

Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people



Centre name:	St. Attracta's Nursing Home	
Centre ID:	386	
Centre address:	Hagfield	
	Charlestown	
	Co Mayo	
Telephone number:	094-9254307	
Fax number:	094-9254019	
Email address:	stattracta@eircom.net	
Type of centre:	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public	
Registered provider:	Kathleen Donohue	
Person in charge:	Caroline Gibbons	
Date of inspection:	03 October, 13 October and 18 October 2011	
Time inspection took place:	Day 1 Start: 09:20 hrs Day 2 Start: 09:10 hrs Day 3 Start: 09:15 hrs	Completion: 19:30 hrs Completion: 17:15 hrs Completion: 10:30 hrs
Lead inspector:	Patricia Tully	
Support inspector:	Bríd McGoldrick (on 03 October and 18 October 2011)	
Type of inspection:	<input checked="" type="checkbox"/> Registration – Application to vary condition <input type="checkbox"/> Scheduled <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

Description of services and premises

St. Attracta's Nursing Home is a purpose-built care facility. It has been built in two phases, with the original home commencing operation in 1992. The second phase has been completed in 2011 and the occupation of this new wing is the subject of this inspection. The inspection was carried out to determine approval to grant a variation to the current registration conditions, which is to increase capacity from 54 to 67 residents; and to the variations set out in the statement of purpose which has been amended to cover all aspects associated with the increased capacity and associated level of services, staffing and facilities. The centre provides care to people over 18 years who require long term care, people who have dementia care needs and those who wish to avail of respite or convalescent care.

The original building is single-storey and the extension is a two-storey structure directly connected to the right of the original building. The additional accommodation for the residents is on the ground floor and the upper floor provides for staff facilities, storage, offices and meeting/training room and is built to a high specification.

The existing premises will be enhanced by the layout and design of the new extension as it offers 15 additional single en suite bedrooms, communal spaces, a dining room, sluice room, visitors' room, reception area, office accommodation, meeting room, staff facilities, storage areas, outdoor and enclosed garden areas, visitor and staff parking.

The current accommodation comprises of 18 double bedrooms, 15 single bedrooms and one triple bedroom. The extension to the nursing home will facilitate the reconfiguration of an existing single bedroom to be converted to a smoking room and a meeting room to be utilised as a store room. The additional 15 en suite rooms and the reduction of one double bedroom to single occupancy will enhance the quality of life and care for the residents by affording greater privacy and choice to residents who would like to reside in a single room. With the occupation of the new extension the nursing home will accommodate a maximum of 67 residents in 30 single bedrooms, 17 double bedrooms and one triple bedroom.

The gardens around the building are landscaped and there are a number of enclosed gardens.

Residents have access to nursing care, physiotherapy and activation programmes in-house and GP, multidisciplinary and specialist services are sourced externally as required.

A day care service is provided for people from the locality if required and deemed appropriate to meet their needs. This service can be a way of introducing life in the nursing home and can be a way of assisting prospective residents in their decision making to take up residency in the nursing home, in consultation with their relatives.

Location

St. Attracta's Nursing Home is set on an elevated site with spacious grounds in a rural location approximately 3 kilometres south of Charlestown, Co Mayo and 3 kilometres north of Knock airport just of the N17 and a short distance from the N5.

Date centre was first established:	June 1992
Number of residents on the date of inspection	52
Number of vacancies on the date of inspection	2

Dependency level of current residents	Max	High	Medium	Low
Number of residents	39	11	0	2

Management structure

The registered provider is Kathleen Donohue. Alison Moore as Assistant Director of Nursing is currently carrying out the role of the Person in Charge. An NF30 pack was subsequently received and a fit person interview was held with Alison Moore on the 18 October 2011. The Person in Charge is assisted by two clinical nurse managers, Niamh Rowley and Lizy Joshy. They are supported by a team of nurses, carers, and ancillary staff, external services and a volunteer.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on morning of inspection	1	4	7	3	2 cleaning and 1 laundry	1	4* 1**
Number of staff on duty on afternoon of inspection	1	4	7	3	2	1	4*

*1 physiotherapist, 2 activity coordinators, 1 maintenance man

**1 volunteer

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*.

The inspection of the centre by the Health Information and Quality Authority (the Authority) was carried out following receipt of the application to vary conditions of registration in accordance with section 52 of the Health act 2007 and the Health act 2007 (Registration of Designated Centres for Older People) Regulations 2009.

Documentation examined included the application for variation of conditions of registration, plans of the new extension, fire safety records, health and safety documentation, operational policies and procedures, staff files, complaints and incidents log, residents' care plans and medication records. The inspectors also reviewed the previous report and action plan, mandatory notifications and information received by the Authority.

All the required policies and procedures were in place. There is a risk management process covering a range of risk factors including fire safety arrangements. However, the evacuation signage needed to be updated following renovations to ensure safe evacuation procedures were in place. Some emergency exit signs were found to be unlit and one sign's directional arrow was directing people in the wrong direction from the actual fire exit. Actions required to address these failings were also included in the immediate action letter issued on the 5 October 2011.

Inspectors met with residents, relatives, staff, the registered provider and the acting director of nursing as the current person in charge. There had been changes to the person in charge personnel which had not been notified to the Chief inspector of Social Services as required under regulation 37 and 38. An action to submit notification and the required documentation for the current person in charge was also included in the immediate action letter issued on the 5 October 2011.

The existing building was very well maintained and the new extension has been designed and built to a high specification. The standard of cleanliness was very good throughout the building however, labels were missing of some bottles containing hand sanitizers and liquid soap.

A secure garden is available but the access from the garden to the centre is compromised by use of fire doors which cannot be opened from the outside and this is included as an action in the action plan at the end of the report. Additional enclosed gardens will be accessible from the new dining room and a small courtyard will be accessible from the new lobby. The paving used in this area does not support safe mobility and requires consideration of its use by residents. The existing parking to the front and rear of the building will be enhanced by additional parking adjacent to the new wing.

Review of findings at previous inspection

The inspectors found at the last inspection in March 2010 that some aspects of the service needed improvement in the following areas:

- provision of bathrooms/showers for the number of residents was below what is required by the standards
- storage space for equipment was insufficient
- absence of hand washing facilities in the cleaners' areas
- the need for the ongoing assessment of residents' potential to improve
- assurance that residents were not unnecessarily cared for in hydro tilt chairs
- ongoing need to review the use of psychotropic/sedative medication so that it is used only in response to clearly identified clinical need.

Inspectors confirmed by observations, review of documentation and written confirmation from the provider that improvement had been made in respect of:

- the provision of hand-washing facilities in the cleaners' area was in place
- ongoing assessments of residents' potential to improve and the response to increase need by the improvements in the choice and range of activities offered were documented in care plans reviewed by inspectors
- a review had been carried out on the use of psychotropic/sedative medication and the report was reviewed by inspectors. The outcome of the audit is assurance that psychotropic/sedative medication is used only in response to clearly identified clinical need as evidenced by interviews with staff and review and care plans
- improved mealtimes by the operation of two sittings was operated daily
- an independent person has been nominated to manage the complaints and documented in all required policies, procedures, guides and statement of purpose
- a detailed resident description sheet had been developed for each resident in the event of an unplanned absence from the centre.

The completion of the outstanding actions in terms of storage, staff facilities and visitors' room are dependent on the occupation and utilisation of the additional facilities provided for in the new extension. The laundry will not be addressed until the next phase of developments.

Information Received by the Authority

The provider led investigation report in response to information received by the Authority concerning staffing levels and resident's healthcare and welfare was evaluated in conjunction with documentation in the centre. A comprehensive complaints policy and procedure is in place and a complaints log is maintained. There were no complaints logged around the 20 August 2011 as referenced in information received by the Authority. No employee had been employed recently that matched the information given by the caller to the Authority. The information provided was therefore considered by the inspectors to be misleading and possibly vexatious in

origin. However, on review of files and minutes of meetings and staff interviews, there was evidence that staff supervision at night requires improvement.

The inspectors were satisfied that residents received a good standard of care based on the inspector's observations, feedback from residents and an examination of care records.

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

A written statement of purpose was available and it broadly described the services and facilities provided in the centre. Some gaps in the statement of purpose were identified to the provider and following amendment the version dated October 2011 now meets all of the requirements of Schedule 1 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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 previous inspection the provider and PIC had established regular meetings to discuss with residents and their representatives any matters in relation to reviewing and improving the quality and safety of care, and the quality of life of residents. Inspectors viewed minutes of the two such meetings and the PIC provided

inspectors with examples of how some changes were made in response to issues raised at these meetings.

The person in charge provided inspectors with audits that had been carried out on incidents and also on complaints and planned changes to be made in future record keeping was outlined. The PIC also confirmed that the residents' care plans were reviewed at three monthly intervals. An external agency was engaged to review the policies and procedures and amendments have been made to shortfalls identified in the policies as confirmed in writing by the person in charge.

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

Residents and their relatives reported to inspectors that they had easy access to the provider and the acting director of nursing to whom they felt they could openly report any concerns and if they were not available they would talk to any member of staff. They held the view that their concerns were taken seriously and acted upon. Staff spoken to clearly articulated adequate response to effectively managing complaints and they could give a satisfactory outline of the appropriate reporting relationships in relation to processing a complaint.

A comprehensive complaints policy and procedure is in place. It was also described in the residents' guide and the statement of purpose.

A complaints log has been maintained. Complaints are audited monthly. A spreadsheet of the September audit was reviewed by the inspector. Complaints and incidents have been captured in the same log since March 2011. The combining of complaints and incidents in the one log has proven unsatisfactory in terms of tracking and auditing. There was no clear sequence of events and records viewed did not contain all the relevant details such as appropriate times, dates, and required signatures. The person in charge concurred that the combination of the two did not lend itself to ease of tracking and auditing. She agreed that the logs for incidents and complaints needed to be separate.

An advocacy service is available to residents through the Mayo advocacy service who attend monthly meetings with the residents.

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

Inspectors viewed adequate written operational policies and procedures relating to residents' personal property and possessions. There was adequate space provided for a reasonable number of personal possessions.

A log is kept of residents' pocket money and transactions were found by inspectors to be signed by the resident or their relative and a member of staff. Good practise guidelines would indicate that a second signature safeguards residents and staff and funding should always be safely stored in a secure safe with limited access in line with written policy and procedures.

It emerged during the review of documentation received with the provider led investigation report that a staff fund is in operation in the centre which is funded by donations. Copies of thank you cards were attached to the report and three of these cards document the enclosure of sums of money to the staff fund. When questioned, neither the provider nor the person in charge could clarify how this practise began or how relatives knew of the existence of such a fund. No written policy or procedure was in place for the management of this fund. While there was no evidence that this fund was promoted in any way, there was also no evidence available publicising that gifts were actively discouraged by notifying residents or relatives on admission or discharge and stating such policy in the residents guide.

A comprehensive policy and procedure was available on elder abuse. However, not all staff interviewed were fully aware of what to do in the event of witnessing an incident of abuse. There was no system to ensure that the staff understood the centre's policy and procedure in relation to elder abuse, including reporting procedures. Training records provided by the person in charge indicated that 21 staff had not received elder abuse training in 2011.

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

Inspection findings

The environment was kept clean and was well maintained. There were measures in place to control and prevent infection, including arrangements for the segregation and disposal of waste, including clinical waste. Staff spoken to had received training on the risks of infection. Staff had access to supplies of latex gloves and disposable aprons and they were observed using the alcohol hand gels.

Inspectors viewed centre-specific written operational policies and procedures relating to the health and safety of residents, staff and visitors. There were measures in place to prevent accidents and facilitate residents' mobility, including safe and appropriate floor covering. The provider had developed a risk management policy to inform practice and there was a health and safety statement in place.

Documents such as the health and safety policy, fire safety and emergency procedure were appropriate in content and described arrangements and the roles that staff had to undertake in specific situations. Staff confirmed that they had regular fire safety training and there was a record of the regular fire drills and checks of the fire alarms and fire fighting equipment.

Inspectors reviewed the fire records which showed that fire safety equipment, including the fire alarm and emergency lighting, had been serviced at appropriate intervals. Fire safety and evacuation training took place on an annual basis. Three staff were recorded as not having received fire training in 2011.

The provider had submitted a satisfactory fire certificate in relation to the centre and the procedures to be followed in the event of fire were displayed in a number of locations. However, inspectors observed the key to a fire doors adjacent to the laundry was missing, not all emergency exit signs were illuminated, the double fire doors out of the dining were not alarmed and were easily opened using the push-bar mechanism and a fire exit directional sign was incorrect which were brought to the attention of the provider and the person in charge for immediate action.

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. 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. Inspectors viewed the processes in place for the handling of medicines, including controlled drugs, as being safe, secure and in accordance with current guidelines and legislation. Nursing staff spoken to demonstrated an understanding of appropriate medication management and adhered to professional guidelines and regulatory requirements.

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

Residents had opportunities to participate in activities, appropriate to their interests and preferences. The arrangements to meet residents' assessed needs were set out in individual care plans, which were drawn up with the involvement of residents and were subject to review.

All staff are actively encouraged to communicate with residents as reported by the administrator who welcomes the opportunity to be able to relate to residents. The provider informed inspectors that a number of the care assistants are assigned the role of activities coordinator. Inspectors observed staff interacting with small groups of residents and residents told inspectors that they liked bingo and card playing.

The provider informed inspectors that she is going to assign one of the coordinators to weekend duty so that activation is available seven days a week for residents in the centre to ensure that activities are improving the quality of life of residents in the centre. The provider has also engaged external activity programme providers and an exercise programme was observed in action on the day of the inspection with a number of residents participating.

Inspectors examined residents care plans and found them to be of a good quality, clear, comprehensive and person-centred. Recognised assessment tools were used to 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. Consents, monthly weight and restraint assessments were also recorded. Three-monthly reviews were completed, dated, and signed by staff and residents. There was evidence of resident and relative involvement in the care plan review as relative's signature was present. A daily log is completed by each shift on the communication sheet. Referrals to multidisciplinary therapists were also recorded. However, one resident who was on thickened fluid did not have a referral to the dietician recorded in her care plan. The provider and the person in charge informed inspectors of the difficulties they are experiencing in accessing speech and language therapy. Referrals are available on an out patient basis only. While the provider and the person in charge confirmed that six new chairs had recently been purchased, five residents were found to be sitting in hydrotilt chairs with no footrests. The person in charge reported that the HSE occupational therapist has agreed to review residents but that this is limited to residents who require specialist seating.

A care plan audit was carried out in June 2011 and one of the recommendations was that the 'All about me' tool and activities survey be used to update the existing social care plans.

One of the actions in the previous inspection report was to store the care plans in secure units. This action can not be completed until the filing storage facilities become available in the new extension. The person in charge and the nursing staff outlined to inspectors how they are moving towards an electronic system with the first of the system in operation which is utilised by care staff to complete their daily logs. The implementation is planned on a phased basis towards a non paper based system. Input monitors are situated on corridors with code access by the appropriate staff so that there is efficiencies in accessing the system and documenting key information.

The centre had general practitioner (GP) cover and access to out-of-hours GP services. Residents were encouraged to retain their own GP. The sample of medical records reviewed also confirmed that the health needs and medications of residents were being monitored on an ongoing basis. However, evidence was not available that all residents had received their three monthly medical reviews. This is a matter to be taken up with the GPs by the provider and the person in charge. Initial discussions have taken place and further meetings are to be held so that there is compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

An incident was also recorded in regard to a GP not attending a resident. The action recommended to staff by the person in charge was to contact the out-of-hours service should the GP not visit the resident. This incident was discussed with the provider and the person in charge and inspectors were advised of a number of meetings taking place with the GP to ensure that a satisfactory response to requests for medical intervention and reviews are provided.

Risk assessments were undertaken before introducing bed rails. The consent forms used did provide details on the reason for the use of restraint and duration for its use signed by residents when possible. However 39 of the 52 residents were recorded as using bed rails, a practise which did not reflect the centre's policy or statement of purpose, and therefore needed to be reviewed.

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

Inspectors viewed the centre's policy on end of life care which was adequate, and a sample of care plans showed that residents' end of life care needs were assessed and documented, and discussed with residents and relatives. The PIC confirmed that each resident would receive care at the end of his/her life which met his/her physical, emotional, social and spiritual needs and respected his/her dignity and autonomy.

The current service will be enhanced by the addition of the palliative care room available in the new extension.

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 observed a plentiful supply of fresh and frozen food. Residents spoken to said that they "can get whatever I want" and "the staff are wonderful people".

The use of protective clothing at mealtimes was commented on by inspectors in terms of dignity but residents confirmed that they have the choice to use them or not and the provider stated that the protective clothing are sought by residents to protect their clothes from soiling. Serviettes are also provided so residents do have a choice. Inspectors saw that residents who needed their food pureed or mashed had the same menu options as others and the food was presented in appetising individual portions. However, staff were observed assisting residents while standing and in a rushed manner.

Jugs of water and a variety of juices were available in common areas and staff regularly offered drinks to residents. Residents told inspectors that they could have tea or coffee and snacks any time and this was evidenced in practice.

Inspectors who met the chef discussed the special dietary requirements of individual residents and how these diets are facilitated such gluten free and diabetic. Inspectors saw that she kept information on residents' dietary needs and preferences in the kitchen. The chef said she got her information from nurses and from residents whom she met in the dining room. She personally served the tea after lunch as this gave her an opportunity to engage with residents and find out their likes and dislikes. She also confirmed that the provider and the person in charge "go to all rounds to get whatever the residents like". However complaints logged indicated that there was some dissatisfaction with the temperature of the food. Inspectors found that teas and coffees were cool and the temperature of the boiler was checked. This was found to be at 92°C when coming out of the boiler but dropped to 68°C very quickly in the tea/coffee crockery. The provider agreed to review temperatures of the food and hot drinks and to consult with residents on their satisfaction levels. It is anticipated that the move to the new dining room and serving arrangements facilitated by the recent kitchen alterations will improve the overall dining experience for residents.

The chef is up to date in her training and recently completed a dysphasia course which gave her a better understanding of residents needs. She also reported that the speech and language therapist had recently assessed some residents with swallowing difficulties and thickening powder was observed being prepared for residents.

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

The provider confirmed that there was an agreed contract with each resident within one month of admission. She also confirmed that each resident's contract deals with the care and welfare of the resident in the centre and includes details of the services to be provided for that resident and the fees to be charged.

A new contract format had been drawn up which residents had received but shortfalls were identified in that the contract did not reflect the ethos of the centre as portrayed in the statement of purpose and the fee structure for additional charges such as hair dressing was unclear.

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 and Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings

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

Residents, visitors and staff told inspectors that both the provider and the PIC were regularly available and they felt that communication was welcomed and encouraged. Inspectors observed good interactions between staff and residents. There was a high visibility of staff in the sitting room and they were observed chatting freely with residents. Residents stated that they felt that they were able to talk to staff at any time. Relatives spoken to were satisfied with information provided by staff about residents' healthcare and general wellbeing. A residents' meeting had been held on two occasions. It met approximately every 2-3 monthly and provided residents with an opportunity to voice their views and participate in the running of the centre. Minutes from these meetings, viewed by the inspectors, showed that it was attended by most of the residents and issues discussed included the activities in the centre and access to newspapers (some residents suggested that all residents should have to contribute towards paying for newspapers but agreement was not reached at this meeting in relation to this matter).

Staff spoken to understood their responsibilities in maintaining dignity, modesty and privacy of each resident through the manner in which they addressed and communicated with residents, and by ensuring appropriate discretion when discussing the resident's medical condition or treatment needs. All residents were dressed well and according to their individual choice. Inspectors observed staff knocking before entering residents' bedrooms, waited for permission before entering, and curtains were used in semi-private rooms to ensure that privacy and dignity was maintained.

Inspectors observed that residents had access to televisions, radio and a telephone. There was an open visiting policy and inspectors met visitors at different times over the two days. Most residents could meet with their visitors in the privacy of their own rooms. However, there were no suitable facilities provided for residents to meet visitors in communal accommodation and there was no suitable private area separate from the residents' own private rooms. This shortfall has been addressed with the facilities provided in the new extension.

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

Residents were encouraged to personalise their rooms and inspectors visited rooms that contained residents' photographs, pictures and other personal belongings. All residents had adequate storage space for clothes and personal possessions and had access to a lockable storage space. The PIC confirmed that each resident retained control over their personal possessions and there was a record kept of each resident's personal property. These records were signed by the resident where possible or their relative as an alternative and each record was kept up to date as required.

There is a laundry system in place and the laundry room is located adjacent to the kitchen. The staff member in the laundry was knowledgeable about infection control and the different processes for different categories of laundry. Residents' clothing was marked and all residents' clothes were folded and returned to the residents' cupboards by the laundry staff. While the laundry was functional, there was inadequate space to sufficiently segregate soiled and clean laundry. The provider advised inspectors that the improvements to the laundry would be undertaken in the next phase of developments.

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 is working full-time and she was a registered general nurse with the required experience and clinical knowledge in the area of nursing older people and she had a current registration PIN. During the fit person interview the person in charge demonstrated a willingness and commitment to the delivery of person-centred care and to meeting the regulatory requirements in line with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) or the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

The person in charge is supported by the provider who is in the centre daily. The provider supports the person in charge to attend training relevant to her role. She had completed a higher diploma in gerontology in 2010 and she is to explore mentoring options to support her on a continuous basis in her new role.

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 recruitment procedure was clearly outlined. The provider and the person in charge outlined the recruitment process.

There was evidence of appropriate Garda Síochána vetting: however, from the staff files reviewed not all the information as required under Schedule 2 was available in all files.

There was ongoing training for staff and this was based on statutory requirements, personal development needs identified and the needs of residents. Training records for 2011 show that three staff have not received fire training, five staff have not received manual handling training and 21 staff out of the total staff compliment of 68 have not received elder abuse training. Staff interviewed reflected inspection findings of poor knowledge particularly in relation to elder abuse. A shortfall was identified in staff not demonstrating a good knowledge of elder abuse during staff interviews.

Infection control measures were of a high standard. 34 of the 68 staff have received training in infection control.

Inspectors found that the skills mix of staff on night duty were insufficient to meet the needs of residents on day one of the inspection on the 3 October 2011. The registered provider and the person in charge both acknowledged that additional night staff and staff supervision would enhance the service and improve the safety and quality of care for residents. The inspector was informed by the person in charge on the second day of the inspection on the 13 October that the skill mix had been changed from one nurse and three carers to two nurses and two carers. A second nurse had been employed to cover skill mix change on the night roster which commenced on the 10 October 2011 and that staff on day and night rosters will be interchangeable in future so that all staff will rotate on night duty. This is regarded by inspectors as a welcome initiative on the part of management in assuring resident care and welfare and up-skilling and supervision of staff.

Staff spoke clearly about their current roles and delegated responsibilities. They were praiseworthy of the provider and the person in charge and the ongoing support they receive on a daily basis and that it was a very positive environment to work in with the resident's needs being at the core of everything that they do. There was an established induction programme and the person in charge and the provider outlined how new staff work alongside permanent staff, observing procedures and practices and reading policies appropriate to their roles prior to taking on healthcare duties and responsibilities. Inspectors reviewed minutes of monthly staff meetings.

Inspectors found that the rosters to be complex and difficult to follow as they are broken into morning shift, evening shift and night shift and by discipline. A planned rota is not maintained separately to the actual rota. The planned rota is used to document staff changes which render it difficult to examine and ensure rotas are covered. A review of the roster is required. All staff who participates in duties should be reflected on the roster.

Additional staff will also be required with the expansion of services for 13 additional residents and to ease the transition to the new extension. There will also be inherent demands as a direct result of the larger building and widely spread layout with sleeping accommodation wings a good distance apart.

An implementation plan has been submitted by the person in charge which sets out the transitional arrangements during the expansion of the services into the new extension. The plan setting out the staff numbers and skill-mix as determined by the size and complexity of the service, to ensure that there are sufficient numbers of competent staff and skill mix on duty, both day and night, to meet the needs of residents has been deemed satisfactory by the inspectors which must remain adaptable to meet any unforeseen risks.

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

Residents reported that the centre offered a homely and comfortable environment and this is in keeping with the ethos described by the provider and the person in charge and which is also reflected in the statement of purpose. Communal areas such as the day-rooms had a variety of pleasant furnishings and comfortable seating and offered beautiful views of the surrounding countryside. The move to the new dining room will result in the conversion of the exist dining are to additional sitting area and space for activities. The premises were adequately clean, well lit and well ventilated in the communal areas. However, the meeting room used by inspectors during the inspection were found to have 4 observations windows with blinds which were operational from the meeting room. The windows looked directly into the two double rooms with unrestricted views. When pointed out to the person in charge, she was unclear as to their original purpose and stated that there was no policy in place covering the use of this observational facility.

The facilities will be greatly enhanced with the utilisation of the new extension which offer additional single bedrooms, storage, dining area, sluice, assisted toilets and bathrooms, visitors are, garden space palliative care, staff facilities and additional parking. Parking bays had not been marked out at the time of the inspection. Because the centre is on an elevated site, a risk assessment of access to the centre by car and residents mobilising around the centre is recommended to ensure the safety of the residents, relatives and staff in gaining access and leaving the centre. This review should inform the layout of parking space and directional signs for traffic and access to the main entrance which will be through the new entranceway/reception area.

The kitchen was found to be well-organised and equipped with sufficient storage facilities. A new kitchen had been fitted on the 13 August 2011 and staff reported that this was an excellent improvement and assisted them greatly in food preparation and serving. Access to staff toilet facilities from the kitchen area was discussed with the chef and the provider in terms of distance to the facilities in the new extension. The provider agreed to re-designate the existing staff toilet adjacent to kitchen staff only.

Hand rails were fixed along all corridors. There was appropriate assistive equipment available such as hoists, pressure relieving mattresses, wheelchairs and walking frames. However, there was inadequate storage space available so that equipment such as a hoist and wheelchairs was stored in shower rooms and hoist flex was found to be plugged into a socket in the corridor and trailed into the assisted bathroom which is unsafe practice. While extensive storage will be available in the new extension, adequate storage for equipment is required in the existing premises so that it is easily accessible.

There were a sufficient number of toilet and washing facilities with wash-hand basins in each bedroom and communal toilets located in close proximity to the communal dining and seating areas. Water tested was found to be within the recommended range of temperature.

7. Records and documentation to be 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:

All the schedule 5 policies were available but were not centre-specific in all instances. An external company had been engaged to help develop the range of documents needed.

The person in charge reported she is in the process of reviewing policies and procedures, for example, "recent audit of policy PR-001 identified a non conformance with section 6 (the policy refers to a code of behaviour) which is not in place".

CCTV is in operation in the centre with 36 views recorded internally and externally. Policy and procedural documents were not available covering CCTV usage.

Resident's Guide

Substantial compliance

Improvements required*

The inspector was provided with a copy of the centres resident guide which contained the information required by regulation.

Records in relation to residents (Schedule 3)

Substantial compliance

Improvements required*

General Records (Schedule 4)

Substantial compliance

Improvements required*

Incidents and complaints need to be recorded in separate logs and give full account of actions taken including, observations and referral to GP in the case of incidents and the actions and outcome including the complainant's satisfaction with the outcome in the case of all complaints.

Operating Policies and Procedures (Schedule 5)

Substantial compliance

Improvements required*

All policies and procedures to be reviewed to ensure they are centre-specific.

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*

Insurance cover in place against loss or damage to the property of residents does not include liability as specified in Regulation 26 (2).

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 noted that quarterly written report returns had been made in respect of the last quarter. However, there was no record of a written report having been returned to the Authority regarding an alleged misconduct of four staff members on the 22 August 2011. Following discussion with the provider and the person in charge (PIC), the PIC confirmed that no written notification had been made to the Authority in respect of this incident. Notifications were submitted subsequently on the 17 October 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

Notifications have been received over the past 18 months setting out the procedures and arrangements for periods during the long term absence of the person in charge. However, the registered provider failed to notify the Chief Inspector of Social Services without delay of changes in the substantive post of the person in charge and the procedures and arrangements in place in the designated centre since those changes were instigated three months previously. This failing was included in an immediate action letter issued to the provider on the 5 October 2011.

The required notification was received by the Authority on the 13 October 2011 in response to the immediate action letter of the 05 October 2011. Alison Moore, as notified to be the person in charge was processed as part of the application to vary conditions of registration and was deemed fit by the inspectors.

Closing the visit

At the close of the inspection visit on the 03 October 2011, a feedback meeting was held with the provider and the acting director of nursing to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

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

REPORT COMPILED BY

Patricia Tully
Inspector Manager
Social Services Inspectorate
Health Information and Quality Authority

03 November 2011

Provider's response to inspection report

Centre:	St. Attracta's Nursing Home
Centre ID:	386
Date of inspection:	03 and 13 October 2011
Date of response:	18 November 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, 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*.

Outcome 4: Safeguarding and safety

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

To make all necessary arrangements, by training staff or by other measures, which are aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse; and record any incidence and take appropriate action where a resident is harmed or suffers abuse.

Action required:

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.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

Action Required:	
Provide suitable training for staff in fire prevention.	
Action Required:	
Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.	
Action Required:	
Display the procedures to be followed in the event of fire in a prominent place in the designated centre.	
Reference:	
Health Act, 2007 Regulation 30: Health and Safety Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Fire certification for all areas of the existing and new building complete. Fire evacuation diagrams introduced in all bedrooms and key areas. Regular checks carried out on all fire equipment and extinguishers. Emergency exit directional signs in line with safety regulations BS5499. Two signs replaced. Checks carried out on all fire exits. One exit door release changed to push bar. All fire exit signs checked to ensure visibility. Light fixtures changed to ensure same. Schedule of fire testing and records for existing and new build. Records of fire drills and fire equipment testing submitted in response to immediate action request of 5 October 2011.	Completed in response to immediate action request of 5 October 2011

<p>Further fire training and evacuation training.</p> <p>Our fire training records demonstrate a commitment to ensure appropriate fire training is maintained for staff. Training was held on 26 and 28 January 2011, 21 and 24 February 2011 and 7 and 10 March 2011. Full nursing home evacuation on 14 June 2011, further training on 8 September 2011, 26 September, 1, 2 and 14 October 2011 and 2 November 2011. Of the records reviewed on the day of inspection three staff members had not received training at that point in time.</p>	<p>Completed 2 November 2011</p> <p>Training remains an ongoing priority</p>
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Outcome 5: Health and safety and risk management

<p>5. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>To provide a comprehensive written risk management policy that takes account of the risks associated with the move to and use of the new extension and the surrounding grounds and traffic flow.</p>	
<p>Action Required:</p> <p>Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.</p>	
<p>Action Required:</p> <p>Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems</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>A change control plan was submitted as part of the documents required for consideration of the request to vary conditions. The plan identified risk factors specific to moving into new surroundings i.e. resident absconding, infringement of residents rights, insufficient communication, inadequate staffing, resident disorientation, staff disorientation. The plan demonstrated a phased occupation of the new accommodation areas to ensure</p>	<p>Plan submitted on 25 October 2011. Review of plan ongoing as occupation of new accommodation progresses.</p>

risks to residents were reduced which has been included in the risk management policy and records as appropriate.	
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Outcome 7: Health and social care needs

<p>7. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>To ensure that each resident receives timely medical attention as required by the resident's changing needs.</p>	
<p>Action required:</p> <p>Provide appropriate medical care by a medical practitioner of the residents' choice or acceptable to the residents.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Health Care Standard 18: Routines and Expectations</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>GP's are requested to attend to residents when nursing staff assess there to be a clinical need or the resident requests that their GP see them. The PIC has discussed with GP's their criteria for making a visit when requested and has been informed that the decision to visit is based on the clinical information given, the assessment of urgency and timescale for visiting is a decision made by the GP based on their assessment of clinical need. It is recognised that GP's have to balance such requests in line with clinical priorities and demands at the time of request.</p>	<p>Ongoing</p>

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>To arrange for the full multidisciplinary assessment of residents with identified needs in terms of seating and nutrition.</p>	
<p>Action Required:</p> <p>Facilitate each resident's access to occupational therapy, clinical nutrition or any other services as required by each resident.</p>	

Reference: Health Act, 2007 Regulation 9: Health Care Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>During the inspection, the person in charge informed inspectors that she had had discussions with community occupational therapy regarding assessments for support chairs and referrals have been made. Referrals to speech and language therapy are through GP's only and a letter had been sent to GP's on 5 July 2011 requesting referral for eight residents to this service. A response had been received from the speech and language service stating that the service was only able to assess people in the outpatient clinic as no domiciliary service is available. Individuals would also need to be mobile, to self transfer and be able to position themselves upright. As all those referred were maximum dependency residents this criteria could not be met. Referrals to multidisciplinary services were noted by the inspectors in the records reviewed and as identified in this report p. 12 "Referrals to multidisciplinary therapist were also recorded."</p>	Ongoing as evidenced in the report.

Outcome 9: Food and nutrition

9. The person in charge is failing to comply with a regulatory requirement in the following respect:	
To provide appropriate assistance to residents during mealtimes.	
Action required: Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.	
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>The provider wishes to stress that the care ethos of the staff at St</p>	Ongoing

<p>Attracta's is one of providing appropriate assistance to residents during mealtimes. Normal practice is for staff to sit with residents requiring assisted dining and ensure a non hurried mealtime. The CCTV footage of the dining rooms were reviewed and of the staff noted to be providing assisted dining they were all seated. The provider is unable to confidently establish if a staff member may have been standing that was not viewed by the CCTV. However, the provider does recognise that there were staff moving around the tables clearing from them and this may have contributed to feeling of a 'hurried' dining experience. The current dining area is cramped and again this would contribute to a 'busy' feeling during the meal time. We are confident that when the new dining area is able to be utilised the greater space will afford a more relaxed dining experience and ensure staff have space to sit and assist residents.</p>	
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Outcome 10: Contract for the provision of services

<p>10. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>To ensure that the contract specifies the services to be provided and the cost of the services.</p>	
<p>Action required:</p> <p>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 and the fees to be charged.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 7: Contract/Statement of Terms and Conditions</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>A revised contract of care has been forwarded to the inspectors as part of the information required to vary conditions. The cost of services has been clearly specified.</p>	<p>Completed</p>

Outcome 14: Suitable staffing

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

To ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre and to maintain a planned and an actual rota.

Action required:

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

Action required:

Maintain a planned and actual weekly staff rosters, showing staff on duty covering 24 hour periods.

Reference:

- Health Act, 2007
- Regulation 16: Staffing
- Regulation 24: Staffing Records
- Standard 23: Staffing Levels and Qualifications

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

Timescale:

Provider's response:

Skill mix on night duty has changed to have two nurses on duty with carers. The numbers of staff on duty will reflect the number of residents and their dependency level also once the new building is operational the size and lay out of the building will inform staffing levels.

A planned rota is now kept separately from the 'actual operational' rota to be able to clearly demonstrate 'planned' staffing levels and 'actual'. Only changes and amendments will be recorded on the 'actual' rota.

Immediate

Outcome 14: Suitable staffing

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

To provide appropriate training in manual handling and fire safety.

Action required:	
Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Reference:	
Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>We are committed to ensuring that all staff are appropriately trained and in a timely fashion to ensure they have the appropriate skills to provide the care required by our residents. The training records reviewed on the day of inspection were records of all training provided in 2011. The PIC and provider plan a schedule of training in advance which covers a 12 month period, training is also provided as needs are identified i.e. new staff. The CNM is also a trainer for manual handling. Elder abuse and manual handling training is renewable two yearly, fire training six monthly.</p> <p>Fire training was provided on 26 and 28 January 2011, 21 and 4^t February 2011, 7 and 10 March 2011, Full nursing home evacuation on 14 June 2011, further training on 8 September 2011, 26 September, 1st 2 and 14th October 2011, and 2 November 2011.</p> <p>Manual handling training was held on 9, 22 and 23 February 2011, 10 and 24 March 2011, 9 and 29 May 2011, 2, 8 and 15 September 2011, 2 October 2011 and 9 November 2011.</p> <p>Our training schedule also demonstrates other training provided other than the mandatory requirements i.e. dementia care, food handling, dysphagia management, infection control, end of life care, nutrition, care of the older person, challenging behaviour and sonas.</p>	Ongoing

Outcome 14: Suitable staffing

14. The provider is failing to comply with a regulatory requirement in the following respect:
To ensure that information and documents specified in Schedule 2 have been obtained in respect of each person employed in the designated centre.

Action required:	
Put in place recruitment procedures to ensure no staff member is employed unless the full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.	
Reference:	
Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
An audit of our recruitment and staffing procedures was carried out on 11 November 2011 and actions on the findings will be implemented.	Ongoing

Outcome 15: Premises

16. The provider has failed to comply with a regulatory requirement in the following respect:	
To provide adequate storage facilities. Inappropriate areas such as the bathrooms were used to store hoists. This compromised the use of these areas and posed a hazard when the hoist is plugged into a socket in the corridor when being recharged while being stored in the bathroom.	
To provide safe access from enclosed garden to the centre.	
Action required:	
Provide appropriate storage areas for equipment in the existing premises.	
Action required:	
Provide easy access from the enclosed garden for residents and staff when returning inside.	
Reference:	
Health Act, 2007 Regulation 19: Premises Standard 25: The Care Environment	
Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:

<p>Provider's response:</p> <p>New storage areas will be utilised in the new building once permission to use the new spaces has been authorised.</p> <p>A room currently used as a meeting room on corridor three will be designated as a store room for equipment used in the existing building.</p> <p>The doors to the enclosed garden are to be replaced which will allow easy access into the building from the garden. The doors have been ordered delivery expected in 4-6 weeks.</p>	<p>Once permission to vary conditions is granted. Immediately.</p> <p>31 December 2011</p>
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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>To review the use of restraint and maintain adequate records on restraint.</p>	
<p>Action Required:</p> <p>Review the assessment for and the instances of use of restraint and maintain, in a safe and accessible place, a record of any occasion on which restraint is used, the nature of the restraint and its duration, in respect of each resident.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 25: Medical Records</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 inspectors have acknowledged that in the records they reviewed 'restraint assessments were also recorded' p. 12 of inspection report. Whilst current practice is to record all use of restraint in the residents' record there is not a specific restraint register in place in line with HSE restraint policy. This will be implemented.</p>	<p>16 December 2011</p>

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>To have all written policies in place.</p>

Action required:	
Put in place a written and operational policy on the use of CCTV.	
Action required:	
Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and ensure that each policy is centre-specific.	
Reference:	
Health Act, 2007 Regulation 27: Operating Policies and Procedures 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>A policy on the use of CCTV is being developed.</p> <p>All policies applicable to St Attracta's nursing home have been developed in conjunction with an external company. The content of these policies are centre specific however it is acknowledged that the logo of the company used may suggest that they pertain to that company and not to St Attracta's Nursing Home. All policies are in the process of being reviewed and at this point the St Attracta's logo will replace that of the external company.</p>	<p>30 November 2011</p> <p>31 December 2011</p>

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

16. The provider is failing to comply with a regulatory requirement in the following respect:
Provide an up to date resident's guide.
Action required:
Produce a residents' guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.
Action required:
Supply a copy of the residents' guide to the Chief Inspector.

Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Standard 1: Information	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A copy of the revised residents guide including the new facilities was forwarded to the Chief inspector on 11 November 2011.	Completed

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

16. The provider is failing to comply with a regulatory requirement in the following respect: To cover liability under insurance as specified under Regulation 26 (2).	
Action required: Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).	
Reference: Health Act, 2007 Regulation 26: Insurance Cover Standard 31: Financial Procedures	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: We are unsure why we are failing to meet this regulation as there appears to be confusion over the interpretation of the wording of the regulations. Our current insurance states that we are covered to the value of €1500 for any one item and any one resident. The regulations state that the 'liability to any resident shall not exceed €1000 for any one item'. We stress that whatever insurance is required we will obtain however our insurance company have confirmed that this is a standard aspect of nursing home insurance policies.	

Outcome 17: Notification of incidents

<p>17. The person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>To maintain a separate log of all incidents in the designated centre and also failed to give notice to the Chief Inspector without delay of the occurrence in the designated centre of allegations of misconduct of persons working in the designated centre.</p>	
<p>Action Required:</p> <p>Maintain a separate record of all incidents occurring in the designated centre (separate to the complaints log).</p>	
<p>Action Required:</p> <p>Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation of misconduct by any person who works in the designated centre.</p>	
<p>Reference:</p> <p>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</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>Records of incidents and complaints were maintained manually. In reviewing this method of recording with the inspectors it was recognised that separate logs would facilitate greater tracking of events. Complaints and incidents will be logged on a separate spreadsheet and full accounts of actions will be documented. Complaints and incidents will be logged on a separate spreadsheet and full accounts of actions will be documented.</p> <p>Notice was given to the Chief inspector of allegations of misconduct on 11 October 2011</p>	<p>Immediate</p> <p>Completed</p>

Outcome 18: Absence of the person in charge

<p>18. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The registered provider failed to notify the Chief Inspector without delay of changes in the substantive post of the person in charge and the procedures and arrangements in place in the designated centre.</p>

<p>Action required:</p> <p>Give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the matters contained in Regulation 38(2).</p> <p>Submit an NF30 pack.</p>	
<p>Reference:</p> <p>Health Act, 2007 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</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>NF30 pack was requested on 5 October 2011 and has been submitted.</p>	<p>Completed</p>

Any comments the provider may wish to make:

Provider's response:

St Attracta's wishes to continually develop its service and wholeheartedly welcome the *National Quality Standards for Residential Care Settings for Older People in Ireland*. We strive to provide a quality, safe and person-centred service and welcome the inspection process as a method of constructively benchmarking our care. However, I wish to acknowledge that aspects of the first day of inspection felt stressful and caused some anguish but recognise that certain complexities of the situation contributed to this. I would like to thank the inspectors for their guidance as we continue to strive to provide a quality care environment for our residents.

Provider's name: Kathleen Donohue

Date: 18 November 2011