

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Carysfort Nursing Home
Centre ID:	ORG-0000022
Centre address:	7 Arkendale Road, Glenageary, Co. Dublin.
Telephone number:	01 285 0780
Email address:	edwardpakenham@carysfortnursinghome.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Breda Pakenham & Edward Pakenham Partnership, trading as Carysfort Nursing Home
Provider Nominee:	Edward Pakenham
Person in charge:	Liny Raju Meparathil
Lead inspector:	Sheila McKeivitt
Support inspector(s):	Bríd McGoldrick
Type of inspection	Announced
Number of residents on the date of inspection:	50
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

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.

Regulation has two aspects:

- Registration: 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.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
 - to carry out thematic inspections in respect of specific outcomes
 - following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
 - arising from a number of events including information affecting the safety or wellbeing of residents.
- Following an application to vary or remove a condition of registration

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

The purpose of this announced inspection was to assess compliance with Condition 8 which was applied to the registration of this centre on 14 February 2015. In addition the provider had applied for the removal of this condition and the inspector made an assessment of this application, in order to make a recommendation to grant or refuse the application.

The inspection took place over the following dates and times

From: 31 January 2017 10:00 To: 31 January 2017 12:00

Summary of findings from this inspection:

Condition 8 was applied to the registration on 14 February 2015 and stated that Bedroom 7, a four-bedded room, located on the first floor shall be reduced to three beds and reconfigured to meet residents' needs. No new residents may be admitted to this room until the number of residents is reduced and the physical environment reconfigured to meet their needs.

Inspectors conducted an announced inspection of the centre to assess Bedroom 7 and determine if it was suitable for the number of residents accommodated. Bedroom 7 was inspected – four residents were living there. Inspectors found that the layout of this room was not adequate to ensure the privacy, dignity and needs of the each of the four residents.

Findings from this inspection

Bedroom 7 was accessible to residents via a stairs with a chair lift and hand rails. Inspectors saw that four residents were occupying the four beds. The room appeared to be well lit with three large windows providing natural light into the room. The room was well heated with three radiators providing heat within the bedroom. There was safe non-slip floor covering on the floor of the bedroom. All four residents had access to a call bell above their bed and an over-bed light. Each bed had screening in place which extended completely around the confined bed spaces.

Three of the four beds were positioned up close to a wall, making the inner side of the bed inaccessible for use of equipment such as a hoist, or for staff to assist the resident from both sides of the bed. Inspectors were informed that none of the current four occupants were dependent on a hoist for transfer, however three used a zimmer frame to mobilise.

Inspectors found that the reason for Condition 8 as detailed to the provider in 2015 has not changed. The layout of Bedroom 7 continued to infringe negatively on the privacy of residents living in the room:

No efforts had been made to personalise any of the four bed spaces, although wall space was available by beds for this purpose. The centre of the room was the only floor space without any furniture and this area was used to access the doorway. There was no television in the room. Two residents did not have access to a bedside locker by their bed as there was no floor space for a locker. This meant that they had no private storage unit within easy reach of their bed space for personal possessions. A small shelf attached to the inner wall held a jug of water and a glass. There were only two comfortable chairs in the room for four residents due to a lack of floor space. The other two small chairs in the room were only suitable for short periods of sitting.

The lack of floor space available by each bed space meant that residents' individual wardrobes were positioned beside the bedroom door, rather than within proximity of their private bed space. One resident had to walk through the private space of the other three residents in order to access the bedroom door and her wardrobe.

Three of the four residents living in the room did not have a sufficient amount of private space to undertake activities in private. They did not have enough private space behind their privacy screening to use a commode or sit on a chair in private. Nor did they have sufficient space to receive a visitor in private in their bedroom.

Although there were two wash hand basins positioned side by side in the bedroom there was no screening around these wash hand basins and there was no lock on the bedroom door, therefore residents' privacy could not be maintained when using either of the two wash hand basins if they wished to wash in the privacy of their room.

Residents did have access to a bathroom. It was situated across the hall from their bedroom. It had a privacy lock in place, contained a shower with a handrail, a toilet and a wash hand basin. However, it was cluttered with furniture including a folded wheelchair, a commode, a clinical waste bin, a normal rubbish bin and a shower chair. Inspectors were informed that the commode was sometimes used but that most residents did not like using the commode in the room. Inspectors observed that there was no room for a commode behind three of the four bed screens.

Inspectors were informed that all four residents spent the most of each day on the ground floor of the centre where they took part in activities, socialised with other residents and had their meals. Residents returned to their bedroom when they requested but this was usually only at the end of the day when they were going to bed.

Inspectors met all four residents. Two were sleeping in their respective chairs in the sitting room; they were not disturbed. One resident spoken with was independently mobile and the remaining resident was actively taking part in the morning quiz.

It was noted that the Registered Provider since, since the imposition of Condition 8, had continued to accommodate four residents in the room. It was noted that a literal interpretation had been taken in respect of the condition's wording despite the rationale for the condition having been communicated at the time the condition was imposed. Therefore, residents new to the centre were not accommodated in Bedroom 7, but existing residents within the centre were moved to the room once a bed became vacant.

Inspectors concluded that the layout of this four-bedded room continues to be unsuitable to meet the needs of four residents.

Report Compiled by:

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