Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	St Vincent's Care Centre
Centre ID:	0483
Centre address:	Athlone Co Westmeath
Telephone number:	090-647 5301
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Email address:	joseph.ruane@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered providers:	Health Service Executive
Person in charge:	Mairéad Campbell
Date of inspection:	08 and 11 July 2011
Time inspection took place:	Day 1: **Start:** 10:00 hrs **Completion:** 19:30 hrs Day 2: **Start:** 06:30 hrs **Completion:** 14:00 hrs
Lead inspector:	Catherine Connolly-Gargan
Support inspector:	Florence Farrelly
Type of inspection:	☒ Announced ☐ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. These is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met 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*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

St Vincent's care centre was built in 1946 and occupies two floors. It shares the campus with a variety of community care facilities including a public health centre, mental health services, an outpatient clinic and an out-of-hours general practitioner (GP) services.

Accommodation currently accommodates 40 residents over 65 years of age requiring long-term care. However, information received post registration inspection from the General Manager Dorrie Mangan, indicated that application for registration was being made for accommodation for 42 residents.

The premises are separated into two units, the Sonas unit on the ground floor and the Auburn unit on the first floor. There is large lift to assist residents and their family with moving from one unit to another.

The Sonas Unit is located on the ground floor and can accommodate 18 residents. There are one single bedroom, two twin rooms, two rooms accommodating four residents and one room accommodating five residents. The residents in this eight-bedded room do not have en suite toilet or washing facilities. However, residents share four toilets, two of which are wheelchair accessible. There are two assisted bathrooms available for residents' use.

The Auburn Unit is located on the first floor and can accommodate 22 residents. There is four single rooms, two twin rooms, two rooms with accommodation for three residents and two rooms accommodating four residents in each. The residents share four assisted toilets and two shower rooms.

Each unit has a kitchenette. The Sonas unit has a combined lounge/dining area while these are separate rooms in the Auburn unit. The oratory is located on the first floor.

Location

St Vincent's Care Centre is located in Athlone town centre, in County Westmeath. It is convenient to all amenities including the bus and train station.

Date centre was first established:	1946
Number of residents on the date of inspection:	40
Number of vacancies on the date of inspection:	2 vacancies

Dependency level of current residents	Max	High	Medium	Low
Number of residents	28	7	1	4

Management structure

The provider of St Vincent's Care Centre is the Health Services Executive (HSE) and the designated contact person is Joseph Ruane.

The Person in Charge (referred to in the centre as the Director of Nursing) is Mairead Campbell, who has responsibility for the day-to-day running of the centre. She is supported in her role by Grainne McGabhann, Community Services Manager and reports to the General Manager, Dorrie Mangan and Local Health Manager, Joseph Ruane, who has ultimate responsibility for the service.

The Person in Charge is supported in her role locally by two assistant directors of nursing, Pauline Quast and Eithne Hanavy. Clinical Nurse Managers, staff nurses, carers, clerical officers, an activity coordinator, catering staff, chefs, maintenance department, security and portering staff, physiotherapy and occupational therapy services. The Assistant Directors of Nursing supervise the staff nurses. The staff nurses supervise the care attendants. A domestic supervisor is also in post who supervises the cleaning and catering staff.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	1 assistant director of nursing 2 x clinical nurse managers grade 2 6 x staff nurses	8	4 x catering staff in kitchenettes	2 x cleaning and 1 laundry person	2	2 x maintenance staff

Background

A scheduled announced inspection had previously been carried out by the Health Information and Quality Authority (the Authority) Social Services Inspectorate on 28 and 29 January 2010. An action plan detailing areas which required attention was forwarded to the provider post this inspection. The action plan contained 45 actions to be addressed referencing 20 breaches in the legislation. The provider's responses were not fully adequate on that occasion and a meeting was held with the local Health Officer Joseph Ruane, the General Manager Dorrie Mangan and other members of the management team on the 25 June 2010 in Mullingar to discuss their response to the action plan. A satisfactory response to the action plan was received by the Authority following this meeting.

A registration inspection took place on the 22 and 23 March 2011. A fit person interview was carried out with the provider Joseph Ruane as part of the registration procedure on the 11 April 2011 in the Authority's offices in Smithfield, Dublin. As part of the registration inspection, a follow-up inspection was completed to assess progress with completing the action plan from the inspection in January 2010. Every action was addressed, while 25 actions were satisfactorily completed, twenty actions were found to be partially completed. However, all partially completed actions were nearing satisfactory completion.

Inspectors found that there were seven allegations of elder abuse. One incident was not recognised or investigated as a possible elder abuse. The remaining six incidents were investigated. However, the outcomes were not clear. Also, five members of staff had not completed mandatory elder abuse prevention training on the day of the registration inspection.

Inspectors found that there were four medication errors, two of which referenced residents receiving unprescribed medications. A further two incidents relating to the centre were documented in the quarterly summary of accidents and incidents. While investigations were done in each case and retraining in medication management training was complete, one of the nurses involved in the incidents had not received this additional training. There was no review of the quality and safety of care to inform practice and to ensure satisfactory resident outcomes.

High legionella levels were found in the water system in the centre. Inspectors were told that all precautions were in place including flushing of water outlets and monitoring procedures. Hot water from the taps in a number of locations measured 51 -52 degrees centigrade. (Temperatures of hot water at point of contact should not exceed 43 degrees centigrade – Standard 25 *National Quality Standards for Residential Care Settings for Older People in Ireland*).

An immediate action letter was sent to the provider on the 24 March 2011 requesting further information and confirmation that residents care, safety and welfare needs were met in management of elder abuse, adverse medication events and management including prevention of legionella bacterial infection.

A satisfactory response was returned on the 01 April 2011 relating to the management of medication errors and of legionella bacterial infection. These responses confirmed that there were systems in place to manage these areas of concern. However, the response referencing the management of two alleged incidents of elder abuse by an agency staff nurse was not satisfactory. Inspectors noted that these incidents were substantiated in an investigation completed by the social worker and were not reported to the statutory authorities as directed by the centre's policy in this area.

Supervision and support for the person in charge was identified as an action in the action plan developed post inspection of January 2010 and this requirement was partially completed. While the person in charge had some support and supervision, the person in charge did not have a documented, structured induction based on an assessment of skills and knowledge requiring development from a mentor with a clear knowledge and understanding of all the requirements of this role. A new person in charge was appointed on the 20 June 2011.

Complaints procedures were not in accordance with the legislation and required revision to ensure all the requirements of the legislation were met.

Residents' access to healthcare was of a good standard. All the health services required to promote residents health and wellbeing were facilitated. Recreational activity provision was of a very good standard with a focus on inclusion of residents with cognitive impairment due to their medical conditions. The 'Butterfly Moments' approach to care was successfully implemented, with positive feedback from all involved. A variety of other activities were facilitated by a full-time trained activity coordinator based on the interests of residents in the centre.

The substantial efforts made to improve the décor and comfort of the current facilities for residents were recognised by inspectors. However, residents continued to be mainly accommodated in units which did not meet the Authority's standards. The shared site for the many other health services, although having benefits of onsite access for those residents who require them, impacts negatively on the quality of life and safety of the centre. This had not been risk assessed to reduce risks of injury.

The management of the centre has made significant improvement in a number of areas for example, person-centred care and recreational activity provision. However, the responses to some actions from previous inspections were not fully completed as agreed at the time of this registration inspection and have been restated in the Action plan at the end of this report.

Summary of findings from this inspection

This inspection was the third inspection of St Vincent's Care centre by the Authority. This inspection was a follow-up inspection to review progress with the action plan developed from findings at the centre's registration inspection on the 22 and 23 March 2011.

There were 24 actions in the action plan of which eleven were satisfactorily completed, 12 actions were partially but nearing completion. However, one action relating to the protection and security of residents and safety of the premises and the external environment was not satisfactorily completed.

While much work has been done on improving the quality of life of residents, there were a number of areas requiring improvement. Inspectors found evidence of institutional practice for example, the majority of residents were in bed for the night in the early evening. While all residents have activity assessments and there were meaningful activities in progress, not all residents were able or facilitated to avail of them. Residents could not safely go outside the centre but there was work in progress to make the front of the building safer. Residents were required to wait to be assisted to eat and not all residents were appropriately supervised at all times.

Interactions between staff and residents were of a good standard. Inspectors observed that staff in the centre on the day of the inspection were respectful and gentle in their approach with residents.

However, the findings from this inspection support on-going inadequate procedures and controls in identifying risk and prioritising the safety and welfare of residents. Water temperatures continue to be in excess of that recommended at the point of contact to avoid scald injury. Security of the centre was not of an adequate standard to protect residents from access by unauthorised persons. Although now improved, not all staff with access to the centre has elder abuse recognition and prevention training.

Management of elder abuse and protection of vulnerable residents remains an on-going issue in the centre.

The Action Plan at the end of this report identifies areas where improvements are still required to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Issues covered on inspection

1. Protection of Residents

On arrival at the centre on the 08 July 2011, inspectors noted that there was unrestricted access to unauthorised persons to the centre. Members of the public entered the centre looking for the out patient department; others were attending the physiotherapy department and the hospice.

Although there was a visitors' log in each on the units located at the door, there was no person supervising it's completion on each and every occasion. Security of the centre was not adequate and as a result residents were at risk from unauthorised access by members of the public and also at increased risk of leaving the centre unaccompanied. The Authority had received notifications of incidents of both these types of events.

A security person was onsite in the reception area inside the front door of the centre from 21:00 hrs till 06:00 hrs each night. The reception area was not staffed from 17:30 hrs up to 21:00 hrs or 06:00 hrs up to 09:30 hrs. The GP on call emergency clinic was located to the right of the lobby area. While CCTV cameras were in located at the entrances to the centre and external doors were locked at night, residents' safety needs were not fully met by this arrangement as the waiting area for the GP on call service was adjacent and accessible to the centre. Cars, vans and heavy vehicular traffic were noted by inspectors. Drivers of the delivery vehicles were delivering goods to the centre and entered the units unrestricted.

Management of elder abuse was not of an adequate standard. While all incidents were investigated, the centre's policy was not followed in response to informing the appropriate authorities. The Authority advised the provider to inform the relevant authorities which was done. The Authority also sent a letter to An Garda Síochána and An Bord Altranais referencing these incidents.

The provider and person in charge were issued with a letter from the Authority informing them that immediate action was required in the area of protection of residents by addressing the security of access to the centre to improve resident safety. The external doors were secured to control unauthorised access before inspectors left the centre on the 08 July 2011. Internal doors to the units were also appropriated secured over the weekend. The person in charge immediately responded and got approval for the work from Dorrie Mangan General Manager. A letter was received by the Authority on the 08 July 2011 in reply to the immediate action letter from the person in charge.

Actions reviewed on inspection:

1. Actions required from previous inspection:
Redraft the complaints policy to ensure all aspects of the complaints procedure are implemented and operational in the centre.

The revised policy must be displayed in the centre.

Ensure residents are fully informed of the revised complaints procedure.

Ensure the outcome and results of investigations are consistently recorded on all complaints.

These actions were satisfactorily completed.

Inspectors were informed that there were no unresolved complaints currently been investigated. The revised complaints policy was available to advise all staff on the complaints procedure in the centre. A revised flow chart displayed on both units advised on the procedure to follow if a resident or visitor wished to make a complaint. A review of the minutes of the residents' meeting of the 29 May 2011 referenced where a discussion on the revised complaints procedure took place. The complaints log referenced verbal complaints had been made. However, written complaints were also welcomed. The complaints were clearly documented and the satisfaction of the complainant was sought and documented. An audit had also been completed on the complaints made since January 2011.

2. Action required from previous inspection:
Provide mandatory training to all staff in the prevention of elder abuse and protection.

This action was partially completed.

Inspectors received signatory confirmation in the days following registration inspection of March 2011 that the five staff referred to in the inspection report and others had received training in elder abuse recognition and prevention. However, inspectors confirmed that other staff employed by the provider and having unsupervised access to the centre did not all have this training completed. The member of staff concerned confirmed that An Garda Síochána vetting was completed for him but he did not have elder abuse recognition and prevention training.

3. Actions required from previous inspection:
Provide a sufficient number of accessible bathrooms/showers having regard for the number of dependent persons and wheelchair users in the centre and in line with the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

Evaluate the ventilation to the external air in the oratory and correct deficits.

Put procedures in place to ensure that recommended maximum hot water temperatures are maintained at the point of contact throughout the areas used by residents.

Install grab rails in all showers to assist residents' independence and reduce their risk of falling.

Ensure all parts of the external areas used by residents and their relatives are suitable, safe and risk free.

Install safety railing on main stairs in the centre to reduce assessed risks to residents.

These actions were partially completed.

An additional shower has been provided on the Sonas unit with appropriate grab rails and was suitable for residents in wheelchairs. A Lossnay air exchange unit has recently been fitted in the oratory and is operational. The oratory has been refurbished to a good standard and is comfortable to rest in. The general manager informed the inspectors at the feedback of inspection findings that thermostats were delivered on site and were scheduled for installation. There were notices over each of the hot water outlet warning of 'very hot water'. The Grab rails have been erected in the bathroom referenced in the action plan from findings of registration inspection of the centre in March 2011.

Inspectors also noted that the areas either side of the main entrance to the centre had been designated as six disabled car parking spaces. The area was screened off on the day of the inspection as it paintwork was in progress. Full completion was on schedule as agreed with the Authority and the provider to be done by the end of July 2011. The provider agreed with the Authority that additional lighting and directional signage would be fitted as necessary by the end of August 2011. Inspectors were told that the site had been surveyed for this purpose. Although walkways were cordoned off with traffic cones and tape, this required a permanent upgrade to ensure the safety of pedestrians in the site. A risk assessment was received by the person in charge relating to installation of handrails either side of the main stairway. The person in charge planned to work with the occupational therapist in bringing this to a conclusion. She also indicated that she intended to evaluate the safety of the balcony area at the top of the stairs.

4. Actions required from previous inspection:
Develop a process where audits carried out are analysed as a means of reviewing the quality of life and safety of care provided for residents in the centre at appropriate intervals.

Utilise data collated to manage clinical risk and improved resident care outcomes.

Evaluate access to the garden for residents in the centre and make it safe to use by residents who are at risk of leaving the centre unaccompanied.

Complete an evaluation of the appropriateness and impact on the quality of life of residents having the MIDOC services located in the building occupied by the centre.

These actions were partially completed.

There was a process for data gathering in relation to patient care and safety parameters in place since November 2010 in the form of a resident monitoring weekly audit which inspectors viewed. This tool was recently revised to capture more specific information. This audit captured resident information relating to numbers of residents who fell, were having psychotropic medications and antibiotics, pressure related skin injury, restraints and residents who suffered pain. Staff on duty on each Sunday populated the audit and the information was stored in the nursing administration office where it was reviewed by the person in charge. Although planned, there was no evidence available of analysis of this information to identify weak areas of practice where improvements could be made and implemented. For example review of the data collated on the monitoring sheet dated 03 July 2011 for one of the units referenced where 20 out of 22 residents spent most of their time in bed, three of which had low dependency needs. In another area 14 out of 18 residents were having psychotropic medications. With the support of the 'Clinical Audit and Risk Management' department other audits were completed on resident falls, medication management, care planning, restraint management and incidents where residents go missing.

The garden designated suitable for use by residents and shared with the hospice unit was viewed by inspectors. It was enclosed by means of a field gate covered by mesh wiring. The centres' two resident dogs were freely running around the garden throughout the day of the inspection. A resident was assisted by the activity coordinator and a carer into the garden to visit the dogs on a number of occasions. While the dogs were secured in to the garden, the gate was not secure to intruders. Inspectors were told a new secure gate was on order and access to the garden from the centre was going to be refurbished to improve accessibility for all residents. The garden was also not available to residents who did not like dogs. Although inspectors were told that a risk assessment was carried out on the garden, there was no documentary evidence referencing this process. Inspectors were also told that a risk assessment had been completed on the location of the GP on-call service. However, the outcome was not documented.

The person in charge told inspectors that a meeting with the emergency GP out-of-hours service and the ambulance service was minuted where discussion took place regarding reducing the impact of the service on the quality of life of residents. Inspectors were told that the management of the centre had instructed the emergency GP service and ambulance services not to use sirens when on campus. No sirens were heard by the inspection team on the day of the inspection. There was a plan in place to ascertain residents views on the location of this service at the next residents' meeting scheduled for 23 July 2011. The provider agreed to satisfactorily complete this action by the 31 July 2011.

5. Action required from previous inspection:
Ensure each resident has a contract that deals with their care and welfare of the resident in the centre and includes details of the services to be provided for them and the fees to be charged.

This action was partially completed.

Residents have been issued with contracts, yet they are not all signed. The management team are working on achieving completion with this.

6. Action required from previous inspection:
Put procedures in place where all information relating to residents in the directory meets the legislative requirements.

This action was satisfactorily completed.

Inspectors viewed the information kept for each resident in the register of residents. An electronic copy was maintained as the master copy which was printed off and maintained for reference for staff without ready access to the register.

7. Action required from previous inspection:
Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

This action was satisfactorily completed. The provider informed the Authority that they no longer carry conventional insurance cover in relation to personal injury and third party property loss/damage risks. The provider stated that the legal liability of the Health Service Executive in relation to such claims is covered by what is called State Indemnity and these claims and associated risks have been delegated to the State Claims Agency.

8. Actions required from previous inspection:
Put procedures in place where all staff have annual fire training and are aware of their responsibilities in the event and participate in fire drills twice yearly.

Complete the fire safety declaration sent to the centre confirming that fire safety is of the required standard.

These actions were partially completed.

While inspectors were told that all staff had annual training in fire safety, there was no evidence to support full attendance by all staff of annual fire training. Staff spoken with regarding fire procedures were informed and able to articulate the procedures they would follow clearly. The person in charge told inspectors that there were arrangements in place where all staff received practical instruction in the use of fire equipment. However, drills were not completed twice yearly. An unannounced fire drill was planned. An independent fire inspection team were due on site on the 19 July 2011. The team were requested to review fire safety in the centre and complete a declaration that it is of the required standard. As of the 26 July 2011 this declaration was not received by the Authority.

9. Action required from previous inspection:
Put in place a formal documented programme whereby the person in charge is given support and supervision to professionally develop the governance and management skills to meet the requirements of the legislation.

This action was partially completed.

It refers to a previous post-holder who is no longer in the position of person in charge. While arrangements were in place to support the newly appointed person in charge in her role, she was not provided with additional resources to assist her in taking over the running of the centre. While the person in charge role was a full-time position in the centre up to the appointment of the new person in charge, it is now filled on a part-time basis. The provider appointed Ms Mairead Campbell as Director of Nursing and person in charge. She commenced duty in the centre on the 20 June 2011. However, this is a dual role as she is also in the post of person in charge in St. Mary's Care Centre Mullingar. This arrangement has not been agreed with the Chief Inspector of Social Services to date.

10. Actions required from previous inspection:

Put procedures in place where all incidents, accidents and near misses are recorded in the risk management log.

Commence a process where analysis is done of all accidents, incidents and near misses in the centre identifying trends and areas where improvement and learning can be implemented.

Revise the emergency plan to reference contingency plans are in place for an alternative safe place of refuge for residents in the event of evacuation.

Revise reliability of all procedures put in place to prevent residents at risk of leaving the centre unaccompanied.

These actions were partially completed.

The inspection team confirmed that all accidents, incidents and near misses were now appropriately recorded from their review of the complaints log and the accident, incident and near miss log. While this information is reviewed locally, there was also a process in place to collate this information at regional level. The inspectors were also told that incidents, accidents and near misses were now formally analysed at the management team meetings for the centre. These adverse events are also reviewed at the health and safety meetings of which the person in charge is a committee member, as is the risk manager. Each incident is analysed locally by the person in charge prior to health and safety committee review. Six staff members have also attended training to date on analysis procedures referenced as 'systems analysis'.

Although the person in charge told inspectors that improvements in this area were informed by learning from analysis of the incidents, accidents and near misses. Inspectors confirmed from a review of the training records that 44 staff had attended training on fall prevention on the 26 April 2011. However, there was little evidence of a falls programme in place or robust use of alarm/alert aids to prevent resident falls.

While one resident in the centre had an alert bracelet to assist with maintaining her safety and managing her wandering behaviour, 28 residents used bedrails while in bed. Another resident had an alarm cushion to alert staff if she was at risk of falling. These were included the both residents care plan and were evaluated at least twice daily. A place of safety for residents was identified and documented in the emergency plan and a key to this area was accessible.

11. Actions required from previous inspection:
Develop and implement a comprehensive medication management policy to reference all aspects of medication management in the centre.

Review the use of long term benzodiazepines for residents in the centre.

Review long term prescription and administration of multiple bowel preparations.

Revise prescribing procedures for 'as required' (PRN) medication to include maximum dose in 24hours.

These actions were partially completed.

Reference to maximum dose administration for PRN (as required) medications is not completed but is within the timescale for completion agreed with the inspectorate of 15 August 2011. A pharmacist from the acute services attends the centre weekly to carry out a comprehensive review of all residents' medication records and prescription sheets. Gaps and weaknesses are identified through this process and recommendations regarding prescribing, interactions or queries are made to the team. Inspectors also viewed a copy of the pharmacist's review of two residents' medications. These reviews are on-going. An audit is planned following review of all residents' medications. A referral process was in place where all residents on multiple bowel preparations were being referred to the continence advisor for assessment. This process is supported by training by the continence advisor regarding improved bowel management and pattern establishment. While there is some progress in completion of three monthly reviews of medications by the GPs, the person in charge is developing a schedule for these reviews to ensure that all residents are reviewed at least three monthly. There were no further incidents of medication error in the centre.

12. Action required from previous inspection:
Outline a statement of purpose that includes all the information required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

This action was partially completed. The statement of purpose had been recently revised but did not contain all the information requirements as outlined in the legislation.

13. Action required from previous inspection:

Using appropriate evidence based tools, review the staffing levels and skill mix on day and night duty, taking into account the size and layout of the centre, the number of residents, their dependencies, their assessed needs and ensure that residents can be safely evacuated in case of fire.

This action was partially completed.

Additional care assistants were rostered from 18:30 hrs to 20:30 hrs as a result of a review of falls and staffing arrangements in October 2010. A plan was in place to repeat this review by the end of July 2011 in conjunction with fire drill training to ensure there was sufficient staff to evacuate the centre in the event of an emergency. 33 staff has attended education on the management of falls in the centre and future training dates have been scheduled for September/November. However, on the day of inspection, inspectors noted residents in some multioccupancy rooms unsupervised for prolonged periods. A resident was also required to wait for up to fifteen minutes for assistance with eating and when assisted, cold food was not refreshed. This finding, together with the significant numbers of residents back in bed for the remainder of the evening and night at 16:35 hrs, inspectors could not conclude that there was adequate staff on duty to meet the needs of residents (the majority of which had maximum dependency needs).

14. Actions required from previous inspection:
Evaluate the impact of windows in the doors on ability to maintain residents' privacy at all times.

In consultation with the residents put documented assessment procedures in place to ensure the level of privacy afforded to them in the multi occupancy rooms is adequate to meets their needs.

This action was satisfactorily completed.

Inspectors were told that consultation with the residents had taken place to agree the most suitable way to maintain privacy in the multi occupancy rooms. Bed occupancy had been reduced in these rooms. Residents were satisfied with small net curtains on the window in the door to these rooms. Inspectors viewed these curtains in place. Inspectors were told that residents expressed their satisfaction with the current privacy arrangements. Inspectors observed no breaches in residents' privacy. Curtains were drawn closed around the bed area and the door to the multioccupancy room was closed while personal care was in progress. Staff also placed a notice on the door advising that personal care was in progress and entry was prohibited. Some other residents had a notice hanging on their door advising those entering to knock. Inspectors were told that as part of the person-centred care programme in the centre, staff all received training in this area and a charter of residents privacy and dignity rights would be developed as part of this ongoing consultative exercise. The provider advised the Authority that this project would be completed by the end of August 2011.

15. Actions required from previous inspection:
Review use of full length bedrails as 'enablers' in line with contemporary evidence-based practice.

Revise the risk assessment tool to assess the need for bedrails to ensure more accurate assessment of need.

Put processes in place where residents have an in-depth assessment of need where restraints are used as a last resort measure for the least amount of time.

This action was satisfactorily completed.

Although there were a large number of residents using bedrails while in bed, a risk assessment for bedrail use had been sourced and was implemented in the centre on the 06 June 2011. A train-the-trainer course on restraint management was completed by two members of staff in May 2011. These trainers will roll out the programme to all staff members during the remainder of the year to be completed in November 2011.

16. Actions required from previous inspection:
Revise the centre's end of life policy to reflect procedures to meet the end of life needs of residents in multioccupancy rooms.

Revise the centre's policy in accordance with current legislation in relation to end of life care and obtaining residents wishes regarding this stage of their lives.

This action was satisfactorily completed.

Residents were consulted regarding their end of life wishes. Their wishes were documented as viewed by inspectors. The minutes of a residents' meeting of the 25 May 2011 referenced discussion with residents regarding the importance of sharing their wishes regarding their end of life.

Family rooms were available on each of the units where families could be facilitated to stay with residents who were at the end of their lives. The inspectors were told that residents in multioccupancy rooms who were having end of life care were moved into single accommodation if available within close proximity of the relatives' rooms so their families could be near them.

17. Action required from previous inspection:
Put systems in place to ensure that residents' needs are set out in an individual care plan developed and agreed with each resident.

Ensure review of residents progress is documented appropriately.

Ensure residents' wishes for the end of their lives is discussed and documented in line with evidence-based practice.

This action was partially completed.

A sample of care plans were reviewed by inspectors. Residents' needs were clearly set out in individual care plans and there was evidence that care plans were regularly reviewed however involvement of the residents or/and their relatives was planned but to date has not been implemented in practice.

While a care plan audit was in place, data collected was not collated to identify trends or areas of weaknesses to inform learning and improvement. However the training records confirmed that some training was done with staff in this area. The inspection team found that residents' progress was documented in both flow sheets and narrative notes and no gaps were noted.

There was evidence that residents' for end of life wishes were discussed with them as part of the care planning process and was documented accordingly.

18. Actions required from previous inspection:
Ensure all aspects of recommended practices are adhered to in managing wounds.

Provide staff with training in contemporary evidenced-based wound care and pressure area care management.

Put in place procedures so that residents' pain are managed with use of a pain assessment tool to reflect best-practice guidelines and resident comfort

This action was satisfactorily completed.

A comprehensive evidence-based wound care policy published in 2009 and revised for the centre in April 2011 was available to staff to inform their practice. The person in charge has developed a monthly tissue viability assessment to promote monitoring and traceability which is copied for her attention. She explained that she will review this documentation on an on-going basis. Wound assessment also includes ongoing nutritional assessment and referral where necessary. One resident has a grade three pressure ulcer on one of their heels. Inspectors were told that this resident's wound care management was complex due to ongoing medical complications. The resident was referred to the acute services and was a programme of treatment had been advised by the tissue viability service there. No other residents had decubitus ulcers on the day of inspection.

Pain assessment charts were in place in residents files reviewed and were completed regularly. A visual analogue pain scale and the abbey pain scale were used. Residents with pain had an associated pain management care plan which was recently reviewed reflecting completion of timely assessments.

19. Actions required from previous inspection:
Produce a written guide "the residents guide" that contains all the information required by the legislation.

Provide each resident with a copy of the revised document.

This action was partially completed.

A residents' guide had been produced as a result of the resident-centred care project and was revised in May 2011 to include missing information. However, a copy of the Authority's report was not included as part of this document. Residents had been given a copy of the document although some residents did not have a copy readily available to show inspectors. However, a replacement copy was available to them and they could also access a communal copy if they wished.

20. Action required from previous inspection:
Ensure all staff employed in the centre has the documents outlined in schedule 2 of the Health Act 2007 (Care and welfare of residents in Designated centres for Older people) Regulations 2009 (as amended).

This action was satisfactorily completed.

Staff files at the centre had the required information in them.

21. Action required from previous inspection:
Undertake an assessment of risk of the accessibility to and from the care environment and the main entrance and implement safeguards to ensure the safety of residents throughout the centre whilst not impinging on their autonomy and independence.

This action was not satisfactorily completed.

Inspectors were told that risk assessments of access and egress for residents have been carried out. However these meetings where assessments were completed were not all minuted. Although work was under way with a number of control measures including additional designated disabled parking spaces at the entrance. There were plans in place to improve access to the garden, improve external lighting and control access to the centre by means of an electromagnetic locking system. Inspectors were told by the provider that an evaluation of the current external lighting was completed. While there was evidence that some work was done, a significant amount of work was still required to assure residents safety and welfare needs were met.

The external environment to the front and side of the building continued to pose risks to residents' safety due to traffic and lack of pedestrian walkways. Large delivery trucks were noted on site. Although the internal garden was of a good standard, access was compromised by the doorway from the centre which tended to 'stick'. While there were plans to improve access to the external garden for residents, the resident dogs had the run of the garden and there was no evaluation done to ascertain whether residents were satisfied with this arrangement. One resident was seen in the garden by inspectors on the day of inspection.

22. Action required from previous inspection:
Provide a written report to the chief inspector at the end of each quarter as required under regulation 36(4)

This action was satisfactorily completed. Inspectors viewed the quarterly notifications submitted on the 31 April 2011 received on schedule. The person in charge told inspectors that she would type future reports to improve legibility.

23. Actions required from previous inspection:
Put systems in place to maintain resident files are kept safely and securely.

Put a robust risk management system in place to address adverse medication incidents where learning is identified to mitigate reoccurrence.

This action was satisfactorily completed.

Systems have been put in place to ensure that resident files were kept safely and securely. A comprehensive system has been put in place at the centre to address the risk of adverse medication incidents in relation to the administration of medicines in the centre. There was no further medication errors reported. Training of staff and auditing of practice was in place. Staff on leave will receive medication management training prior to recommencing their duties in the centre.

24. Action required from previous inspection:
Devise an alternative communication system that ensures that all residents are facilitated and encouraged to communicate enabling them to participate in the activities and running of the centre.

This action was partially completed.

A non verbal communication programme which has been deemed suitable for people with communication impairment was in place at the time of the previous inspection. However, as many of the residents have maximum dependency needs which in many cases limits the amount of activity these residents can participate in. Many of the residents remained in bed for prolonged periods of time during the day without meaningful activity or therapy. This was further impacted by some residents' inability to communicate due to their underlying medical conditions.

Although the centre have revised pictorial menus to match menu choice, further communication tools were being developed and sourced in conjunction with the speech and language therapy service. There was a plan in place to refer all residents to the speech and language therapist for assessment and guidance on the appropriate communication tools for each resident.

Standard	Best practice recommendations
Standard 2: Consultation and Participation	Provide aids to support communication with residents who have dementia or difficulty expressing their needs verbally. **Provider's response:** At the time of the inspection the SONAS Programme was in operation at the centre. This is a non verbal communication programme which has been deemed suitable for people with communication impairment. "Butterfly Moments" approach was in operation at the centre at the time of inspection. **Inspection Findings:** This recommendation was partially completed. The pictorial menu cards were revised. All residents with communication difficulties were being referred to the speech and language therapist for assessment with a view to recommendation of an appropriate communication aid to meet their needs.
Standard 9: The Resident's Finances	Provide residents with a statement of their petty cash account at reasonable intervals. **Provider's response:** Residents will be provided with quarterly statements of their accounts and systems have been put in place to ensure that they can be given outside of this should a resident s wish. **Inspection Findings:** This recommendation was satisfactorily completed. Statements are provided to residents or next of kin to communicate the balance of their accounts.

Standard 25: Physical Environment	Residents did not have suitable sheltered seating available in the garden so they could sit and relax there if they wished. **Provider's response:** At the time of the inspection the garden furniture was being refurbished and redecorated. It is now returned to the garden' sheltered area. **Inspection Findings:** This recommendation was satisfactorily completed. Inspectors viewed sheltered seating in the internal garden.
Standard 26: Health and Safety	Ensure procedures are in place to secure the laundry door when the room is unoccupied. **Provider's response:** Procedures have been out in place to ensure that the laundry door is closed while unoccupied. **Inspection Findings:** This action was partially completed. The inspectors noted that the laundry person pulled the door closed on leaving the laundry. However, it was not locked. Vulnerable residents had access to various detergents should they access this room.
Standard 8: Protection	Put monitoring procedures in place to ensure the visitors' log is completed on entry to and exit from the centre on all occasions. **Provider's response:** All efforts will be made to ensure that the visitors' log is completed on entry to and exit from the centre on all occasions in the future. **Inspection Findings:** This recommendation was not satisfactorily completed. Visitors' logs were available but no member of staff monitored that all visitors signed this log on entering and exiting the building.

Report compiled by:

Catherine Connolly-Gargan
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

08 July 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
28 and 29 January 2010	☐ Registration ☒ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
25 June 2010	☐ Registration ☐ Scheduled ☐ Follow up inspection ☒ Meeting ☒ Announced ☐ Unannounced
22 and 23 March 2011	☒ Registration ☐ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report *

Centre:	0483
Centre ID:	St Vincent's Care Centre
Date of inspection:	08 July 2011
Date of response:	22 August 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 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The Registered Provider and Person in Charge is failing to comply with a regulatory requirement in the following respect: The provider has not taken all reasonable measures to protect each resident from harm or abuse. There is free public access to enter the centre from a number of areas and the health and safety of residents is not protected. The person in charge has not made all necessary arrangements at preventing residents being harmed or suffering abuse.
Action required: Ensure that all reasonable measures are taken to protect each resident. Make all necessary arrangements to prevent 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

* 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:**
Provider's response: Immediate action was taken on 08 July 2011 to control access into centre. All persons providing a service in the centre are now required to have elder abuse training. All staff and volunteers are required to have Garda Síochána and have completed elder abuse training. Training on recognizing and responding to elder abuse in residential care is being provided on an ongoing basis to all staff.	 08 July 2011 16 August 2011 16 August 2011 16 August 2011

2. The provider has failed to comply with a regulatory requirement in the following respect:
Did not appoint a person in charge in the centre on a full-time basis.

Did not seek agreement from the Chief Inspector of Social Services that she was satisfied with the arrangements for the person in charge's engagement in the governance, operational management and administration in the centre while having responsibility for more than one centre.

Action required:
Put a full-time person in the post of person in charge.

Action required:
Seek the agreement of the Chief Inspector of Social Services with the current person in charge arrangements.

Reference:

Health Act, 2007
Regulation 15: Person in Charge
Standard 27: Operational Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The necessary documentation for the filling of the person in charge position has been resubmitted to the Regional Director of Operations (RDO), HSE Dublin Mid Leinster for approval. Letter seeking the agreement of the Chief Inspector of Social	 03 October 2011 22 August 2011

Services with the current person in charge arrangements has been forwarded to the Chief Inspector.	

3. The person in charge has failed to comply with a regulatory requirement in the following respect: All staff had not received training in the prevention of elder abuse and protection.	
Action required: Provide mandatory training to all staff in the prevention of elder abuse and protection.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Mandatory training has been provided to all staff in the Centre and will be provided to new staff as required. Elder abuse training has been made available to all persons providing a service in the centre. Training sessions have been scheduled for the remainder of the year.	 08 July 2011 31 December 2011

4. The provider has failed to comply with a regulatory requirement in the following respect: Hand rails were not adequate on stairs and the stairs posed a risk to residents. Directional signage and poor lighting increased risk of injury for residents and visitors' in the external grounds. The hot water temperatures posed a risk of scald to residents.
Action required Put procedures in place to ensure that recommended maximum hot water temperatures are maintained at the point of contact throughout the areas used by residents.
Action required Ensure all parts of the external areas used by residents and their relatives are suitable, safe and risk free.

Action required Install safety railing on main stairs in the centre to reduce assessed risks to residents.	
Reference: Health Act, 2007 Regulation19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: In order to address the risk of potential scalding to residents the necessary sinks, taps and appropriate thermostatic controls valves have been purchased and are on site, however, the necessary IPS panels which are required for mounting units are out of stock in country. We have received confirmation that they will be available to us in first week of September 2011. External directional signage has been ordered. The tender process has commenced for traffic management survey of St Vincent's Campus. When complete this will guide management in addressing specific safety issues. A risk assessment of the stairs was completed by the occupational therapist. However, a full architectural review has been completed to ensure that stairwells comply with Building regulations and Building for Everyone Guidance document. The report and tendering for work is due by 19 September 2011. Work is expected to take place soon after.	 30 September 2011 30 September 2011 30 November 2011 30 November 2011

5. The provider has failed to comply with a regulatory requirement in the following respect: The location of the GP out-of-hours service had an adverse impact on residents in the centre. Residents did not have free access to the garden. The garden was not enclosed therefore residents at risk of leaving the centre unaccompanied.
Action required: Evaluate access to the garden for residents in the centre and make it safe to use by residents who are at risk of leaving the centre unaccompanied.

Action required:
Complete an evaluation of the appropriateness and impact on the quality of life of residents having the out-of-hours services located in the building occupied by the centre.

Reference:
Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The garden is now enclosed to ensure the resident's safety.	31 July 2011
A separate enclosure for the dogs is now in place.	31 July 2011
The door from the centre to the garden is secured after 17:00 hrs each evening to prevent risk of leaving the premises unaccompanied.	31 July 2011
The access control key pads have reduced the risk of unauthorised access from the garden area into the centre.	08 July 2011
Residents' views on the GP out-of-hours service on site were positive – e.g. "a doctor was available quickly". Residents stated that the ambulance does not wake them at night and the doctor does not disturb them.	Complete
The centre is no longer accessible to members of the public from the waiting area for GP out-of-hours service.	1 August 2011

6. The provider has failed to comply with a regulatory requirement in the following respect:
All residents had not agreed contracts for the provision of services.

Action required:
Ensure each resident has a contract that deals with their care and welfare of the resident in the centre and includes details of the services to be provided for them and the fees to be charged.

Reference:
Health Act, 2007
Regulation 28: Contract for the Provision of Services
Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: All residents have received a Contract of Care and are being actively encouraged to return same. The provision of this contract of care has been discussed with residents at residents' forum meeting in July 2011.	 May 2011 July 2011

7. The provider has failed to comply with a regulatory requirement in the following respect:
Fire safety procedures in the centre were not fully adequate.

Action required:
Put procedures in place where all staff have annual fire training and are aware of their responsibilities in the event and participate in fire drills twice yearly.

Action required:
Complete the fire safety declaration sent to the centre confirming that fire safety is of the required standard.

Reference:
Health Act, 2007
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: All staff must attend fire training on a yearly basis. Fire drills will be conducted twice yearly. One drill has taken place for this year to date on 15 July 2011. The fire safety compliance declaration has been forwarded to the Health Information and Quality Authority on 15 August 2011.	 16 August 2011 31 December 2011 15 August 2011

8. The provider has failed to comply with a regulatory requirement in the following respect:
Did not put adequate risk management procedures in place where recorded incidents and accidents were analysed and used for learning and as a proactive risk management tool.

Action required:
Commence a process where analysis is done of all accidents, incidents and near misses in the centre identifying trends and areas where improvement and learning can be implemented.

Reference:
Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
A log of all accidents, incidents and near misses is kept in the centre.	22 August 2011
Each accident, incident and near miss is reviewed by person in charge of centre at the time of the incident at the time of reporting.	22 August 2011
All accidents, incidents and near misses as a result of falls are being analysed and trended on a monthly basis.	22 August 2011
Resident data is collected on a weekly basis. This data will be analysed also on a monthly basis as above.	22 August 2011
All complaints including those relating to risk management are analysed as they occur and are collated and forwarded to the general manager on a monthly basis.	22 August 2011

9. The provider has failed to comply with a regulatory requirement in the following respect:

The statement of purpose did not contain all the criteria as outlined in schedule 1 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) for example the decrease in bed numbers to 42.

Action required:
Outline a statement of purpose that includes all the information required 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	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The centre's statement of purpose has been amended in line with Schedule 1 the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	01 August 2011

10.The person in charge has failed to comply with a regulatory requirement in the following respect:

Did not ensure that the numbers of staff and skill mix on duty were appropriate to meet the care and safety needs of residents at all times as residents had to wait for assistance with eating.

Action required:

Using appropriate evidence-based tools, review the staffing levels and skill mix on day and night duty, taking into account the size and layout of the centre, the number of residents, their dependencies, their assessed needs and ensure that residents can be safely evacuated in case of fire.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The provider and person in charge have brought to attention of staff the delay in providing resident as detailed with assistance at mealtimes. On day of inspection there were sufficient staff numbers on duty to ensure that the care and safety needs of residents were met. However, since the inspection measures have been put in place to ensure that residents receive meal at correct temperature when staff member is available to assist the resident if required. This issue has been addressed by nutrition team and catering staff – meals are not being brought to resident until staff member available to provide assistance. This will be reinforced to staff at all staff meetings.	11 July 2011 31 July 2011

A review of rosters has commenced in the centre. This process involves discussion and involvement with staff. The provider and person in charge are satisfied that existing rosters have adequate staff numbers and skill mix on duty over 24 hour period to ensure that phased horizontal evacuation of residents can take place safely in the event of fire/any other emergency requiring evacuation. All future rosters arising from staff review will also comply with this requirement although there may be variations to skill mix of staff numbers.	30 September 2011 22 August 2011 22 August 2011

11. The person in charge is failing to comply with a regulatory requirement in the following respect:
There was no evidence of resident involvement in developing his/her care plan or in a review of their care plan.

Action required:
Put systems in place to ensure that residents' needs are set out in an individual care plan developed and agreed with each resident.

Reference:
Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales: Provider's response:	**Timescale:**
Provider's response: All residents are consulted in the planning and three monthly review of their care plan. In the event that a resident is unable to partake in this process their next of kin/family are invited to do so. The importance of their involvement in their care plan is discussed with residents at residents' forum meetings. The CNM2 on each unit will specifically discuss this involvement and this requirement with each resident.	Complete 22 August 2011 22 August 2011 31 August 2011

12. The provider is failing to comply with a regulatory requirement in the following respect:
Did not provide each resident with a copy of the revised residents' guide.

Action required: Provide each resident with a copy of the revised document.	
Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Standard 25: Information	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Each resident has been re-issued with a second copy of the updated copy of the Residents Guide.	 Complete 22 August 2011

13. The provider has failed to comply with a regulatory requirement in the following respect: Did not ensure that external grounds are suitable for and safe for use by residents.	
Action required: Undertake an assessment of risk of the accessibility to and from the care environment and the main entrance and implement safeguards to ensure the safety of residents throughout the centre whilst not impinging on their autonomy and independence.	
Reference: Health Act, 2007 Regulation 31 Risk Management Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: External directional signage has been ordered. The tender process has commenced for traffic management survey of St Vincent's Campus. When complete this will guide management in addressing specific safety issues and will also assess the accessibility to and from the care environment and the main entrance. Six wheelchair accessible car spaces have been provided at the main entrance for use by residents. This has restricted access by vehicles near front door/ramp. Entrance to Units restricted to the public by way of key pad security.	 22 August 2011 30 November 2011 Complete 22 August 2011

	Complete 8 July 2011

14. The provider has failed to comply with a regulatory requirement in the following respect:
Inadequate non-verbal communication systems were in place. It was not possible to facilitate and encourage communication with residents who could not express them verbally.

Action required:
Devise an alternative communication system that ensures that all residents are facilitated and encouraged to communicate enabling them to participate in the activities and running of the centre.

Reference:
Health Act, 2007
Regulation 11: Communication
Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: Communication pictograms have been sourced to enhance communication with residents with communication difficulties. The speech and language therapist will assess residents as requested with communication difficulties. These measures will augment the Sonas programme, activities and Butterfly approach in the units.	31 July 2011

15. The provider has failed to comply with a regulatory requirement in the following respect:

There was poor evidence made available to inspectors that a system was in place for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre.

Action required:
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.

Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Reference:
Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response:	
A log of all accidents, incidents and near misses is kept in the centre.	Complete
Each accident, incident and near miss is reviewed by person in charge of centre as they occur.	Complete
All accidents, incidents and near misses as a result of falls are being be analysed and trended on a monthly basis.	Complete
Resident data is collected on a weekly basis. This data will be analysed also on a monthly basis as above.	Complete
All complaints including those relating to risk management are analysed as they occur and are collated and forwarded to the general manager on a monthly basis.	Complete
An audit schedule has been developed in the centre to review: medication management/falls/missing persons/restraint/care plans.	Complete
Medication review by pharmacist continues on a weekly basis with all residents' medication being review by doctor and pharmacist at least on three monthly basis.	Complete
Residents' health status is reviewed by doctor at least three monthly and more frequently if any change in residents' condition.	Complete
Resident satisfaction surveys will be repeated in centre.	30 September 2011

Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 14: Medication Management	Revise prescribing procedures for 'as required' (PRN) medication to include maximum dose in 24 hours. **Provider's response:** All PRN medication has been prescribed to include the maximum dose in 24 hours. Local policy also reflects this.
Standard 2: Consultation and Participation	Provide aids to support communication with residents who have dementia or difficulty expressing their needs verbally. **Provider's response:** Communication pictograms have been sourced to enhance communication and augment the Sonas Programme, Activities in Care and the Butterfly approach.
Standard 8: Protection	Put monitoring procedures in place to ensure the visitor's log is completed on entry to and exit from the centre on all occasions **Provider's response:** Staff on units will remind visitors to sign the visitors' book. Signage will also be put in place to encourage compliance.
Standard 26: Health and Safety	Ensure procedures are in place to secure the laundry door when the room is unoccupied. **Provider's response:** The laundry door will be locked to prevent resident access when the attendant is distributing the residents' laundry.

Any comments the provider may wish to make:

Provider's response:

The Provider/Person in Charge/Staff of the centre acknowledge that improvements made in the Centre over last 1 – 2 years have greatly enhanced the service provided and will continue to strive towards providing an excellent service to residents.

Provider's name: Mr Joseph Ruane, HSE Midlands Area Manager

Date: 22 August 2011