complainant. The complaints policy has been updated and sent into the inspector for review. Internal training of clinical nurse managers and staff nurses will be completed and formal training will be organised and completed inside 9 weeks.</p> <p>All complaints are reviewed at the monthly management meeting and all personnel informed of the progress of the complaint.</p>	<p>30 November 2011</p>
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Outcome 4: Safeguarding and safety

<p>4. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Management and senior staff were not found to have taken appropriate action or have been adequately trained with regard to dealing with and reporting to the Authority an allegation of abuse.</p>	
<p>Action required:</p> <p>Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.</p> <p>Take appropriate action where a resident is harmed or suffers abuse.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 6: General Welfare and Protection Standard 8 : Protection</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Training in this area is ongoing and all relevant policies and procedures have been updated and are now strictly adhered to. This related to an incident between two residents and did not involve staff member. This matter was dealt with and closed in January 2011. The strict reporting guidelines are now being followed.</p>	<p>30 November 2011</p>

Outcome 5: Health and safety and risk management

5. The provider/person in charge is failing to comply with a regulatory requirement in the following respect: Poor manual handling practices were observed on Oak Unit.	
Action required: Provide training for staff in the moving and handling of residents, and ensure the moving and handling policy is implemented.	
Reference: Health Act 2007 Regulation 3: Risk Management Procedures Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: This training is ongoing for any new staff and regularly reviewed. One of our nurses is a manual handling trainer. Practices are now monitored regularly. Our manual handling trainer will be undertaking regular audits of practises within the nursing home. Our manual handling trainer is a staff nurse in the centre.	30 November 2011

Outcome 6: Medication management

6. The person in charge is failing to comply with a regulatory requirement in the following respect: The medication management policy was not fully in line with An Bord Altranais Guidance for Nurses and Midwives on Medication Management (July 2007) or fully evidence based and required review. The nursing staff had not signed the policy to acknowledge reading and understanding their roles and responsibilities with regard to medication management at the designated centre.	
Action required: Review medication management policy and put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	

Reference: Health Act 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>The medication management policy has been updated. Training has been organised for all nursing staff in relation to changes in the medication policy. During this training there will be an emphasis place on the drug error reporting form.</p> <p>GPs will have completed medication reviews on all residents by 31 October 2011.</p> <p>A self medication questionnaire was sent out to all residents following the inspection and the residents who have requested to self medicate are being assessed to establish their competency.</p>	<p>31 October 2011</p> <p>31 October 2011</p> <p>31 October 2011</p>

Outcome 7: Health and social care needs

7. The person in charge is failing to comply with a regulatory requirement in the following respect: The residents care planning process and electronic record keeping system in place did not ensure the individual needs of each resident were not set out in a care plan that reflected his / her needs, interests and capacities, are was not drawn up with the involvements of the resident and reflect his / her changing needs and circumstances.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Action required: Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances and no less frequent than at 3-monthly intervals. Revise each resident's care plan, after consultation with him/her.	
Reference: Health Act 2007 Regulation 8: Assessment and Care Plan Standard 11: The Residents' Care Plan	
Please state the actions you have taken or are planning to take with timescales:	Timescale:

<p>Provider's response:</p> <p>Currently the person in charge is implementing team nursing. All nurses/carers will be responsible to ensuring that the resident and the resident's family are involved in development of the residents individual care plan. Staff are aware that the resident's care plans are reviewed 3 monthly or as required and changed appropriately to the resident's current condition with the agreement of the resident and family.</p>	<p>30 November 2011</p>
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Outcome 12: Residents' clothing and personal property and possessions

<p>8. The person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>An up to date record of each resident's personal property that is signed by the resident was not available for all residents.</p>	
<p>Action required:</p> <p>Maintain an up to date record of each resident's personal property that is signed by the resident.</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>This is ongoing and will be fully operational by 31 December 2011. With the implementation of team nursing, roles and responsibilities will be more identified which will improve the documentation of resident's personal property at 6 monthly intervals. Once the property list is updated with the resident, it will be completed with the resident's signature.</p>	<p>31 December 2011</p>

Outcome 13: Suitable person in charge

<p>9. The person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>There are no records of management meetings held between the person in charge and the provider for review.</p>	
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Action required: Document any formal management meetings and make available for inspection.	
Reference: Health Act 2007 Regulation 15: Person In Charge Standard 27: Operational Management	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: These meetings occur regularly and will now be documented	Done

Outcome 16: Records and documentation to be kept at a designated centre

10. The person in charge is failing to comply with a regulatory requirement in the following respect: Record retrieval was slow in some cases the use of the electronic record keeping system was difficult for some nursing staff when records were requested by inspectors.	
Action required: Identify training needs by auditing the use of the electronic record keeping system for access and quality and accuracy of records maintained.	
Reference: Health Act 2007 Regulation 25: Medical Records Standard 32: Register and Resident's Records	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Further training on the electronic record keeping system took place for both nursing management, CNMs and staff nurses on 13 September on site, with further dates arranged. The auditing systems were highlighted through the training which will be utilised by management staff in the auditing process of electronic record keeping. As it is an internet based system it can sometimes be slower than normal. Our IT service regularly updates the system to speed it up.	31 December 2011

Outcome 17: Notification of incidents

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

The Authority was not informed without delay by the person in charge of an allegation, suspected or confirmed abuse of a resident.

Action required:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation, suspected or confirmed abuse of any resident

Reference:

Health Act 2007
Regulation 36: Notification of Incidents
Standard 29: Management Systems

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

Timescale:

Provider's response:

This matter was dealt with in detail in early 2011 and new procedures are now in place.

Done

Any comments the provider may wish to make:

Provider's response:

We wish to thank both Leone and Sheila for their helpfulness and continued guidance and constant support.

Provider's name: Martin O Dowd

Date: 27 September 2011