

Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act
2007



Centre name:	Rathkeevan Nursing Home
Centre ID:	0271
Centre address:	Rathkeevan
	Clonmel
	Co Tipperary
Telephone number:	052-6182000
Fax number:	052-6182040
Email address:	Rathkeevinnursing@gmail.com
Type of centre:	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public
Registered provider:	Drescator Ltd.
Person authorised to act on behalf of the provider:	Liam Long
Person in charge:	Marie Slattery
Date of inspection:	4 October, 5 October 2011 and 10 October 2011
Time inspection took place:	Day-1 Start: 10:15hrs Completion: 21:00hrs Day-2 Start: 10:00hrs Completion: 21:00hrs Day-3 Start: 13:45hrs Completion: 17:45hrs
Lead inspector:	Mary Moore
Support inspector(s):	Catherine O'Keeffe
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

Rathkeevan Nursing Home is located in a rural location in Co Tipperary approximately three miles from Clonmel town. The centre is visible and accessed from the main Limerick/Waterford road.

The premises' is single-storey, purpose-built and has operated as a designated centre for dependent persons since 2001. Though built to accommodate 63 residents, some reconfiguration of the service has occurred and currently there is capacity to provide long-term, respite and palliative care for 60 residents. Effectively the premises is laid out in four parallel and interconnected blocks. The main entrance is wheelchair accessible, leads to a spacious lobby from which the main reception area is accessed. The main reception area contains the nurses' station, a designated smoking room, an oratory, a newly provided visitors' room and one of the four available communal rooms; the remaining three communal rooms are located in each of the three interconnecting corridors. There is one central dining room provided.

Resident accommodation is provided in 48 single bedrooms and six two-bedded rooms. All bedrooms have an en suite toilet, wash-hand basin and assisted shower. A further two toilets, and a bathroom with toilet, wash-hand basin and floor level bath are available. A treatment room, sluice room, administration office, laundry, kitchen and ancillary areas, two cleaners stores and staff facilities complete the layout of the premises.

The premises is located on a spacious site that provides for a landscaped area with walkways and three secure patio areas, one off each of the interconnecting corridors.

On the day of inspection there were 48 residents all of whom were in receipt of long-term care. The residents presented with a range of diverse and complex needs and care requirements. While 34 of the residents were greater than 80 years of age, eight residents were less than 65 years of age, five of whom were less than 50 years of age. Eleven residents had a diagnosed dementia.

Date centre was first established:			2001	
Number of residents on the date of inspection:			48	
Number of vacancies on the date of inspection:			12	
Dependency level of current residents:	Max	High	Medium	Low
Number of residents	30	14	4	0
Gender of residents			Male (✓)	Female (✓)

	15	33
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Management structure

The centre is owned and managed by Drescator Ltd. Liam Long, one of two directors of the company is the nominated Registered Provider. The Person in Charge is Marie Slattery and she is assisted by the Key Senior Manager (KSM) Renny Abraham in the daily governance, administration and operational management of the centre. A further Key Senior Manager was on extended leave at the time of the inspection. A team of nursing staff, care staff, catering, administration and cleaning staff attend to the needs of residents on a daily basis. All 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.

This inspection was the second inspection of Rathkeevan Nursing Home by the Health Information and Quality Authority. The first inspection of the 21 April 2010 was an unannounced inspection triggered as a result of concerns raised with the Authority relating to the general care and welfare of residents and staffing levels. On that occasion inspectors found evidence of good leadership and that residents' health needs were well met, with a range of external services and multidisciplinary supports and advice sourced. The premises and equipment were suitable for purpose and well maintained and decorated.

A number of areas for improvement were noted; however, and included:

- nurse staffing levels were not adequate to meet the complex assessed needs of the residents
- improvements in the complaints process,
- risk management strategies
- administration of medication
- review of incidents.

The required improvements are set out in detail in the action plan of that report which can be accessed at www.hiqa.ie

On this occasion inspectors met with residents, relatives, and staff members over the three day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, fire safety records, policies and procedures, complaints records, staff training records and staff files. Prior to the inspection questionnaires were forwarded to the centre for completion by both residents and relatives. Twenty one completed questionnaires were returned and these were also reviewed by the inspector. Responses predominately portrayed a positive experience of life in the centre and the standard of care delivered; residents and relatives' comments are incorporated into the body of the report.

Separate fit person interviews were carried out with the provider and the person in charge, both of whom had completed the Fit Person Self-Assessment document in advance of the inspection. This was also reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

The findings of this inspection are presented under 18 outcome statements. These statements set out what is expected in a designated centre 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) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Again, the findings of the inspection supported that while improvements were required, the centre was organized and well managed and the care needs of the residents were met to a good standard. The premises was fit for purpose, met the individual and collective needs of residents including residents with specific care requirements and was maintained to a high standard. The provider and person in charge demonstrated a high level of commitment to the residents, the staff and the service.

The required improvements primarily centred on fostering and implementing a culture of review and learning and provide care that had a sound basis in evidence based practice. Improvement was required not only to prevent a reoccurrence of negative incidents but also to enhance the many findings of good practice and enhance clinical outcomes for residents. Areas such as complaints management, accidents and incidents, safeguarding and protecting residents' personal possessions, nursing documentation and the monitoring and recording of nutritional and fluid intake would have benefited greatly from such a process of review and learning.

The inspectors were satisfied that staff were committed to meeting the care needs of residents and had available to them good access to advice and support from specialist services and other multi-disciplinary health professionals. However, given the complex and diverse needs of residents, the staff training programme did not provide staff with access to education and training to ensure that all staff had the required knowledge and skills to enable them to provide care in accordance with contemporary evidence based practice. Equally policies to guide practice were not referenced to best practice literature, legislation or nationally agreed guidelines.

Further identified improvements related to the organisation of work practices and routines and the provision of meaningful and therapeutic activities to ensure that the centre was organised in a more inclusive and person-centred manner given the diversity of age profiles of residents and the needs of more dependent and cognitively impaired residents who did not have the capacity to articulate their choices and preferences.

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

There was a written statement of purpose and function in place and it was an accurate description of the service and the facilities provided. However, it requires further review and amendment to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Further detail and clarification is required as to the qualifications and experience of the nominated registered provider, the maximum number of residents who can and who will be accommodated, the age range of residents to be accommodated, and the number and size of available communal and dining rooms.

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

Since the last inspection the person in charge had put in place a system of audit and completed audits included medication management, elder abuse, falls, wound management and infection control. However, the audit tools and findings reviewed by inspectors were generic and check-list in nature, focused on the presence and completion of documentation and did not demonstrate any evidence of change, improvement or enhanced clinical, safety and quality outcomes for residents.

Likewise audits did not identify discrepancies in practice or where improvements were required. For example the wound management and falls audits had not identified that there were two risk assessment tools in use and the potential negative clinical consequences of this for residents in relation to the differing risk rating scores obtained.

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

Questionnaires completed by relatives and relatives spoken with reported ready access to management and ease of communication. No relative spoken with had ever made a complaint but reported that they would if necessary as it was "beholden" upon them to do so.

The written complaints policy and procedure had been revised since the last inspection and now included an independent appeals procedure. A complaints log was in place and the records contained in the log as reviewed by the inspector demonstrated evidence of investigation, the outcome, feedback to the complainant and an evaluation of complainant satisfaction.

However, based on further documentation reviewed by inspectors during the inspection process and discussion with the person in charge and the nominated registered provider, inspectors were satisfied that significant improvement in the management of complaints was required to ensure that all complaints were dealt with transparently and fairly in a spirit of openness and partnership and without fear of adverse consequences for the complainant and/or the resident on whose behalf issues, concerns or expressions of dissatisfaction had been raised.

While a complaints log was in place and made available for inspection it was not an accurate record of all complaints made and further records of complaints made were maintained in residents' records.

The complaints policy and procedure while concise was deficient in detail as to:

- the role, responsibility and accountability of all staff including the registered provider in complaints procedures
- the documentation to be maintained
- the person nominated to ensure that all complaints were appropriately responded to and that all complaints records were fully and properly recorded and maintained was not identified
- the role of the Authority as referenced in complaints policy and procedure requires review and amendment.

There was no evidence of team discussion of complaints logged and the response to complaints to inform future learning.

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

Relatives spoken with said that despite advanced age and dependency they were confident that their family member would report to them any concerns or worries that they might have. Relatives of more dependent residents told inspectors that they would know if their family member was upset or unhappy. Residents who had the capacity to do so told inspectors that they felt "100%" safe. Staff who spoke with inspectors had a sufficient understanding as to what may constitute abuse and their reporting responsibilities. However, training records reviewed by the inspector demonstrated that two staff members had not received education and training in detecting and responding to alleged, suspected or reported abuse.

Administration support was in place and records were made available for the purposes of inspection in relation to the centres charges to residents, including charges for additional services and the amounts paid by or in respect of each resident. No monies or valuables were held in safe keeping for residents and personal locked storage space was available in residents' bedrooms for this purpose.

However improvements were required in relation to safeguarding and protecting residents' personal property and finances. Documentation reviewed by inspectors confirmed reports of the alleged theft/misappropriation of residents' personal property and finances. There was no evidence to support a subsequent review and risk assessment of the systems and procedures in place to safeguard and protect residents' personal/possessions and finances while facilitating in so far as was reasonable practicable the residents right to independence and autonomy. The policy on residents' personal property and possessions did not outline the procedure to be followed when residents reported missing money and valuables. Residents were asked to sign a disclaimer absolving the provider from liability for the theft of any monies or valuables from the locked storage facilities. Notwithstanding criteria 25.21 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*, a review of policy, procedure and practice

is required in the interests of striking a reasonable balance between rights, risks and the provider's legal responsibilities in these matters.

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

Though improvements were required, overall inspectors were satisfied that there was awareness of and proactive measures in place to protect and promote the health and safety of residents, staff and visitors.

Staff had access to a concise and pragmatic emergency plan that outlined the measures to be taken in the event of the unexpected loss of essential services. Alternative arrangements were in place for the accommodation of residents in the event of evacuation of the centre. A centre-specific health and safety statement was in place, responsible persons were identified and a comprehensive range of risk assessments had been completed for all areas of work and associated work practices. However, there was no risk assessment for self-harm and while there was a policy and procedure in place to manage a resident missing without leave, there was no assessment of the risk of this occurring or the measures in place to reduce or minimise its occurrence.

Training records reviewed confirmed that mandatory training requirements for staff in moving techniques in patient care had been met; staff were seen to have been provided with and to use appropriate assistive devices.

Inspectors saw evidence of the implementation of the Hazard Analysis and Critical Control Points (HACCP) food safety management system. Catering facilities were inspected by the relevant Environmental Health Officer (EHO) and recent reports reviewed by the inspector confirmed that the premises was in substantial compliance with the relevant food safety legislation. A food safety statement was clearly displayed outside the main dining room.

Staff training records reviewed and staff spoken with confirmed that staff had current education and training on the prevention and control of infection. Clinical staff and staff with responsibility for environmental hygiene had a sound understanding of appropriate infection control measures. Staff were clear and informed when speaking of and caring for residents who were MRSA positive (Methicillin Resistant *Staphylococcus Aureas*). Personal protective equipment, alcohol hand gel and clinical risk waste receptacles were in place as appropriate to

the level of risk of infection. Regular and current consignment notes for the removal of clinical risk waste by a recognised contractor were available for inspection.

Fire records were well maintained. Certificates were in place confirming that the fire detection/alarm had been serviced and tested on a quarterly basis, most recently in September 2011. Fire fighting equipment was serviced annually as was the emergency lighting and certificates of servicing to this effect were in place. In addition the emergency lighting was checked in-house monthly and staff undertook and maintained records of daily inspection of the emergency exits and escape routes. Inspectors saw that all escape routes were free of obstruction and clearly designated. However, notwithstanding the evidence to support the proactive approach to fire safety, improvements were required.

While records reviewed by the inspector demonstrated that staff had attended fire prevention and management training in April 2011 and simulated fire evacuation drills were undertaken on a regular basis, not all staff spoken with were clear as to the actions to be taken in the event of fire and the safest and most efficient means of evacuating dependent residents to a place of safety.

While a fire evacuation plan was in place it was not specific to the evacuation status of each individual resident; staff spoken with were not familiar with fire evacuation sheets (ski-sheets). Given the dependency levels of the current residents', consideration should be given to the formulation of personal emergency evacuation plans (PEEP) for residents.

Records of accidents and incidents involving residents were maintained. However, record keeping was fragmented and two records were maintained, one for incidents and one for accidents. Inspectors noted; however, as reflected in the records reviewed, that this differentiation was not clearly understood by all staff. While each individual record was comprehensive there was no evidence to support a review of accidents, incidents and adverse events such as falls to identify patterns, trends and measures required for improvement to enhance safety and clinical outcomes for residents. For example, on reviewing the 31 recorded accidents since 31 December 2010 the inspector noted that 29 falls were not witnessed by staff.

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 evidence of good medication management practices. Medication trolleys were in place to address the medication administration issues as identified on the last inspection. Prescribed medications were delivered and unused/unwanted medications were removed by the pharmacist on a daily basis as required. Residents had access to the pharmacist for discussion and advice in relation to their medication regime. Photographic identification was available on both the medication prescription record and medication blister packs. Three-monthly multi-disciplinary medication reviews were current and clearly recorded in the residents' care plan. The inspector observed nursing staff to answer any queries raised by residents in relation to the administration of their medications. A pain scale was utilised by nursing staff to measure the requirement for and efficacy of prescribed analgesia.

Improvements were required; however, inspectors noted that:

- nursing staff transcribed the medication prescription record but, practice was not in line with local policy or regulatory body guidelines. Nursing staff did not sign the records as transcribed and there was no evidence of a counter-checking system (signature of checking nurse) to minimise the margin for error
- one prescription for a controlled drug was altered and not rewritten as a new prescription
- the receipt of controlled drugs while recorded was not witnessed and countersigned
- a medication management audit had been completed in August 2011. It was not centre-specific; however, and did not address particular issues or risks peculiar to the centres medication storage systems. The audit had not identified the non-adherence to transcribing policy and best practice.

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

While improvements were required, inspectors were satisfied that the health care needs of residents, many of which were complex, were met to a good standard.

At the time of inspection approximately seven medical centres and 16 General Practitioners (GPs) attended to the health care needs of residents. Some residents and relatives spoken with confirmed that they retained the services of their long-term GP post admission. Inspectors saw that nursing staff were aware of the changing needs of residents and sought prompt medical review for residents as appropriate. Based on their observations and medical records reviewed inspectors were satisfied that residents had access to medical review and treatment in line with their assessed needs. There was evidence to support a proactive approach to the maintenance of health; residents received influenza vaccination, vital signs and body weight were monitored monthly or more frequently where indicated, there was evidence of regular laboratory blood evaluations and referral and review to optical and audiology services. The KSM was a registered physiotherapist and in addition to his managerial and supervisory functions he facilitated physiotherapy treatments for the residents.

Six residents had specific and complex care requirements. Inspectors reviewed documentation and met with the local Public Health Liaison Nurse for Physical,

Sensory and Disability Services who visited the centre at least once a fortnight. There was evidence of collaborative multi-disciplinary working, ongoing review of care requirements and referral to support services, agencies and other allied health professionals to maximise the residents' health, independence and level of functioning.

As appropriate and available, these residents had access to a personal assistant, transport, respite, physiotherapy, occupational therapy, speech and language assessment and individual assessments were currently ongoing for assistive technology devices via the Central Remedial Clinic. Their maximum dependency and complex care needs however were met on a daily basis by the staff of the designated centre.

Residents in general had good access to multi-disciplinary services such as physiotherapy, speech and language therapy and dietetics in line with their individualised requirements. There was evidence of multi-disciplinary team meetings to discuss and seek satisfactory resolutions to complex care needs including any refusal of prescribed interventions or prescribed treatments by a resident.

Six residents were receiving treatment for wounds, two of which were pressure sores. Inspectors saw that residents were supplied with the required pressure relieving equipment and their care was supported by referral to tissue viability services. However, improvements were required in wound care policy and documentation to support and reflect a high standard of evidence based practice and current evidence-based and nationally agreed best practice guidelines in wound care prevention and management. There were two risk assessment tools unnecessarily in use and completed concurrently by nursing staff, wounds while measured were not graded and not all wound assessments were supported by photographic evidence.

Staff demonstrated an awareness of restraint and monitoring records where restraint was used were completed by staff. Documentation reviewed however, did not support a strong evidence base to practice. Restraint observation forms did not specify the type of restraint in use and were not completed consistently or in line with the guidelines for completion by staff. The restraint assessment in use had a basis in the management of challenging behaviours and was not specific to the context in which restraint was used in the centre; it did not identify any risks associated with the implementation of a restraint such as bedrails.

Each resident had a nursing care plan. Inspectors reviewed seven nursing care plans. Residents or relatives had signed to confirm their involvement in the formulation and review of their care plan and each care plan was kept under formal review as required by the residents' changing needs. However, while the care plans were detailed, the ease of retrieval of information, the ability to establish a concise chronological pattern of improvement and or deterioration, the exact care plans that were currently in place for each resident and the ability of the care plan to provide suitable and sufficient evidence-based care was not at all times clear as;

- while a suite of evidence-based assessment tools were in use and were reviewed at least three-monthly, two assessment tools were in place for assessing both risk of falls and risk of pressure sore development
- the falls risk assessments gave clinically significant differing risk scores for the same resident
- the activities of daily living were reviewed rather than the effectiveness of planned nursing interventions and staff adherence to planned care. Changes were added in the form of supplementary information to the end of care plans and current care plans were held in conjunction with older and outdated care plans many of which were dated 2010
- documentation utilised on a daily basis by nursing staff such as wound assessments and dressing charts were separate to the care plan.

There was evidence of the exchange of comprehensive information when residents were admitted or discharged. The discharge policy however, did not outline the procedure to be followed for self-discharge against medical advice or involuntary discharge.

There was an activity programme and recent efforts had been made to improve the activity programme through the deployment of two staff members to the delivery of activities two evenings per week. A weekly Fit for Life programme was delivered, a live music afternoon was facilitated by local musicians and card games and bingo were facilitated twice weekly. Staff reported that hand massages were given to more dependent residents and one relative spoken with told inspectors how her dependent family member told her how much she enjoyed it when staff “rub my hands”. Many residents spoke of their preference for solitary activities such as reading, listening to the radio or watching television. Residents’ and relatives’ comments were positive and both groups were anxious to recognise and praise the work and commitment of staff. One area identified by them however, as requiring improvement was the range and frequency of available activities and greater access to the outdoors, particularly for residents dependent on staff assistance. Staff spoken with told inspectors that given the care requirements of residents they were often too busy to take the time to chat with residents. As identified on the last inspection inspectors observed a deficit of meaningful and therapeutic activity for more dependent and cognitively impaired residents.

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

Given the predominance of single accommodation the environment facilitated the maintenance of the resident’s privacy and dignity throughout their time living in the

centre and as they approached end-of-life. Relatives who had experienced the end of life care delivered by staff spoke well of the standard of care and attention delivered both to the resident and the family. End-of-life care was enhanced by the provision of designated end-of-life facilities for family members. Inspectors saw that nursing staff monitored and responded appropriately to the needs of residents nearing end-of-life. Staff and the resident had access to the advice and services of local palliative care services and they were accessed and utilised in line with the resident's assessed needs.

Given the age and clinical profile of the current residents, policy and practice on resuscitation was discussed with the person in charge; a policy was in place and one explicit decision not to resuscitate was seen by inspectors in a sample of care plans reviewed. Policy however, did not explicitly state that all residents were to be resuscitated unless it was clearly stated otherwise. The requirement for clarity and to "think ahead" is fundamental to ensuring that the resident's death is responded to and managed appropriately in the event of an unexpected or unanticipated death. All discussions and any anticipatory decisions should be documented, signed and dated on the patient's record, effectively communicated to the team and reviewed at appropriate intervals in line with the resident's clinical status.

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

Inspectors saw adequate and varied stocks of fresh, frozen and dried food products. Catering staff spoken with were knowledgeable as to residents' dietary preferences and specific dietary requirements. Catering staff had direct access to the dining room and told inspectors that this allowed them to meet and receive feedback directly from the residents. Staff also however, maintained formal records of residents' likes and dislikes and were provided with formal communications such as swallow care plans by nursing staff. Residents and relatives spoken with expressed satisfaction with the variety and quality of meals provided and told inspectors that the standard was consistently maintained. Inspectors saw that in between scheduled meals a variety of fluids and snacks were provided to residents. Independence was encouraged and promoted and assistive devices to aid independence were available. Where staff assistance was required a good staff presence was maintained and assistance was provided in a discreet and respectful manner.

The inspector reviewed comprehensive nutritional assessments and nutritional care plans for seven residents formulated by a dietician following referral of the resident by nursing staff.

However, despite the observations of inspectors and the evidence of good practice as outlined above, improvements were required to ensure that each resident on a daily basis was provided with food and drink at times and in quantities adequate and appropriate to their assessed needs.

- the policy on the monitoring and documentation of nutrition and the management of PEG nutrition (Percutaneous Endoscopic Gastrostomy), like other policies reviewed were neither dated or referenced and therefore did not confirm their basis in contemporary evidence-based practice
- there was no policy in place to guide and inform monitoring and maintaining an adequate fluid intake for residents up to and including the provision of subcutaneous fluids. The latter was facilitated by nursing staff but there were no clear evidence-based guidelines or decision making framework in place for its use
- this was compounded by the fact that while fluid intake and output charts were in place a sample reviewed by the inspector demonstrated that they were not consistently maintained or totalled by staff and were therefore of little value in establishing the adequacy of the residents fluid intake. Some records reviewed demonstrated gaps of up to five hours between fluids taken
- likewise, staff maintained food intake records for some residents where a nutritional concern or issue was identified. Again the inspector noted significant deficits in the recorded entries and consequently records did not validate that the nutritional needs of dependent residents were adequately and appropriately met or that the nutritional care plan was implemented.

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

Contracts of care were in place. Contracts reviewed were agreed within one month of admission to the centre and agreed and signed by either the resident or the responsible family member. Contracts reviewed stated the overall fee, reimbursement monies received and the final fee to be paid by the resident. Contracts however, did not outline the services provided outside of the fee and the charges to be levied for such services.

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 observed care practices and interactions between staff and residents and were satisfied that residents were cared for with dignity and respect; residents and relatives' comments confirmed this. Personal care for residents was mainly delivered in the privacy of their own bedrooms with the bedroom door closed. Bed spaces in the twin-bedded rooms were appropriately screened. It was possible for the occupant to lock communal toilets and bathrooms.

Relatives spoken with described the physical environment as "spacious" and the psychosocial environment as "caring and welcoming". They described flexible visiting times and given the predominance of single accommodation securing privacy was not a problem; the centre was described as "a nice place to visit". Notwithstanding the predominance of single rooms the provider had also provided a designated visitors' room.

The person in charge told inspectors that as she was present and visible in the centre daily it was part of her daily routine to ascertain and attend to the concerns and requests of residents and relatives. This was augmented by more formalised systems of consultation; a residents' committee was in place and a suggestion box was available. Relatives of residents had also been invited to join the residents' committee and relatives spoken with confirmed their participation in the residents' committee and spoke of their hopes of strengthening links with the local schools and access to the local community and services.

The inspector reviewed the minutes of the residents' committee meetings that were held on average every quarter; the most recent meeting was convened on 13 September 2011. The minutes reflected that a broad range of topics were discussed such as financial reimbursement schemes for residential care, to issues relevant to daily life in the centre such as a new television purchased or organising

a communication link with the local parish church. The relevant religious personnel were working with the provider on the implementation of this project.

Mass took place on the first day of inspection and staff were seen to make this an inclusive event and assisted residents to make their way to the main dining room where mass took place. An oratory was also available and residents told inspectors that they enjoyed the peace and tranquillity that it provided.

More independent residents reported having choice and flexibility in their daily routine and retained good family and social links. Inspectors met with residents who enjoyed attending local day care services, visiting their family home or receiving regular, sometimes daily visits from their family. The independence and autonomy of residents with specific and specialised care requirements was facilitated by the appointment of personal assistants. Inspectors met and spoke with residents who were eagerly looking forward to shopping trips and social excursions.

Residents were seen to have good access to radios, televisions, newspapers and personal mobile phones. Arrangements were in place for one resident to facilitate ongoing visits from his cat that remained in his home and had been cared for since his admission by his neighbours.

While a comprehensive and inclusive communication policy was in place; improvements in practice were required however, to ensure that the centre was organised in a more inclusive and person-centred manner given the diversity of age profiles of residents, and the needs of more dependent and cognitively impaired residents who did not have the capacity to articulate their choices and preferences. Residents had access to three secure courtyards but many were dependent on staff assistance to access them when and "if there was somebody about" to assist them. Inspectors noted that older cognitively impaired adults were placed in the day rooms with little to engage or stimulate them for prolonged periods of time other than the television that was at times quite loud and unattended to in terms of content and volume. In the evening inspectors noted that younger residents were segregated from the main residents' communal room which was observed by inspectors to be the main hub of activity within the centre and the room in which staff presence and attention was focused.

Staff spoken with told inspectors that breakfast for ten dependent residents commenced at 06:30hrs. The person in charge told inspectors that this was necessitated to ensure regular and frequent nutrition yet this was not evidenced in the food records reviewed by inspectors; meals taken were recorded but not mealtimes. Inspectors observed little in the way of signage or communication tools to maximise independence and communication.

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

Inspectors observed that the personal grooming of residents was met to a high standard and this standard of attention was confirmed as consistent by relatives of more dependent residents. A laundry service was provided and staff spoken with by inspectors were aware of their responsibilities in relation to the laundering and safe return of residents' personal clothing. One resident succinctly described the attention given to his personal belongings as "I never lost as much as a sock". Laundry staff also demonstrated competency in relation to infection control practices, had the required equipment available to them and clearly outlined the processes for grading and managing different categories of laundry.

Residents' bedrooms were homely and personalised with memorabilia such as family photographs and religious items. Adequate storage space was provided for the storage of personal items and clothing in both single and twin-bedded rooms.

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 person in charge was a registered general nurse, employed full-time and had been person in charge since 2001. She had extensive nursing experience and prior to taking up this post she had worked as a staff nurse in another residential care setting for approximately 12 years. Relatives and residents spoken with confirmed the availability of the person in charge; residents referred to her as "Matron Marie".

Inspectors saw that the nominated registered provider was supportive and available to the person in charge who had great autonomy, accountability and responsibility in

relation to the organisation and management of the centre and services provided on a daily basis.

The person in charge demonstrated evidence of continuing professional development to assist her in exercising her clinical and managerial responsibilities and had completed education and training such as medication management, person-centred care, fire safety, infection control, inspection and regulation, elder abuse, nutrition and manual handling.

The person in charge had sufficient knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* to allow her to fulfil her role and legislative responsibilities.

Systems were in place to ensure that the person in charge was adequately supported and the centre was appropriately governed and organised. A key senior manager was in place. He was observed by and interacted with inspectors throughout the inspection process. He had a sound understanding of his role, duties and the limit of his responsibilities in relation to clinical matters as he was not a registered nurse. In the absence of the person in charge a senior nurse was on duty and in charge of the designated centre and this was clearly indicated by day and by night on the staff roster.

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 have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:

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

Inspection findings

The centre has the capacity to accommodate 60 residents. At the time of this inspection there were 48 residents living in the centre, 30 of whom were assessed by staff as being of maximum dependency in their daily care requirements. Inspectors were satisfied that the current staffing levels and skill mix were adequate to meet the care needs of the current profile of residents given their dependency levels and complex care requirements. Rosters were reviewed, they

were clearly presented and the inspector easily retrieved the required information from them in relation to skill-mix and consistency of staffing levels. Sufficient catering, environmental hygiene, laundry and administration staff were employed.

Inspectors also noted however, that staff were busy and given the profile of the current residents there was an inevitable preponderance on the completion of tasks and meeting the physical care requirements of residents. A review of retrospective rosters demonstrated that in the past, the staff skill mix and numbers was not at all times sufficient to meet the needs of all residents. It is imperative that the person in charge in consultation with the registered provider keep staffing levels under constant review and ensure that the numbers and skill mix of staff are at all times appropriate to the numbers and assessed needs of the residents and the size and the layout of the building.

There was evidence to support that the provider and the person in charge understood the importance of robust recruitment procedures. A sample of staff files were reviewed, they were well maintained and largely contained all of the required documentation as prescribed in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Improvements were required; however, in relation to the verification of references. References for staff reviewed were largely of a testimonial type and there was no evidence to support their verification by the provider. One staff file reviewed did not contain a reference from the employee's most recent employer.

There was evidence of current registration with their regulatory body An Bord Altranais in place for all nurses employed.

Inspectors saw that there was appropriate supervision of staff and formal systems of delegation of tasks and duties were in place. The person in charge had introduced a formal system of staff appraisal and though not complete inspectors saw frank and transparent analysis of strengths and areas where improvements were required. Though informal, staff spoken with described their induction process at commencement of employment.

All staff spoken with were clear as to the roles of the person in charge and the key senior manager and their reporting relationships. Daily notices were displayed in the centre outlining the staff on duty and their posts of responsibility.

A review of staff training records demonstrated that the primary focus of the staff training programme was mandatory training requirements such as manual handling, fire prevention and safety, HACCP training, and infection prevention and control and elder abuse training. Some nursing staff had attended medication management training and the management of challenging behaviours; carers had completed the Care Skills Module to FETAC (Further Education and Training Awards Council) Level 5. While staff had good access to specialist advice and support such as tissue viability, dieticians, and speech and language therapy, there was little evidence to support that the staff training and development programme encompassed the care requirements of residents as they presented on a daily basis

to ensure that all staff had the required knowledge to enable them to provide care in accordance with contemporary evidence-based practice.

Inspectors noted inconsistencies in the frequency, format and records maintained of staff meetings. Staff spoken with told inspectors that meetings were infrequent and informal and records initially presented for inspection indicated that the last staff meeting took place in February 2010. A further record was presented for inspection on the second day of the inspection containing records of staff meetings held in March, June and September 2011.

Staff were described by residents and relatives spoken with as gracious, respectful, having "great patience" and willing to go "the extra mile".

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 premises was purpose-built to a high standard in 2001 and had been well maintained in the intervening period. It was in good decorative order, appropriately heated, lighted and ventilated. The design and layout of the premises facilitated the fulfilment of the stated aims and objectives of the statement of purpose. Residents and relatives spoke of how the physical environment allowed them both space and privacy and many residents valued the single storey construction as they did not have to "go up and down stairs".

Residents were accommodated in 48 single and six twin-bedded rooms. All bedrooms had en suite facilities of assisted shower, toilet and wash-hand basin. Inspectors saw that the size and layout of bedrooms were sufficient to meet the requirements of residents including those with specialised needs; modifications as required on an individualised basis were facilitated by the provider. Shared bedrooms were appropriately screened to offer privacy to each occupant and separate and segregated storage space was provided. A further two toilets and a bathroom were available to residents and these were located in relative proximity to the communal and dining areas.

Though fit for its stated purpose, the provider had made recent further changes to the physical environment to enhance its compliance with the *National Quality Standards for Residential Care Settings for Older People in Ireland* and other

relevant legislation. A visitor's room, overnight guest facilities, treatment room and separate cleaning rooms for catering and cleaning staff had been provided. Rooms had been fitted out in line with the criteria as laid down.

Residents had adequate communal and dining space. Four communal areas were available; the dining room was spacious and allowed for ease of access and the accommodation of residents with specialised seating and mobility needs.

Circulation areas were well equipped with handrails and again inspectors saw that they were sufficiently wide and free of obstructions to allow ease of access for residents dependent on mobility aids and wheelchair users.

Furnishings and fittings were of a high standard and residents were supplied with therapeutic equipment in line with their assessed needs. A service agreement was in place for the servicing and maintenance of equipment and certificates were in place stating that a service had been undertaken in September 2011. Mechanical hoists for assisting staff in moving techniques in patient care were serviced every six months.

The call bell system was in good working order, was serviced in May 2011 and inspectors noted that staff responded promptly to call bells.

The standard of environmental hygiene was high and residents and relatives told inspectors that the centre was always "spotless".

On visible inspection the inspectors saw that all fire exits were clearly designated, unobstructed and exited on the flat and safe internal areas to evacuate to in the event of fire were available in each block. Written confirmation was available stating that the requirements of the fire authority had been substantially complied with.

The laundry was well equipped with industrial standard machines, was clean, tidy and organised. There was sufficient space for the segregation and storage of clean and dirty laundry. The laundry was seen to be locked when unattended.

The kitchen was clean, tidy and organised and adequately equipped to meet the requirements of residents. Food stocks were hygienically stored and the catering facilities were segregated from the main care environment to restrict unauthorised access.

Staff were provided with suitable storage, changing and dining facilities.

The external grounds were suitable for the use of residents, were free from any obvious hazards and were well maintained.

Minor improvements were required to reduce risk and promote the health and safety of residents, staff and visitors:

- the sluice room door was unlocked and was used to store clinical risk waste and the used sharps container

- five portable cylinders of oxygen were stored internally in the treatment room
- bedroom windows though all at ground level had unrestricted openings.

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*

General records (Schedule 4)

Substantial compliance

Improvements required*

Operating policies and procedures (Schedule 5)

Substantial compliance

Improvements required*

The suite of policies in place satisfied the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). However, a sample of policies reviewed directly relevant to the care requirements of the residents such as falls prevention, nutrition, wound management, the management of PEG nutrition, restraint, and infection prevention and control policies such as the management of MRSA, Novovirus and Clostridium Difficile were undated, did not have a review date and were not referenced to best practice literature, relevant legislation and national guidelines. Other policies such as the management of complaints, residents' personal possessions and the discharge policy required review as outlined in the body of the report.

Directory of residents

Substantial compliance

Improvements required*

A sample of records reviewed demonstrated that the required information including the cause of death was not consistently entered by staff.

Staffing records

Substantial compliance

Improvements required*

A system was required to ensure the authenticity of staff references.

Medical records

Substantial compliance

Improvements required*

Insurance cover

Substantial compliance

Improvements required*

Adequate and appropriate insurance was in place to satisfy the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). A disclaimer was in place however signed by some residents and this requires review in line with the responsibility of the provider for loss or damage to the property of residents as outlined in the legislation.

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

The person in charge had not fully exercised her responsibility in relation to the submission of notifications to the Chief Inspector. While notification of an accident and serious injury to a resident had been received, it was not returned in the correct format and within the required timeframes. The Chief Inspector had not been notified of the occurrence in the centre of pressure sores Grade 2 and above. Quarterly notifications had not been returned for 2011.

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 had been no expected or unexpected absence of the person in charge of a duration that required notification to the Chief Inspector. The person in charge and the nominated provider were aware of the notification requirements.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Mary Moore

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

18 October 2011

Provider's response to inspection report*

Centre:	Rathkeevan Nursing Home
Centre ID:	0271
Date of inspection:	4 October, 5 October and 10 October 2011
Date of response:	11 November 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

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

The statement of purpose did not consist of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required:

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

Reference:

Health Act 2007
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

* 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>The revisions to the statement of purpose to comply with Schedule 1 of the Health Act 2007 have been addressed and resubmitted.</p>	<p>11 November 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 existing system of audit did not demonstrate any evidence of change, improvement or enhanced clinical, safety and quality outcomes for residents.</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. The system established identifies omissions and improvements required.</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>The audit system will be reviewed to establish a review of incidents and to address the causes and to put in place improvements or strategies to minimise recurrences. All reviews will be documented.</p>	<p>17 February 2012</p>

Outcome 3: Complaints procedures

<p>3. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The management of complaints did not at all times support an environment where residents, family, advocates or representatives were able to raise issues, make suggestions and complaints (verbally and in writing) in a spirit of openness, partnership and transparency.</p>	
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Action required:	
Provide written operational policies and procedures that are fully in compliance with best practice and all legislative requirements, relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.	
Action required:	
Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.	
Action required:	
Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).	
Action required:	
Ensure that any resident who has made a complaint or on whose behalf a complaint has been made is not adversely affected by reason of the complaint having been made.	
Action required:	
Ensure that complaints are raised and discussed at team meetings for feedback and to inform future learning. Ensure measures required for improvement are put in place.	
Reference:	
Health Act 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>The complaints policy and procedures have been revised to be inclusive of all staff members receiving, dealing with and reporting complaints and concerns. All complaints/concerns will from now on be recorded in the complaints log.</p> <p>The registered provider is also available as part of the revised procedures to assist in resolving any complaint or concern raised. Complaints will be discussed at team meetings which will be held on a formal basis each month. Feedback and any required improvement measures will be discussed, recorded and</p>	1 December 2011

<p>implemented.</p> <p>The registered provider will be the person responsible to ensure that the nominated person, i.e. the person in charge appropriately responds to each complaint and maintains the records.</p> <p>It is the clear policy of the centre that any resident who expresses a concern or complaint or on whose behalf a complaint is made will not be adversely affected in any way because of this - this will be fully implemented and monitored.</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>Not all staff employed had attended elder abuse training.</p> <p>Where a resident had reported an alleged theft there was no evidence of review of the systems in place to protect and safeguard residents' finances and personal possessions.</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>Action required:</p> <p>Review and amend the centres policy and procedure for the management of residents' personal property and possessions. Policy and procedure to manage any allegations of theft in a spirit of fairness, openness and partnership is clearly outlined.</p>
<p>Action required:</p> <p>Put in place explicit guidelines for the facilitation and management of personal locked storage facilities for residents including an appropriate risk assessment where required.</p>
<p>Action required:</p> <p>Policy and procedure in relation to residents personal property, valuables and monies shall at all times reflect the liability of the provider as outlined in Regulation 26 (1).</p>
<p>Reference:</p> <ul style="list-style-type: none"> Health Act 2007 Regulation 6: General Welfare and Protection Standard 8: Protection Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Staff not already trained will attend elder abuse training and also receive in-house instruction from the person in charge on preventing abuse or being placed at risk.</p> <p>The home's policy and procedures for the management of personal property and possessions will be amended to outline a fair and open procedure to deal with any allegations of theft and to include detailed guidelines for use of locked storage facilities.</p> <p>The current disclaimer form shall be removed from individual care plans and no resident will be required to sign any such disclaimer in future.</p>	<p>15 December 2011</p>

Outcome 5: Health and safety and risk management

<p>5. The provider/person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>The risk management policy did not include all of the risks as specified in the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).</p> <p>Not all staff had adequate knowledge of their required actions in the event of fire.</p> <p>There was no evidence of the review and learning from accidents, incidents and adverse events.</p>
<p>Action required:</p> <p>Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.</p>
<p>Action required:</p> <p>Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents</p>
<p>Action required:</p> <p>Ensure by means of further fire drills and fire practices that the staff and, as far as is reasonably practicable, residents, are fully aware of the procedure to be followed in the case of fire, including the procedure for saving life.</p>

Action required:	
Given the dependency levels of residents the provider will give consideration to the development of PEEPs for residents. These will be reviewed at suitable intervals and brought to the attention of all staff.	
Reference:	
Health Act 2007 Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>The risk management policy will be revised to outline the precautions in place to control the risks specified, i.e. unexplained absence of a resident, assault, accidental injury to residents or staff, aggression and violence and self harm.</p> <p>A single incident book to cover all accidents/incidents is now in place.</p> <p>The risk management policy will include for the documented review of incidents/adverse events involving residents to ensure measures required for improvement are put in place.</p> <p>Regular fire drills will continue to be carried out and instruction given to ensure that staff and residents are aware of the procedures to be followed.</p> <p>PEEPs will be put in place for residents and reviewed regularly and all staff will be made aware of the contents of these plans.</p>	31 December 2011

Outcome 6: Medication management

<p>6. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Not all medication management practices were in line with best practice and regulatory body guidelines.</p>

Action required:	
Put in place appropriate and suitable practices and written operational policies relating to the transcribing, prescribing, delivery, storage and administration of medicines to residents and ensure that staff are familiar with and implement such policies and procedures.	
Action required:	
The practice of transcribing will be the subject of regular audit as recommended in An Bord Altranais Medication Management Guidelines 2007.	
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>Written operational policies and suitable practices relating to the transcribing, prescribing, delivery, storage and administration of medicines to residents in accordance with the improvements identified at the inspection and outlined in the report will be put in place.</p> <p>The practice of transcribing will be regularly audited as recommended in An Bord Altranais Guidelines.</p>	9 December 2011

Outcome 7: Health and social care needs

<p>7. The person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>Wound care policy and documentation did not support a high standard of evidence-based practice or reflect current evidence based and nationally agreed best practice guidelines in wound care prevention and management.</p> <p>The restraint assessment in use had a basis in the management of challenging behaviours and was not specific to the context in which restraint was used in the centre.</p> <p>The ability of the care plan to provide suitable and sufficient evidence-based care was not at all times clear.</p> <p>Discharge policy did not outline the procedure to be followed for self-discharge against medical advice or involuntary discharge.</p>
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Action required:	
Ensure that on each occasion that restraint is applied that the assessment is specific to the type of restraint and the context in which the restraint is used. The assessment establishes both the requirement for and the potential risk involved in using the restraint.	
Action required:	
Review the care plans and the process of care planning. Ensure that the care plan is an integrated and accurate organising framework of the resident's care and clearly sets out the resident's most recent assessment, current identified needs, current plan of care and each evaluation of that care. Ensure that nursing assessment tools are specific and valid to the resident and care setting and ensure a high standard of evidence based nursing care.	
Action required:	
Review the discharge policy to include guidelines for all staff on the procedure to be followed should a resident wish to discharge him or herself; or any occasion and the circumstances in which the provider may wish to discharge a resident to ensure that the resident is discharged in a planned, equitable and safe manner.	
Reference:	
<ul style="list-style-type: none"> Health Act 2007 Regulation 8: Assessment and Care Plan Regulation 29: Temporary Absence and Discharge of Residents Standard 10: Assessment Standard 3: Consent Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence 	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>When used, restraint assessment will be documented that is specific to the type of restraint and its use context and will establish the requirement for its use and the risks associated with its use.</p> <p>All care plans will be reviewed and streamlined to provide an integrated, organised plan. Duplication of assessment tools has been discontinued.</p> <p>The discharge policy will be reviewed to include specific guidelines for all staff on self discharge by a resident or when the provider wishes to discharge a resident.</p>	20 April 2012

Outcome 8: End of life care

8. The person in charge is failing to comply with a regulatory requirement in the following respect:	
End of life policy and practice did not explicitly state that all residents were to be resuscitated unless it was clearly stated otherwise.	
Action required:	
The person in charge will ensure that there is discussion and clarity in policy and practice on all end of life issues including sudden death. All discussions and any anticipatory decisions will be documented, signed and dated on the resident's records and effectively communicated to the team.	
Reference:	
Health Act 2007 Regulation 14: End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The end of life policy will be amended to explicitly state that all residents will be resuscitated unless clearly stated otherwise. Discussions on end of life care will take place on admission and will be reviewed as clinical status requires. Discussions and decisions will be documented, signed and dated on the residents' records. Nursing staff will be made aware of these decisions.	16 December 2011

Outcome 9: Food and nutrition

9. The person in charge is failing to comply with a regulatory requirement in the following respect:
There was no policy in place to guide and inform the management of adequate fluid intake for residents. Significant deficits were noted in fluid and dietary intake records and consequently records did not validate that the nutritional needs of dependent residents were adequately and appropriately met on a daily basis.

Action required:	
The person in charge will implement comprehensive evidence based policy and guidelines for the monitoring and documentation of residents' nutritional and fluid intake.	
Action required:	
The person in charge will implement comprehensive evidence based policy and guidelines for the administration of subcutaneous fluids to residents.	
Action required:	
The person in charge will ensure by means of regular review that staff accurately and consistently complete records maintained of residents dietary and fluid intake. Where omissions or deficiencies are detected these are investigated to ensure that the needs of residents are at all times adequately addressed.	
Reference:	
Health Act 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Comprehensive evidence based policy and guidelines will be put in place and implemented for monitoring and documentaion of residents nutritional and fluid intake and for the administration of subcutaneous fluids to residents.</p> <p>Regular reviews that staff complete and maintain records of dietary and fluid intake will be carried out.</p>	16 December 2011

Outcome 10: Contract for the provision of services

10. The provider is failing to comply with a regulatory requirement in the following respect:
Contracts of care did not specify the services that were provided outside of the agreed contract and the fees to be charged for such services.
Action required:
Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident including details of services provided outside of the agreed contract and the fees to be charged for such services.

Reference: Health Act 2007 Regulation 28: Contract for the Provision of Services Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All services to be provided for each resident will be outlined in the contract including associated charges and also charges for any services available outside of the agreed contract.	27 January 2012

Outcome 11: Residents' rights, dignity and consultation

<p>11. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Adequate arrangements were not in place to ensure the organisation of the designated centre was conducted with due regard to the age, cognitive capacity, and any disability of residents.</p> <p>Inspectors noted a deficit of meaningful and therapeutic activity for more dependent and cognitively impaired residents.</p>
<p>Action required:</p> <p>The provider will ensure that care and care practices at all times preserve and promote the choices and preferences of all residents regardless of their capacity and dependency.</p>
<p>Action required:</p> <p>The provider will provide facilities for the meaningful occupation and recreation of each resident. Cognitively impaired residents will have access to meaningful and therapeutic programmes or interventions.</p>
<p>Action required:</p> <p>The provider will ensure through education of staff, consultation with relatives and a review of the organisation of care that each resident regardless of capacity is facilitated and encouraged to communicate.</p>

Reference: Health Act 2007 Regulation 10: Residents' Rights, Dignity and Consultation Regulation 11: Communication Standard 1: Information Standard 2: Consultation and Participation Standard 17: Autonomy and Independence Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Staff members will attend a specialised workshop provided by "Sonas" on the next available course to receive training in communication and therapeutic activity for cognitively impaired residents.</p> <p>Therepeutic programmes will be made available to cognitively impaired residents and staff time will be allocated to encourage these residents to communicate.</p>	17 February 2012

Outcome 14: Suitable staffing

<p>14. The person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>Staffing levels and skill mix of staff were not at all times appropriate to the assessed needs of residents, and the size and layout of the designated centre.</p> <p>There was no evidence to support the verification of staff references.</p> <p>The staff training and development programme did not encompass the care requirements of residents as they presented on a daily basis to ensure that all staff had the required knowledge to enable them to provide care in accordance with contemporary evidence based practice.</p>
<p>Action required:</p> <p>Ensure that the numbers and skill mix of staff are at all times appropriate to the assessed needs of residents, and the size and layout of the designated centre.</p>
<p>Action required:</p> <p>Provide all staff members with access to education and training based on an assessment of the needs of the residents to enable them to provide care in accordance with contemporary evidence-based practice.</p>

Action required:	
Put in place recruitment procedures to ensure the authenticity of the staff references referred to in Schedule 2.	
Reference:	
Health Act 2007 Regulation 16: Staffing Regulation 17: Training and Staff Development Regulation 18: Recruitment Standard 22: Recruitment Standard 23: Staffing Levels and Qualifications Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Staff numbers and skill mix will be continually reviewed to ensure adequate and appropriate staff are available at all times. Ongoing training will be provided to all staff. Nursing staff to attend wound care management course on 9 November 2011 and 17 November 2011. Recruitment procedures have been amended to ensure references are checked and this is documented.	18 November 2011

Outcome 15: Safe and suitable premises

15. The provider is failing to comply with a regulatory requirement in the following respect:
Minor improvements were required to reduce risk and promote the health and safety of residents, staff and visitors.
Action required:
Restrict access to the sluice room.
Action required:
The provider shall arrange for the risk assessment of window openings and the storage of oxygen; identify and implement required controls to enhance resident and staff safety.
Reference:
Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>A keypad/digital lock will be fitted to the sluice room door. Oxygen cylinders will be stored external to the building. Restrictors will be fitted to the vulnerable windows following assessment of risk.</p>	16 December 2011

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

<p>16. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Policies and procedures were undated, did not have a review date and were not referenced to best practice literature, relevant legislation and national guidelines.</p> <p>The directory of residents was not consistently maintained.</p>	
<p>Action required:</p> <p>Review all the written operational policies and procedures of the designated centre on the recommendation of the findings of this inspection. Ensure policies are dated, have a clear review date and are appropriately referenced to support a high standard of evidence based nursing practice.</p>	
<p>Action required:</p> <p>Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.</p>	
<p>Reference:</p> <ul style="list-style-type: none"> Health Act 2007 Regulation 27: Operating Policies and Procedures Regulation 23: Directory of Residents Standard 32: Register and Residents' Records Standard 29: Management Systems 	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>All policies and procedures will be reviewed as specified and will be dated, have a review date and be referenced. The Directory of Residents will be kept in accordance with Schedule 3 of Health Act 2007.</p>	17 February 2012

Outcome 17: Notification of incidents

17. The person in charge is failing to comply with a regulatory requirement in the following respect:	
The person in charge had not fully exercised her responsibility in relation to the submission of notifications to the Chief Inspector.	
Action required:	
Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident including the incidence of pressure sores.	
Action required:	
Provide a written report to the Chief Inspector at the end of each quarter of the occurrence in the designated centre of any accident.	
Reference:	
Health Act 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems Standard 30: Quality Assurance and Continuous Improvement Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All notifications to the Chief Inspector will be submitted within the specified timeframes.	Immediate, i.e. 11 November 2011

Any comments the provider may wish to make:

Provider's response:

We wish to acknowledge the fairness and courtesy shown by the inspection team during the three days. While the process by its nature can be somewhat stressful for staff and indeed residents, the inspection team were very helpful and explained the process in detail.

We found the explanation at final report to be very clear on how to proceed with the improvements required to practices and procedures.

Our aim and priority is to provide a high quality service to ensure the care, happiness and safety of our residents and the inspection process greatly assists us in achieving this.

Provider's name: Liam Long

Date: 11 November 2011