

Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act
2007



Centre name:	St Camillus Nursing Centre
Centre ID:	098
Centre address:	Killucan
	Co. Westmeath
Telephone number:	044-9374196
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Email address:	riverstown@eircom.net
Type of centre:	<input type="checkbox"/> Private <input checked="" type="checkbox"/> Voluntary <input type="checkbox"/> Public
Registered provider:	Order of St. Camillus
Person authorised to act on behalf of the provider:	Father Frank Monks
Person in charge:	Brother John O'Brien
Date of inspection:	04 and 05 October 2011
Time inspection took place:	Day 1: Start: 09:30 hrs Completion: 18:50 hrs Day 2: Start: 07:30 hrs Completion: 20:30 hrs
Lead inspector:	Ann Delany
Support inspector(s):	Catherine Connolly Gargan
Type of inspection:	<input checked="" type="checkbox"/> Registration <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced

About registration

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

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

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

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

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

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

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

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

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

About the centre

Location of centre and description of services and premises

St. Camillus Nursing Centre is located adjacent to Killucan Village. The Order of St. Camillus has been providing health services in the area since the 1930's. The centre is surrounded by farmland and a small river runs through the grounds. The Order of St. Camillus maintains a residence on the grounds adjacent to the centre.

The centre is single-storey, with a new block built on to the original building in recent years. The residents are accommodated in 14 single rooms, 1 of which has an en suite toilet, shower and hand-washing facility, 3 have en suite toilet and hand-washing facilities, 2 single rooms have a shared en suite facility consisting of a bath, toilet and hand-washing facility and 8 rooms have shared en suite toilet and hand-washing facilities. There are 8 twin rooms of which 1 has an en suite shower, toilet and hand-washing facility, 6 have an en suite toilet and 1 has no en suite facilities. There are also three rooms accommodating five residents in each and two rooms accommodating six residents in each. All of these rooms have with en suite toilet and hand-washing facilities. The centre has two palliative care beds. There is a spacious modern oratory linked to the centre that is used by residents and the local community, two dining areas and two sitting rooms.

The centre provides long term care to residents over 65 years with differing ranges of abilities and cognitive capacity. Care is also provided to residents requiring palliative, convalescent and respite care. Many of the residents come from the surrounding area and adjacent counties.

Date centre was first established:			01 January 1976	
Number of residents on the date of inspection:			53	
Number of vacancies on the date of inspection:			2 vacancies and 2 residents in hospital	
Dependency level of current residents:	Max	High	Medium	Low
Number of residents	24	18	7	4
Gender of residents			Male (✓)	Female (✓)
			18	35

Management structure

The centre is under the management of the order of St. Camillus and Father Frank Monks is the nominated provider on behalf of the order. Brother John O'Brien is the Director of Nursing/Person in Charge of the centre. Yvonne Lynam is the assistant Director of Nursing.

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

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

Inspectors met with residents, relatives, and staff members over the two day inspection. Inspectors observed practices and reviewed documentation such as clinical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge, both of whom had completed the Fit Person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

The inspectors found substantial compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and *the National Quality Standards for Residential Care Settings for Older People in Ireland*. This was reflected in the positive outcomes for residents evidenced throughout the inspection and confirmed by residents and relatives. Overall, the inspectors found that resident's received a high standard of clinical care. The services and facilities outlined in the centres' statement of purpose were reflected in practice and served to meet the needs of all residents.

Inspectors found that staff were knowledgeable about the residents and their needs. There was a sense of good teamwork, with all members of the team involved in meeting daily to discuss residential care needs. Staff were observed interacting with residents in a very respectful and caring way.

Residents' access to healthcare was of a high standard. All the health services required to promote residents health and wellbeing were facilitated. There were appropriate staff numbers and skill mix to the assessed needs of residents, and to the size and layout of the designated centre. Residents were facilitated to exercise choice and personal autonomy and their views were sought and listened to.

While policies, procedures, systems and practices regarding managing risks were in place they were not comprehensive and had not identified all risks within the centre including adequate arrangements for evacuation in the event of a fire. An immediate action letter was issued to the provider in relation to this and a response was received within five working days outlining an appropriate action plan.

Other areas identified for improvement in order to comply with legislation related to contracts of care, statement of purpose, infection prevention and control and the complaints process. These are described under the outcome statements and related actions are set out in the Action Plan at the end of this report.

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

The statement of purpose set out the services provided in the designated centre. The profile of the residents reflected the statement of purpose. The inspectors observed that the centre's capacity to meet the diverse needs of residents, as outlined in the statement of purpose, was reflected in practice. Staff knew residents as individuals. Inspectors' noted that care was provided in a way that reflected the ethos of the centre. This was confirmed by residents and relatives who spoke to inspectors throughout the inspection and in their comments in the resident and relative questionnaires submitted to the inspectors.

The statement is kept under review by the provider and the inspectors observed that a copy of the statement of purpose was provided at the nurses' station.

However, the statement of purpose did not meet all the requirements of Schedule 1 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and required to be updated in relation to the organisational structure to reflect the governance of the centre, the number and size of all rooms and the total staffing compliments, in whole time equivalents, with the management and nursing compliments given by grade.

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

A system had commenced to gather information relating to accidents, incidents, complaints, medication management, and activities. The inspectors reviewed a small number of audits completed by the assistant director of nursing. Audits of areas such as falls by residents and medication practices were reviewed and results analysed to determine patterns and areas for improvement and development.

These systems were in an early stage of development and require further progress.

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 the inspectors that they had easy access to the person in charge, assistant director of nursing and the provider and they could report any concerns which were addressed in a timely manner.

A complaints policy was in place. The person in charge was identified as the nominated person to whom a complaint should be made. The assistant director of nursing was nominated to ensure complaints are appropriately responded to and records maintained. An independent appeals process is also detailed in the policy if the complainant was dissatisfied with how the complaint had been handled. The complaints procedure contained timescales to investigate a complaint. However, the complaints process was not prominently displayed within the centre.

The complaints log for 2011 contained records of four complaints. All relevant information about the complaint, investigation made and the outcome was detailed. However, the complainant's satisfaction with the outcome was not recorded.

Through interview the inspectors identified that not all verbal complaints were logged and of those that were logged they were recorded in a separate "concerns" book.

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 found that measures were in place to protect residents from being harmed or suffering abuse.

A review of training records indicated staff had been trained and were knowledgeable on protecting vulnerable adults. Staff spoken with were able to inform the inspectors of what constituted abuse and of their duty to report any suspected or alleged instances of abuse.

Residents stated that they felt safe in the centre and that there were adequate measures in place to protect them from harm. Questionnaires completed by residents and their relatives confirmed to inspectors that residents felt safe.

Garda Síochána vetting was in place for staff employed by the provider. This was evidenced by a review of staff files. The Authority had applied for Garda Síochána vetting for senior members of the management team engaged in the governance of the centre.

There was a centre-specific policy in place on the protection of residents from abuse. The policy defined the various types of abuse. However, the policy did not provide sufficient guidance to staff on the assessment, reporting and investigation of all allegation of abuse as it did not describe the process if an allegation of abuse is made about a senior member of staff nor did it provide contact details of the local elder abuse officer in the Health Service Executive (HSE) and the local An Garda Síochána office.

Inspectors reviewed the procedures for managing residents' finances. Comprehensive records were maintained to provide an audit trail of each resident's finances. A policy and procedure was in place which was reflected in practice.

The inspectors observed that members of the public could easily access the centre, without meeting a member of staff, as the front door was on a release button and the staff work station is located at the back of the centre. A Closed Circuit Television (CCTV) monitoring system is in place on the door. However, there is not always a member of staff located at the staff work station. This poses a potential risk to the safety of the residents.

Outcome 5

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

References:

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

Inspection findings

There were systems in place for the management of risk situations including a safety statement, emergency plan and risk management policy. However, these systems were not comprehensive and did not meet all the requirements of regulation 30, 31 and 32.

There was a missing person policy which included clear procedures to guide staff should a resident be reported as missing. A profile description sheet with photographic identification was provided for each resident and was held in the nurses' office. A missing person drill had taken place on 19 May 2011.

There was an emergency plan in place which included contingency arrangements should it be deemed necessary to evacuate all the residents from the building. A generator was available in the event of power failure. However the emergency plan was not comprehensive as it did not outline clear procedures to follow in the event of fire, loss of electric power, flood, gas leak or security concerns. It also did not contain specific action instructions for staff to follow in the event of an emergency, for example, how residents would be moved in the event of evacuation.

A centre-specific safety statement was in place which identified individual hazards. However, not all hazards had been identified, for example external steps a number of the fire exits and steps in one of the dining areas. Precautions to control or minimise risks were in place for those hazards identified. Handrails were provided on both sides of the corridors throughout the building, promoting the independent movement of residents. Residents were observed moving around the building during the day using the handrails for support. The entrance door was ramped ensuring ease of access for residents with mobility impairment. Floor tiles in bathrooms were non slip and floor covering in bedrooms and communal areas was safe and easily cleanable. The inspector observed residents moving freely and easily around the communal areas.

However, three of the emergency exits had steps and did not have ramp access and the centre did not have a visitors' log in place to monitor the movement of persons in and out of the building to ensure the safety and security of residents. The enclosed garden was not secure due to a broken fence and when following the pathway around the centre residents could gain access to steps that were not adequately protected to facilitate residents descending them in a safe manner. Not all bathrooms had grab rails in place in bath, shower and toilet areas. There was no evidence of routine safety audits to proactively manage risk on a regular basis as required by regulation 31.

A smoking room had been provided for residents use since the last inspection. However, the smoking room was located beside another sitting room and the inspectors could smell smoke in the non smoking area as the wall separating the rooms was only a partition wall.

A number of televisions in residents' rooms were observed to be positioned on furniture that did not provide sufficient support and posed a health and safety risk to residents, visitors and staff.

While there was a range of risk management procedures the policy did not fully meet the requirements of regulation 31. The risk management policy did not contain procedures to guide staff in the event of violence, aggression, self harm and assault, record incidents, accidents or near misses or how to undertake a risk assessment. Furthermore, it did not include a governance procedure for formal arrangements to ensure learning for all staff from serious or untoward incidents or adverse events.

There were arrangements in place for recording and investigating untoward incidents and accidents including falls by residents in care. The incident report was held in residents' records and contained details of the accident and the investigations undertaken. Overall the inspector noted the number of falls sustained by residents was not high. Preventative measures to reduce the likelihood of reoccurrence were implemented. All residents were risk assessed for their vulnerability to falls while in care. However, a large number of residents were observed to be transported to the dining area and oratory in wheelchairs rather than encouraging them to walk with assistance to promote a good balance between mitigating risks and enhancing residents' quality of life.

A number of measures were in place to control and prevent infection including policies and procedures, availability of hand-wash sinks and alcohol hand gels, appropriate use of personal protective equipment, cleaning of the premises, segregation of linen and segregation and disposal of waste, including clinical waste. However, the centre did not have a bedpan washer. Inspectors observed moderate levels of high dust on bed curtain rails in a number of bedrooms and on picture frames in the corridors. A number of pieces of equipment were observed to be dusty and not visibly clean. The household team reported that there were no written operational procedures to guide staff on how to clean the premises effectively. A colour coded cleaning system was not in place and a member of the household team was observed cleaning residents bedrooms in the dark.

Clinical waste was disposed of at the local health clinic. However, clinical waste was not tagged to facilitate identification of the origin of the waste. Sharps bins were observed not to be assembled in line with best practice and the lids were observed in an open position which poses a risk to residents and staff as the door to the clinical room was open.

The inspectors was provided with written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for dependent people. Since the last inspection fire curtains had been installed in the attic of the centre and the centre had also had new fire doors and a fire alarm system installed.

Emergency lighting was provided throughout the building. An inspector viewed contracts of the servicing of fire alarms, smoke and heat detectors. Fire extinguishers were serviced annually. Routine inspection of the fire doors and fire panel were undertaken daily to ensure they were operational. Plans to show the escape to the nearest fire exit were displayed at the nurses' station.

The inspector viewed records of fire safety training which had been completed by staff. Records indicated that 18 staff had yet to receive training in fire safety procedures in 2011. Training was scheduled for 12 and 19 October 2011.

However, the inspectors were not assured that mechanisms to safely evacuate residents, especially those requiring assistance, were in place. Exit signage over doors was not lit to identify that these doors were designated means of escape. Staff spoken to reported that residents requiring assistance would be evacuated with the use of blankets and sheets. However, during a fire drill, earlier this year, staff had identified that their use was not appropriate. No alternative had been identified at the time of the inspection. It was not clear, when residents were evacuated from the building, what direction they should go in or where the external assembly point was. The path around the extern of the centre was found to be uneven, some manholes/drainage areas were uncovered and in some areas the path was moss covered. These matters were discussed the management at the close of inspection.

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

A policy on medication management, to manage aspects of medication from ordering, prescribing, storing and administering was available. There were also appropriate procedures for the handling and disposal for unused and out of date medicines.

Photographic identification was available on the medication chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets indicated the dosage, route and time of administration. The medication administration sheets viewed were signed by the nurse following administration of medication to the resident.

All medication was securely stored in a locked cupboard. 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.

All medication was reviewed by the prescribing doctor every three months or more frequently should a change in residents' health occur. A pharmacist also reviewed each resident's medication on a monthly basis. While all prescription sheets reviewed were signed by the prescribing doctor they had all been transcribed by a nurse and had been countersigned by another nurse. The column which requires the prescriber to state the date the medication commenced was completed with the date the drugs

were transcribed. Therefore it was not clear how long residents had been taking their current medication.

No audits had taken place in relation to the practice of transcribing with the exception of a medication audit that looked at whether two nurses had signed the transcription. An Bord Altranais medication management guidelines states that “the decision to transcribe a prescription should only be made in the best interests of the patient/service user... The practice of transcribing should be the subject of audit.”

A new syringe driver, for pain management, had been implemented in the centre in August 2011 and all qualified nurses had received training on how to use the syringe driver.

Four medication audits had taken place in 2011 and the person in charge took responsibility for ensuring any required corrective actions were implemented.

Single patient use insulin pens, were stored appropriately in a medication fridge. However each pen did not have the residents name identified on it to ensure it would not be used on another resident. The Irish Medicine Board has issued safety guidance in relation to this issue late last year.

The inspector observed that greater than 50% of the residents were prescribed and administered laxatives. A nutritional assessment by a community dietician in 2009 had identified that the centre had had a 7% increase in spend on laxatives in 2008 and recommended the centre focus on bowel health through nutritional means. However, the centre was unable to demonstrate any quality improvements in relation to laxative use.

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

Inspection findings

Inspectors found that the provider and person in charge worked with staff and residents to proactively promote health. Inspectors found a good standard of evidence-based nursing care and appropriate medical and allied health care. Residents were assessed to meet their changing needs.

The centre had a policy for the admission, temporary absence and discharge of residents. Pre-admission assessments were completed by the person in charge to ensure the needs of the potential resident could be met. However, the admission policy did not sufficiently inform practice, for example what is involved in pre-assessment and assessment on admission, and required review.

Inspectors found that residents' healthcare needs were well attended to. Residents could choose to remain with the own GP or a more local GP would be arranged by the provider with their consent. A GP service outside of core hours is available to residents. Records demonstrated that there was timely access to medical care and residents' healthcare needs were regularly reviewed.

Residents were observed to have had a comprehensive assessment carried out on admission which included recognised evidence-based assessment tools. However, the inspectors did not see evidence of any care plans detailing the plan of care to be implemented. While comprehensive narrative nursing reviews of care were observed to be documented in the residents care file, they were not completed on a daily basis.

Physiotherapy, occupational therapy, speech and language therapy and chiropody services were provided to the centre on a regular, as required basis and all therapists documented their care and requirements in the clinical files reviewed. One of the inspectors spoke to a resident who reported that their quality of life had recently been significantly improved, following assessment by the occupational therapist in relation to an appropriate assisted chair to facilitate them to attend mass and go outside which is what they wanted to do. There was also evidence, in the residents' clinical files, of good links with community mental health services. Medication was reviewed routinely by the psychiatrist to ensure optimum health. The inspectors viewed evidence in medical notes of residents attending the local mental health services clinic.

An evidence-based wound care policy was in place and the inspector observed that wound management, within the centre, was effective. Seven of the centres qualified nurses had attended wound management training in 2011.

The centre had a restraint policy in place. Restraint measures were observed to be utilised including the use of bedrails by 41 residents and lap belts by 23 residents. Through interview and review of clinical files inspectors found that bedrails were used at the request of 22 residents/representatives as an enabler.

However, on review of the bed rails in use in the centre they were observed to restrict residents' movement and behaviour and a large number had bumper padding. Consent for restraint was observed to be provided by relatives and residents, where possible. However, practices of restraint management were not reflective of best practice for example, a consensus judgement that the intervention was in the best interests of the resident was not evident, as there was not consistent evidence of other health professionals' involvement in the concluding decision to use bedrails or lap belts and there was no evidence that alternative less restrictive measures had been considered. The inspectors did not observe any documentation of when the restraint is released on each of the residents.

Inspectors observed that a large number of residents were seated in wheelchairs for a large part of the day. On speaking to some of the residents they told the inspectors that they would like more opportunities to walk with assistance or to be brought for walks. However, the inspectors observed these residents being brought to the dining room in wheelchairs. Inspectors also observed 10 residents seated in an open area sitting room "the green" unsupervised. 5 of these residents were in wheelchairs and 2 were in assisted chairs.

There was a structured program of activities in place which was facilitated by an activities coordinator. One of the inspectors spoke with the activity co-ordinator. She had attended training and completed a course in activities for older persons. Activities forming part of the weekly program included daily mass, daily reading of the newspapers, bingo, exercises, card games, music sessions, arts and crafts and story telling to ensure meaningful engagement for residents. The activity schedule provided for both cognitive and physical stimulation. Inspectors observed staff taking the time to include those residents with cognitive impairment and to encourage them to take part in activities in a sensitive manner. Attendance at activities was observed to be recorded in the residents care record.

Nursing staff, care staff, residents and relatives also confirmed that there were regular activities provided. There was an events notice board with up-to-date activities listed and other relevant notices posted.

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 were satisfied that caring for a resident at end of life was regarded as an integral part of the care provided. Practice was informed by the centres' care of the dying policy. However, this policy did not cover end of life wishes, facilitation of family and friends to be with the resident when they are dying, the availability of overnight facilities for family and friends and identification of each resident's choice as to the place of death being identified and facilitated where possible.

Inspectors were informed through staff interview that, where possible, a separate room was made available to residents who required it and whilst there were no specific overnight facilities for family and friends they could be accommodated in the sitting room or a vacant bedroom if there was one available. The provider indicated that all residents are given an opportunity to pay their respects on the occasion of a death.

The centre had two beds allocated for palliative care both of which were vacant on the days of the registration inspection. Palliative care residents are admitted on a respite basis or towards the end of their lives. The local palliative care team provide support and advice when required. Nurses said that hospice services were provided for residents with a cancer diagnosis who required specialist symptom management. Nursing staff had attended a course on end of life care.

The inspector reviewed care plans and noted that personal wishes in relation to religious and spiritual needs were assessed there was no reference to end of life wishes or wishes for place of death. Further development is required in this area to ensure sufficient information is available to plan and meet end of life care.

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

The food provided to residents was of a good standard. Mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff. Two dining rooms were used, one for those residents who could dine independently and one for those who required assistance. Residents who required assistance with nutritional intake were respectfully assisted. Staff were present at all times in both rooms while the residents were having their meal. Residents were seen to enjoy a hot well presented meal. Inspectors spoke to staff serving the meals in the dining room and found they were knowledgeable about individual resident's specialised needs such as a pureed or minced diet.

There was a policy in place to guide and inform staff on the procedures to ensure residents' nutritional and hydration needs were met. Documentation indicated that each resident's weights were checked on monthly basis or more regularly if required. Nutrition assessments were used to identify residents at risk of malnutrition and residents were referred to community dieticians and to speech and language therapists, as required, as evidenced in care plans.

The kitchen was suitable in size to cater for the residents' needs. It was clean, well equipped and contained suitable facilities for the storage, preparation and cooking

of food. A copy of the latest environmental health report was available and evidenced that the kitchen was in substantial compliance with all statutory requirements.

The planned menu was a three week rolling menu offered to the residents on the previous day. However the menu was not displayed. The menu identified that residents, who required their food to be pureed or minced, had the same menu options and this was observed by inspectors on the day of the inspection. Alternatives were provided where the residents did not like the options indicated on the menu. Inspectors observed residents change their mind when they arrived in the dining room and their requests were promptly met by the catering staff. Inspectors also observed staff asking residents about the type of potato they would like and whether they would like gravy or not.

Residents had input into the menu identifying suggested changes at the residents' council. This information was fed back to the catering supervisor via the person in charge. A resident's questionnaire had also recently been undertaken in the centre and the results fed back to the catering supervisor. Residents were also facilitated to cater for themselves as a kitchenette was available, including a fridge, kettle, toaster and microwave.

A substantial proportion of residents were brought to the dining room in wheelchairs and twenty five residents were observed to be served their meal while they sat in the wheelchair.

Inspectors observed residents being offered a variety of snacks and drinks at regular intervals. However, inspectors did not observe access to a supply of fresh drinking water at all times, especially in common areas.

A nutritional assessment of the menu had been undertaken in 2009 by a community dietician. This assessment identified that a 3 week nutritionally complete menu cycle was in place. However, inspectors were informed by the catering supervisor that the three week rolling menu was not always followed. These changes to the menu were not documented and therefore would not facilitate any person inspecting the record to determine whether the diet is satisfactory, in relation to nutrition or otherwise. The 2009 nutritional assessment recommended further areas to focus on including bowel health and fluid promotion. As stated in outcome six a large proportion of residents were prescribed and administered laxatives.

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

Each resident had been provided with a contract of care. The contract of care's terms and conditions included an undertaking to pay an extra charge in respect of any additional service for those ineligible for treatment under the GMS scheme. These services were outlined in the contract of care and included for example, physiotherapy and chiropody. However, the individual cost per item was not specified and therefore was unclear to the resident.

The inspector observed that not all contracts of care had been signed by the residents or their family and not all contracts clearly identified the overall fee payable. A number of contracts identified the fee as "as per fair deal assessment".

The contract of care was contradictory of the requirements of regulation 26. The contract of care identified that the centres insurance policies covered personal effects up to a maximum of £500 per resident. The contract identified that property of greater value was required to be covered by the resident's own insurance.

Outcome 11

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

References:

Regulation 10: Residents' Rights, Dignity and Consultation

Regulation 11: Communication

Regulation 12: Visits

Standard 2: Consultation and Participation

Standard 4: Privacy and Dignity

Standard 5: Civil, Political, Religious Rights

Standard 17: Autonomy and Independence

Standard 18: Routines and Expectations

Standard 20: Social Contacts

Inspection findings

Residents confirmed to the inspection team that the centre was a good place to live and staff cared for them in a dignified and courteous manner. This was confirmed by the questionnaires completed by residents and their relatives submitted to the Authority.

Both relatives and residents confirmed that the provider and person in charge are easily accessible and approachable. Communication between staff and residents was observed to be warm, respectful and amicable and it was obvious that they knew each other well. There was a high level of one-to-one interaction between staff and residents.

This communication was consistently observed to be calm and unhurried over the two days of inspection. Relatives confirmed that they were kept fully informed of any changes or plans regarding their relative's care.

Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move around the centre freely and have visitors at any time, with the exception of mealtimes. Residents had access to a range of newspapers both national and provincial, television and telephone. The provider read both national and provincial papers on a daily basis for the residents and this was viewed very positively. There were notices boards located around the building containing information on the activities planned for the day. However, not all residents in the multi-occupancy rooms could view the televisions due to their positioning in these rooms and residents did not have access to a radio.

Residents could influence change in the centre as a residents' council was established and met on the first Tuesday of every month. The council was chaired by one of the residents. A council meeting took place on one of the days of the inspection and an inspector observed the meeting. 9 residents were in attendance, 5 relatives and 4 staff members, one of whom acted as secretary. Through observation and review of documentation the inspectors identified that a number of the suggestions by the residents' council had been reviewed and implemented. This included portion sizes of meals, menu options, activity choices. The person in charge had facilitated a group of staff to review reported delays in residents being brought to the bathroom and an action plan had been put in place. This action plan included revising the staff allocation rota to ensure a member of staff was available at all times of the day to facilitate this issue.

Residents recently completed questionnaires on catering, dignity and privacy and activities. However, the findings had not been collated into a report with a copy made available to the residents.

Residents maintained social relationships. Inspectors observed that family contacts were supported, as visitors were welcomed throughout the day, with the exception of mealtimes. Residents and their relatives confirmed that flexible visiting was usual. There were areas available for residents to spend time alone with their visitors that assured confidentiality.

Residents could practice their religious beliefs and this was observed to be part of the residents' daily routine with options to attend mass daily, or watch it on TV, and to participate in the rosary. A large oratory was provided. Residents told an inspector they were able to practice their faith and worship according to their wishes. Staff identified that all residents were on the local electorate and members of staff had requested presidential candidates to call to the centre.

While staff were observed to be courteous, the inspectors did observe residents rooms being cleaned in the early morning while residents were still sleeping and the rooms were in darkness. Inspectors also observed that visitors could gain easy, unobserved access to the centre which posed potential risks to residents' privacy and

dignity, if visitors accessed residents' rooms without permission. Inspectors also observed that some resident's bedrooms could be overlooked from corridors as there were no blinds on the windows.

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

Clothing viewed by the inspector was marked discreetly to indicate ownership. No concerns were raised regarding clothes going missing in questionnaires submitted by residents and their relatives. The inspectors visited residents' bedrooms and noted all residents had individual wardrobes and sufficient space to store their clothes. Residents were dressed well in clean clothes that were in good condition and according to their individual choice.

A large laundry facility with space and areas to segregate soiled laundry and store clean items was located within the centre with dedicated staff and secure access. However there was no facilities for residents to do their own laundry if they so wished.

Residents' were encouraged to personalise their bedrooms. Many residents had framed photographs and ornaments located within the vicinity of their beds. There was a policy on the management of residents' personal property and possessions which inspectors noted was consistent with practice. However, an up to date property list was not maintained for each resident. Most residents were provided with a lockable facility by their bedside to allow them secure personal possessions. However, a number of residents did not have a lockable facility.

5. Suitable staffing

Outcome 13

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

References:

Regulation 15: Person in Charge

Standard 27: Operational Management

Inspection findings

The post of the person in charge was full time. The person in charge was a registered nurse with the required experience in the area of nursing of older people to manage the service. The person in charge conveyed a good knowledge of their responsibilities and demonstrated leadership skills. The person in charge demonstrated procedures were in place to ensure the provision of clinical care and the general welfare and protection of residents.

The person in charge continued to keep his skills up-to-date by undertaking ongoing professional development in the areas of healthcare. He was supported in his role by a senior nurse, who deputises in his absence.

The inspectors were satisfied the person in charge had the qualifications, skills and experience to ensure the centre meets its stated purpose, aims and objectives as defined in the statement of purpose.

All members of the team, spoken with were clear about their areas of responsibility and the reporting systems. The management structure ensured sufficient monitoring of and accountability for practice.

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

There were appropriate staff numbers and skill mix to the assessed needs of residents, and to the size and layout of the designated centre. Staff were observed to be skilled and motivated. In the questionnaires returned to the inspectors all relatives said they found there was adequate staff on duty.

The inspectors found that the levels and skill mix of staff were sufficient to meet the needs of residents on the days of inspection and a review of staffing rotas indicated that these were the usual arrangements. The inspector also spoke to night staff who displayed a good understanding of evidenced based nursing. The inspector observed that handovers between night and day staff were well organised and ensured the effective communication of residents needs from one shift to another.

A senior nurse deputised for the person in charge when he was absent. Part-time staff did additional hours to cover other staff absences, so agency arrangements were not necessary. The review of the rota found that absences were sufficiently covered. There was a low staff turnover within the past 12 months ensuring continuity and consistency in care.

Staff informed inspectors that copies of both the regulations and the standards had been made available to them and they expressed knowledge of their content to the inspectors. The person in charge maintained a record of An Bord Altranais PINs (professional identification numbers) for all registered nurses. This was reviewed by inspectors and seen to be up to date. 19 of the 27 care assistants had completed Further Education and Training Awards Council (FETAC) level five training or equivalent. All staff spoken to were clear about their roles and responsibilities and were able to explain these to the inspector.

A policy for the recruitment, selection and vetting of staff was in place. However this policy was not comprehensive as it did not sufficiently inform practice, for example selection of a candidate, the requirement to check three references, the registration status of relevant professionals and the requirement to vet volunteers. A formal induction process had recently been implemented and records of induction training were maintained. A sample of ten staff files were examined to assess the documentation available, in respect of persons employed. While the majority of the information required by schedule two of the regulation was available in the staff files there were not three written references in place in respect of each employee and only one of the files had a copy of the person's birth certificate.

Volunteers did not have their roles and responsibilities set out in a written agreement and were not vetted appropriate to their role and level of involvement in the designated centre.

The provider and person in charge were committed to providing on going training to staff, and both participated in training events. Mandatory training in adult protection had been completed by all staff. However, 18 staff had not completed their fire training. This included two nurses who worked on night duty and 10 carers. The person in charge has scheduled further fire training for the 12 and 19 October 2011. A range of modular training was undertaken by accredited trainers and an inspector reviewed the certificates issued by trainers in staff files. This included care of the elderly with dementia and behaviours that challenge, infection prevention and control, medication management, and wound management.

6. Safe and suitable premises

Outcome 15

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

References:

Regulation 19: Premises

Standard 25: Physical Environment

Inspection findings

The centre was specifically built to meet the needs of dependent older people. The environment was bright and clean throughout. Residents reported that the centre offered a homely comfortable environment and told inspectors that they enjoyed the lifestyle provided. Communal areas such as the day-rooms had a variety of pleasant furnishings. There was an enclosed garden provided with seating available for use by residents. Furthermore, an external seating area was provided close to the main entrance and the area was decorated with potted flowers.

Single and twin bedded bedrooms were furnished and equipped to assure the leisure and comfort needs of residents were met. The physical environment of multi-occupancy rooms posed challenges in ensuring residents' privacy and dignity though residents told inspectors that they liked sharing a room and would not be anxious to move to a smaller room. There was no treatment room available for clinical examinations and the delivery of intimate care.

There was a call bell system in place at each resident's bed with which residents were familiar and found easy to use. Bedrooms and communal areas were found to be comfortably warm. Windows were at a level where residents could sit and look out in both their bedrooms and the day rooms.

There were a sufficient number of toilets provided to meet the needs of the residents. Bathrooms were designed to provide easy access by wheelchair users. Showers were level with the floor finish allowing for ease of use by the residents. Hand testing indicated the temperature of radiators and the hot water did not pose a burn or scald risk to residents. There were toilet facilities beside day areas for residents' convenience and they did not have to return to their bedroom to use the bathroom.

Inspectors found there was appropriate assistive equipment available such as specialised beds, hoists, pressure relieving mattresses, wheelchairs and walking frames. While corridors were narrow, a one way system was in place to facilitate accessibility for residents in wheelchairs or those with mobility aids. Hand rails were available to promote independence.

Service records for equipment were reviewed by the inspector and included beds, call bells, mattresses and feeding pumps. Parts had been identified as missing for hoists in November 2010. However, there was no evidence that these parts had been replaced. The inspector did not see evidence that wheelchairs and assisted chairs had been serviced.

Staff facilities were provided which included a changing room with lockers and toilet facilities. Separate toilet facilities were provided for catering staff in accordance with best practice for infection prevention and control.

Suitable external lighting was provided. The entrance to the centre was monitored by Closed Circuit Television (CCTV) surveillance. However, the nurses' station was located towards the back of the centre leaving this entrance area unsupervised.

The physical environment did not comply fully with the regulations:

- there were not an adequate number of bathing facilities to meet the individual needs of the residents. Taking into account the maximum number of residents that can be accommodated; there are only four suitably adapted bathrooms with a shower/bath available to meet the needs of 52 residents. Not all of these baths were fit for purpose
- the sluice room did not contain a bed pan washer which posed an infection control risk as bed pans and urinals were used within the centre
- walls and doors in both bedrooms and communal areas were not well maintained and required redecoration
- the pathway surrounding the perimeter of the centre had uncovered manholes and was uneven posing a risk to residents walking around the centre and in the event of evacuation of the centre in the event of an emergency.

7. Records and documentation to kept at a designated centre

Outcome 16

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

References:

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

Inspection findings

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

Resident's guide

Substantial compliance

Improvements required*

There was a residents' guide available in a communal area which contained valuable information to assist prospective residents to make a decision regarding choosing a placement. However, the inspectors have no evidence that each resident had been provided with an individual copy of the residents' guide and the complaints process required updating.

Records in relation to residents (Schedule 3)

Substantial compliance

Improvements required*

Formal care plans were not in place for each resident.

General records (Schedule 4)

Substantial compliance

Improvements required*

The centre did not have a record of furniture brought by a resident into the room occupied by them.

The centre did not hold a complete record of all complaints made and the action taken by the registered provider in respect of any such complaint.

The centre did not have a record of the food provided for residents in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory, in relation to nutrition and otherwise, and of any special diets prepared for individual residents.

The centre did not maintain a record of the names of all visitors to St. Camillus Nursing Centre.

Operating policies and procedures (Schedule 5)

Substantial compliance

Improvements required*

There was no written health and safety policy including food safety, of residents, staff and visitors.

Inspectors viewed a sample of policies and found that, as identified in outcomes four, seven, eight and fourteen; some policies did not sufficiently inform practice and required review.

Directory of residents

Substantial compliance

Improvements required*

Staffing records

Substantial compliance

Improvements required*

Staff records did not contain all documents as set out in Schedule 4.

Medical records

Substantial compliance

Improvements required*

While comprehensive narrative nursing reviews of care, including the resident's condition and any treatment or surgical intervention, were observed to be documented in the residents care file, they were not completed on a daily basis. A record of any restraint used on a resident was not observed

Insurance cover

Substantial compliance

Improvements required*

Public and employers liability insurance was provided. However, it was not clear from the information presented that insurance cover for residents' property to the value of €1000 per item was in place in accordance with Regulation 26 and confirmation of this is requested in the action plan of this report.

The contract of care was contradictory of the requirements of regulation 26. The contract of care identified that the centres insurance policies covered personal effects up to a maximum of £500 per resident. The contract identified that property of greater value was required to be covered by the resident's own insurance.

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

Practice in relation to notifications of incidents was satisfactory. Inspectors reviewed records of incidents that had occurred in the designated centre and were satisfied that all relevant incidents were notified to the Chief Inspector as required.

At interview the person in charge demonstrated a good understanding of his responsibilities to maintain records of all incidents occurring in the centre. He was also aware that he was legally obliged to notify the Chief Inspector of incidents such as serious injury to a resident or an outbreak of infection. Quarterly notifications had been submitted to the Authority as required.

Outcome 18

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

References:

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

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

Standard 27: Operational Management

Inspection findings

There were appropriate arrangements in place for the absence of the person in charge. The assistant director of nursing deputised for the person in charge. Inspectors were informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

At interview the provider demonstrated a good understanding of his responsibility to notify the Chief Inspector of the expected or unexpected absence of the person in charge and the arrangements in place for the management of the designated centre during his absence. The person in charge confirmed that he had not been and did not plan to be absent from the centre.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Ann Delany
Inspector, Social Services Inspectorate
Health Information and Quality Authority
18 October 2011

Action Plan

Provider's response to inspection report*

Centre:	St Camillus Nursing Centre
Centre ID:	098
Date of inspection:	04 and 05 October 2011
Date of response:	2 November 2011

Requirements

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

Outcome 1: Statement of purpose and quality management

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

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

Action required:

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

Action required:

Make a copy of the statement of purpose available to the Chief Inspector.

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

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 statement of purpose has been revised and amended as recommended. A copy has been sent to the Authority.	12 November 2011

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

2. The provider is failing to comply with a regulatory requirement in the following respect: A formal survey was undertaken to review the quality of life and safety of care. However, the findings had not been collated into a report with a copy made available to the residents.	
Action required: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.	
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: Report of audits on dignity, meals, dining and activities was examined by inspectors. It has now been made available to residents. Audits will continue to be carried out in these areas and made available to residents when complied.	31 October 2011

Outcome 3: Complaints procedures

3. The provider is failing to comply with a regulatory requirement in the following respect: The complaints process was not prominently displayed within the centre.
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Action required: Display the complaints procedure in a prominent position in the designated centre.	
Reference: Health Act, 2007 Regulation 39: Complaints procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Copies of the complaints policy are available to be taken by anyone so desiring. Copies are now prominently displayed at nurses' station and in the sitting rooms as well as in the front hall.	1 November 2011

4. The provider is failing to comply with a regulatory requirement in the following respect: Not all complaints were recorded in the complaints log and the log did not always record the complainant's satisfaction.	
Action required: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.	
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All complaints are now logged in one complaints log. Staff have been briefed on the new procedure that all complaints are to be made known to the nurse in charge and that all complaints must be logged. Complainant's response to the outcome is now also recorded.	1 November 2011

Outcome 4: Safeguarding and safety

<p>5. The provider is failing to comply with a regulatory requirement in the following respect: The Elder Abuse policy did not provide sufficient guidance to staff on the assessment, reporting and investigation of all allegation of abuse as it did not describe the process if an allegation of abuse is made about a senior member of staff nor did it provide contact details of the local elder abuse officer in the Health Service Executive (HSE) and the local An Garda Síochána office.</p>	
<p>Action required: Review policy on and procedures for the prevention, detection and response to abuse to include process if an allegation of abuse is made about a senior member of staff and contact details for An Garda Síochána and the Health Service Executive Elder Abuse Officer.</p>	
<p>Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response: Policy and procedures have now been revised to outline procedures to be followed if any allegation of abuse is levelled at a member of the senior management team. This policy now also includes contact details for Garda and HSE Elder Abuse Officers. Staff have been informed of the contact phone no now in the policy and updated on the new policy. A copy of the policy is on display in the staff canteen for easy access.</p>	<p>1 November 2011</p>

<p>6. The provider is failing to comply with a regulatory requirement in the following respect: The inspectors observed that members of the public could easily access the centre, without meeting a member of staff, as the front door was on a release button and the staff work station is located at the back of the centre.</p>	
<p>Action required: Put in place all reasonable measures to protect each resident from all forms of abuse.</p>	
<p>Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection</p>	

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>The CCTV monitoring system screen has now been moved. The front door can now be monitored from the Administrators office as well as at the nurses' station.</p> <p>The front door will be locked and an intercom or bell system put in place for gaining access to the centre. Staff will have a card swipe system for access. We are sourcing different systems at the moment and have obtained one quote. The new systems will be installed as soon as possible.</p>	<p>1 November 2011</p> <p>31 December 2011</p>

Outcome 5: Health and safety and risk management

<p>7. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The centre did not have written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.</p>	
<p>Action required:</p> <p>Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 30: Health and Safety Standard 26: Health and Safety</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>We have sourced a company who are to work on our behalf in devising a Health and Safety Policy which will include all the requirements. They are starting to prepare this statement on 21 November 2011.</p> <p>We will forward these policies as soon as they are completed.</p>	<p>9 December 2011</p>

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

The risk management policy did not contain procedures to guide staff in the event of violence, aggression, self harm and assault, record incidents, accidents or near misses or how to undertake a risk assessment. Furthermore, it did not include a governance procedure for formal arrangements to ensure learning for all staff from serious or untoward incidents or adverse events.

Action required:

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.

Action required:

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

Action required:

Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

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

Timescale:

Provider's response:

We have sourced a company who are to work on our behalf to update our policies. They are starting to prepare these policies on 21 November 2011. They will include formal arrangement for learning from all incidents.

We will forward these policies as soon as they are completed.

9 December 2011

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

Not all bathrooms had grab rails in place in bath, shower and toilet areas.

Action required:

Provide grab-rails in bath, shower and toilet areas.

Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Grab rails to be inserted in all toilets and bathrooms.	30 November 2011

10. The provider is failing to comply with a regulatory requirement in the following respect: Hazards, including the open lids on sharps bins, unidentified clinical waste, the broken external fence, the external path, moderate levels of high dust, unclean equipment and the supports for televisions in residents rooms placed residents, visitors and staff at risk of accidental injury There was no evidence of routine safety audits to proactively manage risk on a regular basis.	
Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All reasonable measures to be taken regarding safety in the centre and in the grounds. <ol style="list-style-type: none"> 1. Sharps bins are now kept in a locked restricted entry room. 2. Clinical waste is now clearly labelled with name and date and kept in a restricted entry locked room 3. Colour coded cleaning equipment has been purchased and staff are currently being trained and will commence using on 1 December 2011. A new cleaning routine will commence 	9 November 2011 24 October 2011 1 December 2011

<p>on this day, detailing specific duties to be completed on designated day (high dusting etc.)</p> <ol style="list-style-type: none"> 4. External paths to be adjusted and maintained. 5. TV's to be wall mounted. Old style TV's to be replaced. 6. External fence to be repaired. 7. Safety audits to be commenced in line with revised health and safety policy as prepared by outside company. 	<p>30 November 2011 30 November 2011 16 November 2011 9 December 2011</p>
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<p>11. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The centre did not have adequate means of escape and adequate arrangements were not in place for the evacuation, in the event of fire, of all persons in the designated centre.</p>	
<p>Action required: Provide adequate means of escape in the event of fire.</p>	
<p>Action required: Make adequate arrangements for the evacuation, in the event of fire, of all people in the designated centre and the safe placement of residents.</p>	
<p>Reference: Health Act, 2007 Regulation 32: Fire precautions and records Standard 26: Health and Safety</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> <ol style="list-style-type: none"> 1. A review of our evacuation policy has now been undertaken. (attached) This began with the recent fire drill carried out by the fire inspector. We have visited another nursing home to study their means of evacuation and are taking on board some of their ideas. 2. A fire strategy plan is being devised by the company we have employed, a basic plan is attached. Staff training will be incorporated into the new fire plan. Training will be completed by 31 December 2011 3. In the meantime, the local Mullingar fire station have been contacted and asked to visit the centre to familiarise themselves with the building and they are putting a fire plan in place for St. Camillus'. The civil defence have also been contacted and are arranging a visit to the Centre. 4. Map depicting details of fire detection and alarm system is displayed beside the detection panel. This map clearly depicts all exits. 	<p>16 November 2011 9 December 2011 16 Nov 2011 30 Oct 2011</p>

5. Extra signage is in place clearly indicating the position and direction of exits.	30 Oct 2011
6. The three emergency exits which have steps outside will be ramped in line with health and safety regulations. Work is underway on these at the moment, one is completed and work has commenced on the other two.	20 Nov 2011
7. The pathways leading away from these exits will be widened for ease of movement of wheelchairs. Work has commenced on these pathways.	20 Nov 2011
8. The manholes have been covered.	13 Nov 2011

Outcome 6: Medication management

<p>12. The provider is failing to comply with a regulatory requirement in the following respect: Single patient use insulin pens did not identify the individual resident that had been prescribed the medication.</p>	
<p>Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, administration and storing of medicines to residents and ensure that staff are familiar with such policies and procedures.</p>	
<p>Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response: Insulin pens are now individually labelled with a pharmacy supplied label. This requirement has been inserted into the medication management policy and staff nurses have been made aware of the changes to the policy.</p>	<p>30 October 2011</p>

Outcome 7: Health and social care needs

<p>13. The person in charge is failing to comply with a regulatory requirement in the following respect: Care plans detailing the plan of care to be implemented were not documented and care plans in relation to restraint were not fully reflective of best practice.</p>	
<p>Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.</p>	

Action required: Make each resident's care plan available to each resident.	
Action required: Put in place appropriate and suitable practices relating to the use of restraints in accordance with evidenced-based practice.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Residents needs will be set out in an individual care plan. This Care Plan will be compiled in conjunction with and agreed by the resident. 40 are completed (16 November 2011)	9 December 2011
This plan to be made available to the resident.	9 December 2011
Restraints Policy and education to be implemented in line with evidenced-based practice.	31 January 2012

14. The provider is failing to comply with a regulatory requirement in the following respect: Residents were not being supported on an individual basis to achieve and enjoy the best possible health as they were not being facilitated to mobilise with assistance.	
Action required: Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.	
Reference: Health Act, 2007 Regulation 9: Health Care Standard 13: Healthcare Standard 15: Medication Monitoring and Review Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	Timescale:

<p>Provider's response:</p> <p>Rotas are now in place to assist residents maintain, or improve where appropriate, their level of mobility. This is to include more walking to and from the church and the dining rooms.</p>	30 October 2011
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Outcome 8: End of life care

15. The provider is failing to comply with a regulatory requirement in the following respect:
 Personal wishes in relation to end of life care were not sufficiently detailed in each case file and further development is required in this area.

Action required:
 Identify and facilitate each resident's choice as to the place of death, including the option of a single room or returning home.

Reference:
 Health Act, 2007
 Regulation 14: End of Life Care
 Standard 16: End of Life Care

Please state the actions you have taken or are planning to take with timescales:	Timescale:
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<p>Provider's response:</p> <p>End of Life care is an integral part of the life at St. Camillus. The practice is now detailed in the policy.</p> <p>Before speaking with residents about end of life issues it is our pastoral practice to get to know the resident. This is now documented in the policy.</p> <p>A single room is always offered when available to a resident at the end of their life. A small number of residents have gone home for end of life care. This practice of choice is now documented in the policy.</p> <p>In the upgrading of the centre, which is planned for next year, a room is laid aside for those facing their final days and an adjacent sitting room for their relatives.</p>	<p>30 October 2011</p> <p>30 October 2011</p> <p>30 October 2011</p> <p>September 2012</p>
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Outcome 9: Food and nutrition

16. The person in charge is failing to comply with a regulatory requirement in the following respect:
 Residents did not have access to fresh drinking water at all times.

The daily menu was not displayed for residents	
Action required: Provide each resident with access to a safe supply of fresh drinking water at all times.	
Action required: Display the daily menu in a suitable format so that residents know what is available at each mealtime.	
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:
Provider's response: Fresh drinking water is now available in all sitting rooms. The staff will encourage the residents to drink more fluids during meals. The daily menu is now displayed in the dining rooms. The changes to the three week rolling menu are now being documented by the catering staff.	30 October 2011 30 October 2011

Outcome 10: Contract for the provision of services

17. The provider is failing to comply with a regulatory requirement in the following respect: Not all contracts were signed within one month of admission and a number of contracts did not include details of the fees to be charged or services provided.
Action required: Agree a contract with each resident within one month of admission to the designated centre.
Action required: Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>The contract of care is to be updated to include fees, services provided and additional charges. Legal opinion is currently being sought on the updated contract of care.</p> <p>A procedure is now in place to ensure that the Administrator arranges for all Contacts of Care to be signed within one month of admission.</p>	<p>30 January 2012</p> <p>30 October 2011</p>

Outcome 11: Residents' rights, dignity and consultation

<p>18. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Residents' rooms were cleaned in the early morning while residents were still sleeping.</p> <p>Some resident's bedrooms could be overlooked from corridors as there were no blinds on the windows.</p>	
<p>Action required:</p> <p>Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 4: Privacy and Dignity Standard 17: Autonomy and Independence</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Cleaning timetable has been revised to ensure that cleaners start cleaning at the later time of 08:30 hrs.</p> <p>Residents' privacy in overlooked rooms will be ensured by the hanging of net curtains on the relevant windows (rooms 1-6). These have been measured and purchased and will be in place next week.</p>	<p>30 October 2011</p> <p>30 November 2011</p>

<p>19. The provider is failing to comply with a regulatory requirement in the following respect: Not all residents in the multi-occupancy rooms could view the televisions due to their positioning in these rooms and residents did not have access to a radio.</p>	
<p>Action required: Put arrangements in place for each resident to access radio and television.</p>	
<p>Reference: Health Act, 2007 Regulation 11: Communication Standard 20: Social Contacts</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response: To ensure all the residents in the multi occupancy rooms can enjoy the television larger flat-screen TV's will be mounted on the walls. These have been purchased and will be mounted on wall brackets. Radio access will also be provided to residents.</p>	<p>30 November 2011</p>

Outcome 12: Residents' clothing and personal property and possessions

<p>20. The provider is failing to comply with a regulatory requirement in the following respect: An up to date property list was not maintained for each resident.</p>	
<p>Action required: Maintain an up to date record of each resident's personal property that is signed by the resident.</p>	
<p>Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity Standard 17: Autonomy and Independence</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response: An up-to-date list of individual residents' property will be maintained. This process has commenced with comprehensive lists of all possessions and clothing and 20 are completed. However, a number of residents are refusing to complete the property list.</p>	<p>9 December 2011</p>

Outcome 14: Suitable staffing

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

A policy for the recruitment, selection and vetting of staff was in place. However this policy was not comprehensive as it did not sufficiently inform practice, for example selection of a candidate, the requirement to check three references and the registration status of relevant professionals.

While the majority of the information required by schedule two of the regulation was available in the staff there were not three written references or birth certification in place in respect of each employee.

Action required:

Put in place written policies and procedures relating to the recruitment, selection and vetting of staff.

Action required:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

Action required:

Put in place recruitment procedures to ensure the authenticity of the staff references referred to in Schedule 2.

Reference:

Health Act, 2007
Regulation 18: Recruitment
Standards 22: Recruitment

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

Timescale:

Provider's response:

The recruitment policy has now been update to include the procedures for the selection and vetting of new staff.

30 October 2011

Procedures have been put in place to ensure that all documentation specified in Schedule 2 has been obtained and references are verified by telephone with the referee.

30 October 2011

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

Volunteers did not have their roles and responsibilities set out in a written agreement and were not vetted appropriate to their role and level of involvement in the designated centre.

Action required: Set out the roles and responsibilities of volunteers working in the designated centre in a written agreement between the designated centre and the individual.	
Action required: Ensure volunteers working in the designated centre are vetted appropriate to their role and level of involvement in the designated centre.	
Reference: Health Act, 2007 Regulation 34: Volunteers Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All volunteers will have a written agreement outlining their roles and responsibilities, signed by the volunteer. Some of these agreements are in place. All volunteers are now supervised by the nurse in charge or the head of the relevant dept. Garda vetting will be obtained for each volunteer. In the meantime, self declaration forms are being sent out for completion.	31 January 2012 15 November 2011 31 March 2012

Outcome 15: Safe and suitable premises

<p>23. The provider is failing to comply with a regulatory requirement in the following respect: The physical environment of multi-occupancy rooms posed challenges in ensuring residents' privacy and dignity.</p> <p>The nurse's station was located towards the back of the centre leaving this entrance area unsupervised.</p> <p>There were not an adequate number of bathing facilities to meet the individual needs of the residents.</p> <p>The sluice room did not contain a bed pan washer which posed an infection control risk as bed pans and urinals were used within the centre.</p> <p>Walls and doors in both bedrooms and communal areas were not well maintained and required redecoration</p> <p>The pathway surrounding the perimeter of the centre had uncovered manholes and was uneven posing a risk to residents walking around the centre and in the event of</p>
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<p>evacuation of the centre in the event of an emergency</p> <p>Service records for all equipment was not available in the centre.</p>	
<p>Action required: Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.</p>	
<p>Action required: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.</p>	
<p>Action required: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.</p>	
<p>Action required: Provide a sufficient number of baths and showers having regard to the number of residents in the designated centre.</p>	
<p>Action required: Provide necessary sluicing facilities.</p>	
<p>Action required: Provide and maintain external grounds which are suitable for, and safe for use by residents.</p>	
<p>Action required: Maintain the equipment for use by residents or people who work at the designated centre in good working order.</p>	
<p>Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment</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> <ol style="list-style-type: none"> 1. The issue of the multi-occupancy rooms, bathing facilities and physical design of the centre will be addressed in the planned extension to the centre. Plans are currently with Westmeath County Council, awaiting a decision on planning permission and have been made available to the Authority. In the meantime, curtains are provided around each bed which provides privacy, when having a conversation staff lower their tone or if possible, residents are moved to a 	<p>September 2012</p>

private room.	
2. The bathroom and shower needing repair are to be converted into one large wet room and a new wheelchair accessible shower facility built in an existing storage room. Work on these will commence asap. The new build planned for 2012 will provide all private rooms with en suite facilities.	31 December 2011
3. The smoking room dividing wall is to be a permanent wall and work will commence on this asap.	31 December 2011
4. As stated previously, the front door will be locked and there will be restricted access to the nursing home.	31 December 2011
5. A new bed-pan washer and hopper has been ordered and will be installed in 6 – 9 weeks.	31 December 2011
6. An on-going painting and decorating programme is in place. The painter has been commissioned to start painting the areas needing decorating.	31 December 2011
7. The Pathways around the centre are being widened, builders are on site, the fire exit ramp is completed and the cement is being poured tomorrow for the others and the man-holes have been covered.	20 November 2011
8. Service records are maintained for all equipment and were available to the inspectors of the day of inspection.	

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

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

The residents guide did not contain a copy of the revised complaints policy and a copy had not been provided to each resident.

Action required:

Produce a resident's guide which includes a summary of the revised complaints procedure provided for in Regulation 39.

Action required:

Supply a copy of the resident's guide to each resident.

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:
<p>Provider's response:</p> <p>The residents' guide is in the process of being updated to include the revised complaints policy and a copy of the contract of care and the approved statement of purpose. Once we have obtained the legal opinion on the contract of care, and the statement of purpose is satisfactory, we will ensure that every resident has a copy of the guide. The contract is with our solicitor. Statement of purpose is attached.</p> <p>In the mean time, copies of the revised Complaints Procedure are available in all public areas, inside the front door, communal areas and at the nurses' station.</p>	<p>31 January 2012</p> <p>30 October 2011</p>

<p>25. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Formal care plans were not in place for each resident.</p> <p>Records were not maintained of the food provided for residents in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory in relation to nutrition and otherwise.</p> <p>A record of all visitors to the designated centre, including names of the visitors, was not maintained.</p>	
<p>Action required:</p> <p>Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 22: Maintenance of records Standard 32: Register and Residents' Records</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Residents need's will be set out in an individual care plan. This Care Plan will be compiled in conjunction with and agreed by the resident. 40 are completed (16 November 2011).</p> <p>A centre-specific formal care plan template has now been</p>	<p>9 December 2011</p> <p>30 October 2011</p>

<p>developed with the assistance of an expert from the HSE. The care plan is drawn up, in conjunction with the resident or their relative, to meet their individual needs. Every resident or their representative signs the care plan. The assessments will continue to be reviewed on a three monthly basis. Care plans reflect the changing status of the resident. Problems and goals are identified and an action plan put in place to achieve this.</p>	
<p>A record of all visitors to the centre is now maintained with the provision of a log inside the front door and notifications are posted to remind visitors to sign in and out.</p>	<p>30 October 2011</p>
<p>The assistance of a dietician is being sought to ensure that the food provided to the residents meets their nutritional needs. A procedure will be put in place to record all food provided to the residents.</p>	<p>31 January 2012</p>

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

While comprehensive narrative nursing reviews of care, including the resident's condition and any treatment or surgical intervention, were observed to be documented in the residents care file, they were not completed on a daily basis. A record of any restraint used on a resident was not observed.

All medication was transcribed by registered nurses within the centre in the absence of an audit of transcribing practices. The commencement date of the medication was not transcribed onto the medication kardex.

Action required:

Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Action required:

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.

Action required:

Maintain, in a safe and accessible place, a record of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.

Reference:

- Health Act, 2007
- Regulation 25: Medical Records
- Standard 13: Healthcare
- Standard 14: Medication Management
- Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>A comprehensive narrative will be maintained, in line with the revised Care Plans, on each resident on a daily basis, signed and dated by the nurse on duty.</p> <p>A record of restraint is maintained on individual residents. The nature of restraint and its duration is recorded. This was available on the day of inspection.</p> <p>A procedure is now in place to record each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of drug or medicine, method of administration, signed and dated by the medical practitioner and the nurse administering the drug and medicines.</p> <p>The decision to transcribe prescriptions has been made in the best interest of residents in accordance with section 2 of the An Bord Altranais guide, July 2007, on medication management. Monthly audits will be undertaken, checking that the transcribing has been signed by 2 nurses, correct date of commencement of drug is documented, that the drug and dosage is correct. Our policy will also detail the procedure if a nurse is unclear about a transcribed prescription.</p>	<p>30 October 2011</p> <p>30 October 2011</p> <p>22 November 2011</p>

<p>27. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>It was not clear that the insurance cover in place was in accordance with Regulation 26 (2).</p>	
<p>Action required:</p> <p>Ensure the insurance cover in place against loss or damage to the property of residents including liability is as specified in Regulation 26 (2).</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 26: Insurance Cover</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Clarification is being sought from the insurance co. Email will be forwarded as soon as received.</p>	<p>In progress</p>

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

There was no written health and safety policy including food safety, of residents, staff and visitors. A number of the schedule 5 policies did not sufficiently inform practice as identified in outcomes four, seven, eight and fourteen.

Action required:

Put in place all of the written and operational policies listed in Schedule 5.

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:

Provider's response:

The assistance of professional health and safety and risk management advisors is being sought to develop the policies relating to these areas.

9 December 2011

The schedule five policies in relation to outcomes:

No 4. End of life care.

3 November 2011

No 7. Provision of Information to residents. This policy will be complete when the residents' guide is available.

31 January 2012

No 8. Creation of, access to, retention of and destruction of records. This policy will be revised.

30 November 2011

No 14. Missing persons. This policy has been revised.

30 October 2011

Any comments the provider may wish to make:

Provider's response:

None supplied

Provider's name: Fr. Frank Monks.

Date: 22 November 2011