Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

Centre name:	Merlin Park Hospital Unit 5 and Unit 6
Centre ID:	0635
Centre address:	Merlin Park Hospital Merlin Park Galway
Telephone number:	091 775569
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Email address:	David.OKeeffe@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive (HSE)
Person authorised to act on behalf of the provider:	Dr. David O'Keefe
Person in charge:	Angela O'Donoghue
Date of inspection:	11 and 12 October 2011
Time inspection took place:	**Day-1 Start:** 09:30 hrs **Completion:** 17:30 hrs **Day-2 Start:** 08:45 hrs **Completion:** 18:00 hrs
Lead inspector:	Nan Savage
Support inspector:	Finbarr Colfer
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **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

Unit 5 and unit 6 are located on the Merlin Park Hospital site and are situated approximately 5 kilometres from the centre of Galway City.

Both units are located in a single-storey building which opened in the 1940s as a tuberculosis hospital and was later used as an orthopaedic and paediatric unit. The Units became residential centres for older people in 1988.

The provider has applied for 52 residential places including two dedicated special need places for the delivery of palliative care. At the time of inspection there were 48 residents. Unit 5 originally had places for 41 residents but this number has now been reduced to 26 while unit 6 can accommodate a maximum of 26 residents. A considerable number of residents in both units had dementia.

Units 5 and 6 have separate entrances and each entrance door is fitted with a key-pad system. Both units are similar in layout. There is an entrance area and the administration offices, medication room and staff facilities are located in this vicinity. A wide corridor extends the full length of the building and residents' bedrooms, the day-room and toilets are located off this corridor. The day-room in Unit 5 is also used as the dining room and is near the entrance area. Since the previous inspection a second day-room has been provided in Unit 5 and a new dining room with a seating area has been provided in Unit 6. A conservatory is positioned off the day-room in each unit. The conservatory in Unit 6 is used as the designated smoking room for both units.

In Unit 5 there are four single bedrooms without en suite facilities and six four-bedded rooms all with en suite assisted shower, toilet and wash-hand basins. There are four additional residents' toilets and one of these toilets has an assisted shower. An assisted bathroom and assisted shower room are also located in each unit. Nine single bedrooms and three twin bedrooms without en suite facilities are used for respite purposes in Unit 6. There are also three four-bedded rooms all with an en suite assisted shower, toilet and wash-hand basin in this Unit. One of the single bedrooms in each unit is a special care needs room with a separate seating area. These rooms are used for palliative care. Another single room in Unit 5 is used as a designated infection control room and has an en suite facility. These rooms are used to meet the needs of existing residents ad are not used to accommodate additional residents.

The building is wheelchair accessible and parking for staff and visitors is provided. At the rear of the building there is a secure landscaped garden and a patio area with seating. Residents can access this area from both conservatories.

A resource centre and day-care centre are located on the grounds of Merlin Park Hospital and residents may attend if they so wish. A church, coffee shop, pedestrian walkways and public transport are also available within the grounds.

Date centre was first established:			1988	
Number of residents on the date of inspection:			48	
Number of vacancies on the date of inspection:			4	
Dependency level of current residents:	Max	High	Medium	Low
Unit 5 Unit 6	16 15	5 6	2 1	1 2
Gender of residents			Male (✓)	Female (✓)
			✓	✓

Management structure

Reporting structures for Units 5 and 6 are within the management arrangements for the acute services of Merlin Park Hospital, part of Galway University Hospital. The Registered Provider is the Health Service Executive (HSE), and is represented by the Clinical Director of Acute Services and Continuing Care, Dr. David O'Keefe. Dr O'Keefe made the application for registration on behalf of the Provider and is referred to as the Provider throughout the remainder of this report.

Mary Mc Hugh is the Director of Nursing (DON) for the hospital, including Units 5 and 6 and reports to David O'Keeffe. She is supported by an Assistant Director of Nursing (ADON), Angela O'Donoghue who is responsible for a number of Units including Units 5 and 6. Since the last inspection Angela O'Donoghue has been appointed Person in Charge. She is supported in her role by a Clinical Nurse Manager 1 (CNM1) in Unit 5 and a CNM1 in Unit 6. Additional support is also provided by nursing administration and a CNM3 who also deputises for the Person in Charge in her absence.

Staff nurses and care assistants all report directly to the CNMs in each unit who in turn report to the Person in Charge. Domestic staff and the Porter report to the Person in Charge on a daily basis and also to a CNM3 in support services. A Ward Clerk provides administrative support in each unit and reports to the Person in Charge.

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

This report 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.

Prior to the inspection, the Authority received information of concern that related to staffing, use of resources, provision of activities and complaints management. These issues were included in the inspection. Inspectors found no evidence to support the information relating to complaints management and use of resources but did find that there were issues in relation to staffing and the provision of activities for residents with a cognitive impairment. These are discussed in the body of the report.

Inspectors met with residents, relatives, and staff members over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. A fit person interview was carried out with the person in charge who had completed the fit person self-assessment document in conjunction with a CNM2 from Unit 5 and the provider. All information provided in the registration application form and supporting documentation were reviewed prior to inspection.

The previous action plan contained a substantial number of required actions and inspectors noted that significant progress had been made and that the majority of these actions had been addressed. While some actions relating to areas such as residents' care planning and social care had not been fully addressed, improvements had been made.

The management team were committed to providing ongoing training to staff and had priortised training based on need. Staff had received education in areas such as dementia care and inspectors noted that staff interaction with all residents was sensitive and appropriate to the needs of the resident. Overall residents' healthcare needs were being well met and there was good access to allied health and specialist services. There were no residents with pressure sores and inspectors found that good systems were in place for the prevention and management of wounds. Since the last inspection some facilities had been upgraded and this had created a more pleasant living environment for residents. The dining experience had been enhanced and this gave residents a greater opportunity to interact with each other and with staff. A risk management policy was in place and included risk assessments for specific areas within the units.

Despite this good practice, inspectors found that the staffing arrangements were not adequate to consistently meet the needs of residents. During some parts of the day residents, including some very dependant residents were not adequately supervised. Inspectors noted that even though extra staff were on duty during the inspection, all staff during these periods were very busy providing direct care and were not available to provide adequate supervision for residents in communal rooms.

Parts of the documented care planning process were completed to an adequate standard but some gaps were identified and the plans did not reflect the good standard of care being provided. Some aspects of the medication management process and management of the use of restraint also required improvement.

Some other improvements were required to comply with the Regulations. While the person in charge had completed an extensive review of the operational policies some did not reflect centre specific arrangements. Other policies were still in draft format and had not been implemented.

These issues are discussed under the outcome statements and related actions 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 met the requirements set down in the Regulations.

Inspectors found that the statement of purpose included a statement of the aims, objectives and ethos of the centre. The facilities and services that the centre provided were clearly described and a statement as to the matters listed in Schedule 1 of the Regulations were included.

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
Systems were in place to review the quality and safety of care. Audits had been completed in areas such as hygiene control and falls. While action had been taken in this area since the previous inspection, some improvements were required to ensure all information gathered informed learning.

Inspectors viewed a sample of audits that had been carried out in hygiene control and falls management. The audit results were used to inform learning and brought about service improvement. For example, a hygiene audit carried out in June 2011 had identified some areas for improvement. Minutes viewed confirmed that the audit results and subsequent learning was shared through a staff meeting to discuss hygiene control and address the areas for improvement. Inspectors also noted that the clinical nurse specialist (CNS) in infection control completed educational talks with staff on areas that related to the audits. The person in charge stated that areas for improvement were re-audited within a short timeframe. An inspector reviewed the audit findings from the follow up hygiene audit carried out in July 2011 and noted that a higher standard of hygiene practices had been obtained. The results demonstrated that issues identified in the previous audit had been substantially resolved.

An inspector also reviewed a sample of statistics that were gathered on falls and noted that this information was used to inform staff practice. The information had been analysed and the findings had been relayed to the person in charge. Areas for improvement had been identified and communicated to staff through staff meetings. The findings and learning from a recent falls report had been discussed at a general staff meeting in September 2011.

Information was also gathered on other clinical issues but this information was not being analysed to inform learning. The person in charge had put in place a system for gathering statistics on each resident's clinical issues such as weight loss, use of bedrails and falls. This spreadsheet was completed monthly and the statistics were communicated to staff during the reports. However, there was no formal analysis of the information gathered to inform care management decisions.

At the time of inspection there was no formal method in place to review the quality of life of residents. The person in charge stated that she planned to carry out a resident satisfaction survey in the near future.

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
Systems were in place to manage complaints but some improvements were necessary to comply with all of the requirements of the Regulations.

The complaints policy did not fully comply with the requirements set down in the Regulations. The generic procedure for all areas of the HSE was in use and did not fully meet the Regulations. For instance, inspectors noted that a second nominated person had not been appointed as required to ensure complaints were properly recorded.

The complaints procedure was prominently displayed at the entrance area and on the residents' notice board in the main day rooms. The complaints procedure identified the nominated contact person for dealing with complaints. However, the procedure did not clearly outline the appeals process if the complainant was not satisfied with the outcome of the complaint investigation. Once brought to the attention of the person in charge, the procedure was amended to comply with the Regulations. Inspectors were informed that the revised complaints procedure would be brought to the attention of residents and relatives.

Complaints, including verbal complaints, were documented in a complaints register in both units and inspectors noted that most of the complaints were responded to well. However, the satisfaction level of the complainant with the outcome of the investigation was not consistently recorded. Also, sufficient information was not recorded on one complaint to confirm that it had been adequately addressed to prevent recurrence.

The person in charge and her deputy were in the process of reviewing the complaints management system. An inspector viewed the new template for recording verbal complaints that had been developed. This form included prompts to ensure that required information was recorded. The person in charge confirmed that she planned to implement the new template within two weeks.

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
Safeguarding arrangements were in place to protect residents from being harmed or suffering abuse but some improvement was required in the management of residents' monies.

Staff spoken to, including domestic staff confirmed that they had received training on elder abuse and they demonstrated a good awareness of the subject. They explained clearly the different types of elder abuse and outlined what action they would take in response to suspected abuse.

The policy on the prevention of elder abuse was very informative and included details on the categories of elder abuse and staff responsibilities including what action they should take in the event of the occurrence of elder abuse. However, there was no reference to the requirement that the Authority must be notified of suspected abuse.

During the fit-person interviews, the person in charge demonstrated good understanding of the internal and external procedures to follow in the case of alleged abuse of residents. She confirmed that to date there had been no allegations of abuse.

The provider looked after the personal finances for a small number of residents through the accounts department in the hospital. There were robust measures in place to safeguard residents' money and these were independently audited on an annual basis. An inspector was informed that requisition forms were submitted to the accounts department on behalf of the residents when they requested money. However, arrangements were not in place to facilitate resident's access to their own money over the weekend or holiday periods when the accounts office was closed.

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
Inspectors found that the management of risk generally promoted the safety of residents, staff and visitors. Also specific risks identified in the previous action plan had been addressed. However, one significant risk was identified during this inspection that compromised residents' safety.

Although a risk assessment had been carried out on security relating to access and egress to Unit 5 and a visitors' book was in place this was not sufficient. Inspectors found that the entrance door which had a key pad fitted was left open and this enabled direct access and egress to and from Unit 5 during the morning. Inspectors noted that this was a risk to the safety of mobile residents with dementia who lived in this Unit.

However, other areas of risk were well managed. A new risk management policy was in place that outlined responsibilities and risk management processes. Inspectors noted that the policy included localised policies on specific risks identified in the Regulations. The policy also contained environmental and clinical risk assessments for Units 5 and 6. Risk assessments had been undertaken for moving and handling, disposal of sharps and for areas in the centre including the designated smoking area in Unit 6 and security at the external doors.

The provider had taken fire precautions to protect residents, staff and visitors' safety. Inspectors reviewed the fire safety register which included guidelines on the principles of fire safety and the responsibilities for fire safety management. Fire safety equipment was adequately serviced and maintained. Maintenance records showed that the fire alarm system was serviced in both units on the 11 October 2011 and fire equipment in May 2011. Fire equipment was serviced annually and although the fire alarm was not serviced quarterly during 2011, a maintenance contract to do this had been put in place. Procedures to be followed in the event of a fire were displayed prominently in the centre. Training records viewed indicated that all staff had received training in evacuation procedures as part of the formal fire safety training. Staff spoken with during the inspection demonstrated knowledge of the fire safety and evacuation procedures.

However, written confirmation from a competent person confirming that the centre was in substantial compliance with all fire and building control Regulations had not been submitted as required prior to the inspection. The technical manager for Merlin Park Hospital confirmed that a fire safety inspection of Units 5 and 6 had taken place and that a schedule of works was currently being reviewed. She confirmed that a plan was in place to address the issues identified and submit a letter from a competent person early in 2012.

A detailed emergency plan for the centre was in place and inspectors found that it identified a range of specific emergencies including utility failure and risk of flooding. The plan included instructions for staff and management to follow in the event of specific emergencies. The plan had been revised in May 2011 and included details of the premises to which residents could be evacuated in the event of an emergency. Contact telephone numbers of management and emergency services were also included as well as transport arrangements in the event of the centre having to be evacuated.

Training records reviewed indicated that some staff had not received up-to-date training in moving and handling. An inspector viewed records that confirmed that this training had been scheduled for later in October 2011. During the inspection staff were observed using safe practices to assist residents to mobilise.

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

Good practices were noted in medication management but some processes required improvement.

The medication policy was centre-specific and informed staff practice. Policies and procedures were in place for the ordering, prescribing, storing and administration of medicines. However, there was no specific procedure for PRN medication prescribing, administration and review. Inspectors also noted that while there were no residents self-medicating at the time of inspection there was no procedure in place for self administration of medication.

Medications were administered correctly and medications which required strict controls were safely stored and managed appropriately. They were checked and signed by two nurses at each change of shift. The register of controlled drugs was reviewed and found to be well maintained, completed and up-to-date. A system was also in place to ensure that medications transported to the Units could not be tampered with. Medications that required refrigeration were stored appropriately in a fridge and temperature records were maintained. Also resident's medications were reviewed three monthly by the Doctor or more often if required.

An inspector observed safe administration practices and found that nursing staff adhered to appropriate medication management practice and were knowledgeable of the procedures in place. However, crushed medications were not individually prescribed and signed by the resident's Doctor. Instead, the Doctor had made a general note in the nursing notes. An inspector also found that there was no space on the administration sheet to record comments on matters such as withholding or refusing medications.

3. <u>Health and social care needs</u>

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings
Overall, inspectors found that residents' healthcare needs were met and that they had very good access to appropriate medical and allied healthcare services.

The person in charge confirmed that any new admissions would have the choice to retain their own general practitioner (GP). All residents were consulted on the current GP arrangements and indicated that they were satisfied with these arrangements. A review of residents' medical notes confirmed residents had ready access to a Consultant Geriatrician and his team who provided medical cover for the centre. Arrangements were also in place for an on-call doctor and an arrest team to be available at all times. There was direct access to other hospital based consultants including renal, palliative, neurology and old age psychiatry. Residents also had very good access to allied health services including, chiropody, dietetic, ophthalmology, speech and language therapy (SALT), occupational therapy (OT) and physiotherapy. Records of appointments, referrals and visits by health professionals were maintained on the residents' files.

The person in charge was endeavouring to support an approach to care that respected the autonomy of residents while minimising risk. Fall prevention measures were in place and inspectors noted that falls were well managed. A resident fell during the inspection and an inspector observed staff responding immediately and taking all necessary precautions when assisting the resident. The resident was seen by the doctor within a short timeframe and an incident form was completed. Fall risk assessments were carried out and reviewed in the event of a resident having a fall. Inspectors noted that the consultant geriatrician had reviewed residents who had sustained any injuries and also advised on required action. The physiotherapist also provided guidance on mobility and the management of falls.

A new process was in place for assessing the use of restraint but some improvement was required. Inspectors noted that a new HSE policy on the use of restraint was in the process of being implemented for all residents. Alternatives to the use of restraint had been explored and implemented for a number of residents. Although alternatives had been investigated for all residents, potential alternatives to the use of restraint that had been identified had not been put in place for some residents.

The person in charge confirmed that she was seeking resources to purchase additional height adjustable beds for these residents. An inspector viewed correspondence that confirmed this to be the case. Although a safety assessment was in place for residents who used devices such as bedrails or lap belts, the information recorded on some assessments did not clearly identify the reason for using a specific form of restraint.

Since the previous inspection, monitoring systems had been put in place to manage residents with behaviour that challenges and there was evidence that learning had taken place from incidents that had occurred. Monitoring logs had been put in place and incidents of behaviour that challenges were now being recorded. Staff had received training in managing behaviour and non violent interventions. Staff spoken with demonstrated adequate knowledge on the management of behaviour that challenges. Some areas for improvement were also identified by inspectors. Intervention plans had been developed for most residents with behaviour that challenges but some of these interventions were not individualised to the needs of the resident. Also, a care plan to guide staff on how to manage the behaviour of one resident had not been implemented. An inspector noted that a new draft policy on behaviour management had been developed but not implemented as required by the Regulations.

Inspectors noted that improvements had been made in the provision of social activities. Inspectors saw some residents taking part in activities including arts and crafts, exercises and reminiscence. Since the last inspection music therapy had taken place and both relatives and residents were pleased with this activity. In response to the previous action plan a number of staff had received education on dementia care. Inspectors noted that staff had a heightened awareness and understanding of the needs of residents with cognitive impairment and were observed interacting in an encouraging and inclusive manner. Some staff had also received training in Sonas activity, a programme based on the stimulation of the five senses to promote communication, and inspectors noted that both group and individual sessions had taken place with residents. Residents and relatives who completed questionnaires and spoke with inspectors were overall satisfied with the variety of activities available. Some said that they would like more music and that there were fewer activities because of cuts in funding.

However, inspectors found that residents with a cognitive impairment did not have the opportunity to engage in sufficient social care appropriate to their needs. Inspectors observed long periods when very dependent residents were left sitting in the day rooms on their own and there was no engagement or activity.

While reviewing residents' care plans, inspectors noted that comprehensive nursing assessments were completed that involved input from residents or their representatives. Inspectors saw entries where input had been sought from residents about their preferred name, routine and activities. Validated assessment tools were being used to identify resident's specific needs. Inspectors noted that the views of residents or their representatives were reflected in resident's care plans. Good processes were also in place to prevent and manage wounds. At the time of inspection there were no residents with pressure ulcers.

However, inspectors found that residents or their representatives were not consistently involved in the care plan reviews. Inspectors also noted that although residents' care plans were kept under formal review, the information in the reviews was limited and did not reflect a consideration of the individual needs of the resident. Some were not updated in line with residents' changing needs as required by the Regulations. For instance, one resident was no longer able to mobilise but yet the entry in the care plan review stated 'no change'.

Links were maintained with the local community through the activities programme. A musician attended weekly and an artist from the Arts Trust came to the centre and facilitated the arts and crafts programme. Residents told inspectors that they had attended art exhibitions. The more independent and mobile residents were assisted to attend external events in the day care centre and resource centre both located on the grounds of Merlin Park Hospital. Relatives spoken with and who completed questionnaires commented that they were made to feel welcome and that their visits were encouraged. Voluntary groups including the St Vincent De Paul and Contact also visited residents in the centre.

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
Adequate arrangements were in place for residents to receive care at the end of life to meet their needs but these arrangements were not formalised in a care plan.

A policy on end-of-life care was available but had not been signed or dated. Although the policy stated the importance of being mindful of the resident's physical, psychological, spiritual and social requirements, the policy did not give adequate direction on collecting and recording that information in a specific end-of-life care plan. However, an inspector noted that resident's wishes were being documented in the nursing notes.

Facilities were available for residents at end of life. A special needs room was available in each unit which included a comfortable seating area for relatives. Staff also confirmed that family were facilitated to stay overnight.

The person in charge and staff confirmed that support services were available from the palliative care consultant and clinical specialist team on areas such as pain management. Inspectors reviewed residents' files which confirmed this to be the case.

Since the previous inspection staff had received education on end-of-life care. An inspector viewed training files that confirmed a number of staff had received training from a CNS in palliative care. Inspectors also noted that up to date resource material was available for staff to reference.

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
Residents received good quality food and a varied diet that offered choice.

The dining experience had been significantly enhanced since the previous inspection. The atmosphere was relaxed and socialable. Height adjustable round tables had been purchased and this afforded opportunities for more residents to sit comfortably at the tables and interact with each other and staff. The table settings in the dining rooms were nicely presented and a variety of condiments were available. Inspectors observed the midday meals and found that residents were offered a healthy and varied diet. Some residents had special or modified diet requirements and these needs were met.

The quality and presentation of the meals were of a good standard. All residents and relatives spoken with and who had completed questionnaires were very satisfied with the quality of food provided. Although a seven day menu cycle was in place there was a choice of meals each day with three options available for lunch. Inspectors noted that there was a range of home baked foods including homemade cakes. Domestic assistants who worked in the kitchen were aware of residents' preferences, likes and dislikes. However, this information was not recorded and maintained in the kitchen for other staff including relief staff to refer to if required. There was also no record maintained of those residents who had special dietary requirements.

Residents' independence was maintained and encouraged during meal times. Residents in the dining room were given time to eat independently and were offered the choice to have their meals at preferred times. Residents who required assistance with their meals received this in a very respectful and unhurried manner.

Inspectors found that there was a plentiful supply of fluids during the inspection. Staff were observed encouraging residents to take drinks and there were formal systems in place to monitor fluid intake. Residents and relatives confirmed that snacks were available outside of meal times including fresh fruit and yoghurts. The shop trolley attended the units daily and this afforded residents a further opportunity to purchase a variety of confectionery and snacks.

A draft policy for the monitoring and documentation of nutritional intake was in place. While the policy was informative it did not reflect some good practices in place such as input from dietetics and SALT. Inspectors noted that weight loss was closely monitored, all residents were nutritionally assessed on admission and weights were recorded on a monthly basis. Inspectors were informed that if there was a change in a resident's weight, the resident would be reassessed, input sought from the doctor and a referral made to the dietician. An inspector viewed residents' files and found that nutritional assessments had been completed and that residents' weights were recorded monthly. Records showed that residents who required it had been reviewed by a dietician.

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

Contracts of care were available for all residents but did not meet all the requirements outlined in the Regulations. Most of the contracts were not signed by the residents or their representative.

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 were consulted on the organisation of the centre and inspectors observed practices which enabled residents to exercise choice and control over areas of their lives. Inspectors also noted that residents' religious rights were supported and staff practices promoted residents' privacy and dignity.

Inspectors found that improvements to the environment and to staff practices had been reviewed to promote residents' privacy and dignity. For instance, in response to the previous action plan blinds had been fitted to the small glass panes in some residents' bedrooms and screens fully extended around each resident's bed. Staff ensured that screening curtains were fully closed when personal care was being delivered in shared rooms. Residents spoken to confirmed that their privacy and dignity was always respected by staff.

Inspectors observed staff consulting with residents throughout the inspection. Staff engaged with residents in a sensitive and caring manner and residents praised staff for the level of care they provided and their respectfulness. Residents' meetings took place and this gave most residents an opportunity to bring forward suggestions. Minutes confirmed that relatives also attended the meetings and discussions took place on topics such as access to specific allied services and the furnishings. Some residents and the person in charge confirmed that residents' input was sought when selecting colours for the recently purchased armchairs.

Independent trainee advocates were completing the national advocacy programme for older people in the centre. On successful completion of this course the person in charge stated that four volunteer advocates would be designated to provide an advocacy service in Units 5 and 6. An inspector met with one of these trainee advocates who stated that she would be volunteering in the centre for two years. She outlined how she planned to speak on behalf of the residents and would also assist those that could advocate for themselves.

Inspectors found that residents could exercise choice and control over many aspects of their daily routine. For instance, male residents who preferred a wet shave received this discretely from a male staff member. The more independent residents' exercised choice in the activities that they attended as outlined in Outcome 7.

Inspectors noted that religious rights were supported. Residents and relatives informed inspectors that they had opportunities to attend various religious services. Mass took place in the centre monthly and daily mass was also took place in the church located on the grounds. The person in charge confirmed that arrangements were also in place for other religious denominations.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings
Residents' bedrooms were personalised with residents' belongings including family photographs and ornaments. Each resident had access to a private lockable space in their bedroom. Inspectors noted that information contained in the Residents' Guide encouraged residents to bring memorabilia of sentimental value in order to personalise their bedroom space.

Inspectors found that there was limited wardrobe space to store residents' clothing but the provider had plans in place to address this matter. Residents had facilities to store their own clothes but these facilities were not adequate for some residents to store all their belongings. This resulted in some residents' clothing that was not used regularly being stored in sealed bags in the laundry room. This had not created a negative outcome for residents during this inspection. The person in charge confirmed that this issue was being reviewed as part of the plans to upgrade the multiple-occupancy bedrooms.

Sufficient arrangements were in place for the laundry of residents' clothing but the laundry policy had not been updated in line with current practices. Adequate arrangements had been put in place since the previous inspection to ensure that residents own clothes were returned to them. An inspector reviewed the laundry arrangements in one of the units and noted that residents' clothing was labelled with a tag system. Residents and relatives spoken with and who had completed a questionnaire expressed satisfaction with the laundry service provided. Both residents and relatives spoke highly of the housekeeper and were very pleased with the level of care that she took with residents' clothing. Some also commented that she was very kind to residents and often took time to chat with them while she went about her work.

Property lists of residents' belongings were maintained in residents' folders. While lists were kept of residents' belongings when they entered the nursing home this list was not updated to include new items.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings
The person in charge was a suitably qualified nurse and had the necessary experience in the area of geriatric nursing, as required in the Regulations.

She had completed a Higher Diploma in Gerontology and Diploma in First Line Management. The person in charge's knowledge of the Regulations and her statutory responsibilities was sufficiently demonstrated both during the interview and inspection. She made all of the documentation requested by inspectors available in a timely manner.

Inspectors observed her strong leadership skills and found that she had directed the staff and service through a process of change that resulted in a significant improvement in compliance with the requirements of the Regulations and Standards since the previous inspection.

Throughout the inspection process she demonstrated competence, a strong focus on residents' needs and the delivery of good quality care to residents informed by ongoing review of practice. The person in charge also sought input from a range of other departments to support residents in the centre. She was the chairperson of the operational policies and procedures committee in the hospital and also a member of the Merlin Park hygiene team. The person in charge stated that she used these forums to discuss any corrective action required and proposed changes in the centre.

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
Inspectors found that the staffing arrangements did not meet the needs of all residents throughout the day even though additional staff had been scheduled for the inspection.

Adequate staffing arrangements were not in place for the supervision of some residents during some parts of the day and in particular during the morning and late afternoon. Inspectors noted that residents in communal rooms were unsupervised for long periods and that staff were busy providing direct care to individual residents during this time. Inspectors were particularly concerned that some very dependant residents were left unsupervised during these periods. Inspectors viewed records that confirmed staff had raised this as an issue of concern with the person in charge.

Some staff informed inspectors that they did not have time to chat with residents and that when a resident was sick, the staff were very stretched and had even less time to spend with residents. Inspectors noted that the person in charge was reviewing staffing levels and arrangements. While many residents and relatives spoken to and who completed questionnaires were satisfied with the staffing levels, some felt that there was a need for more staff during the day. One relative complemented the way that staff promoted residents' independence but said they were limited in this by their workload.

The person in charge was very committed to developing the skills of staff. Inspectors found that the person in charge had put in place a staff training and education plan. Training had been facilitated both in-house and externally during 2011. Training records viewed confirmed that many staff had received formal training on dementia care, reminiscence therapy, Sonas and continence management. Members of the nursing team had been appointed link nurses in specific areas such as diabetes, manual handling, continence care and wound care. Additional education was provided to the link nurses in their specific area of expertise. Three nurses had also obtained a Post Graduate Diploma in Gerontology and two nurses had commenced this course in September 2011. Fifteen care assistants had completed Further Education and Training Awards Council (FETAC) Level 5 programme in care of the older person and 14 care assistants had completed stand alone modules from the course.

The provider had put in place a staff recruitment, selection and vetting policy dated March 2011. Inspectors reviewed the policy and found that it was centre-specific and informed practice. Inspectors viewed a sample of staff files and found that they met with the requirements set down in the Regulations. For example, up-to-date registration numbers were available for all nursing staff and Garda Síochána vetting was in place.

Inspectors found that communication processes were in place for staff and management. Management meetings took place between the provider, the person in charge, the consultant geriatrician for Units 5 and 6 and the medical director in Merlin Park. Areas discussed included admissions to Units 5 and 6 and updates on the action plan in the previous inspection report. Minutes of these meetings were maintained by the person in charge. Unit staff meetings took place monthly. An

inspector reviewed minutes of recent meetings held in July 2011 and noted that a range of topics were discussed including elder abuse, incident reports and staff shortages. Inspectors also noted that general staff meetings which included staff from both Units took place. These meetings were attended by the person in charge. Items discussed at a recent meeting in September 2011 included health and safety requirements, falls management, restraint and infection control.

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 location of the centre was suitable for the centres stated purpose and met residents' collective needs in a comfortable and homely way. There was appropriate equipment maintained in good working order. The provider had carried out specific renovations in response to the previous inspection report but some areas of the centre did not fully comply with the Standards.

Since the previous inspection the provider and person in charge had creatively reconfigured some parts of the centre to meet residents' needs. Inspectors noted that the purpose of some rooms had been changed to enhance the facilities available to residents and make best use of these rooms. Inspectors saw that the exercise room in Unit 6 had been converted into a dining room with a comfortable seating area to the back while a storage room in Unit 5 had been changed into a dining/day room. Both rooms were decorated with domestic style furniture and fittings that created a homely feel. Residents and relatives were complimentary of these changes and residents input had been sought in some of the decision making regarding the choice of furnishings.

Nine bedrooms exceeded the maximum occupancy of two residents contained in the Standards. Since the last inspection the occupancy levels of some bedrooms had been reduced. This afforded residents living in these bedrooms additional personal space and the rooms were now of an adequate size to meet the needs of current residents. The person in charge was aware of the requirement to meet this Standard by 2015.

Inspectors found that while the centre was maintained in a clean condition there were times when the measures to manage unpleasant odours were not very effective some parts of the centre. However, an inspector interviewed a member of the domestic staff and found that this member of staff demonstrated a good awareness of infection control precautions. Many residents and relatives spoken with and who

completed questionnaires were very satisfied with the standard of cleanliness in the centre.

Assistive equipment was provided to meet the needs of residents, including seated weighing scales and hoists. Inspectors viewed the servicing contracts and found that the records were up-to-date and confirmed this type of equipment was maintained in good working order. Inspectors noted that maintenance issues were responded to promptly and records of repairs were kept on file. Inspectors were informed that twenty-four hour maintenance was available on call.

An inspector visited the kitchen in one of the units and found it to be maintained in a very clean and hygienic condition. The kitchen located in each unit was mainly used for food service and washing up. All main meals were produced in a central kitchen and safely transported to Units 5 and 6. The most recent correspondence from the Environmental Health Department indicated no contraventions of food safety legislation.

The centre was surrounded by well maintained grounds. An enclosed garden was located at the rear of the centre and accessible through the conservatory in each Unit. Some residents commented that they liked to sit in the garden during the fine weather and feed the birds.

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* ☒

The Residents' Guide was very informative and written in an accessible format. However, the Guide did not comply with all the requirements of the Regulations. For example, there was a reference in the Guide that the centre did not accept any responsibility for damaged or lost items despite a requirement in the Regulations that residents' property be insured to the maximum value of €1,000 per item.

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required* ☒

While the majority of records relating to residents were maintained in the centre some records were absent as outlined in Outcome 7.

General records (Schedule 4)

Substantial compliance ☒ Improvements required* ☐

Inspectors reviewed a sample of general records that are required by law to be maintained in the centre and found that these records were available.

Operating policies and procedures (Schedule 5)

Substantial compliance ☐ Improvements required* ☒

The provider had put in place the policies required in Schedule 5 of the Regulations. Inspectors reviewed a sample of polices and noted that they were very informative but some were in draft format and had not been implemented. Other polices did not give adequate direction to staff on the specific arrangements for this centre.

Directory of residents

Substantial compliance ☐ Improvements required* ☒

The majority of required information was recorded in the directory of residents but some information was not documented. The time of death and cause of death was not recorded for residents who had died in the centre.

Staffing records

Substantial compliance ☒ Improvements required* ☐

Medical records

Substantial compliance ☐ Improvements required* ☒

There were some issues identified in medication management that did not comply with the Regulations and An Bord Altranais guidelines. These issues are outlined in Outcome 6.

Insurance cover

Substantial compliance ☐ Improvements required* ☒

Confirmation was not received that this centre was covered for insurance purposes.

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings
The person in charge was aware of the legal requirement to notify the Chief Inspector of incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge. However, some serious occurrences had not been notified to the Chief Inspector within the required timeframe.

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. 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.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge, the person in charge's deputy, a resident representative and staff from both Units 5 and 6. Others staff and management in attendance included the director of nursing responsible for Units 5 and 6, the services manager for Galway University Hospital, the maintenance manager for Merlin Park and representatives from nursing administration. This meeting was used 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:

Nan Savage

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

14 October 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report*

Centre:	Merlin Park Hospital Unit 5 and Unit 6
Centre ID:	0635
Date of inspection:	11 and 12 October 2011
Date of response:	15 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 2: Reviewing and improving the quality and safety of care

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

Systems were in place to review the overall quality and safety of care but some areas were not adequately reviewed. There was no formal method in place to review the quality of life of residents.

Action required:

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

Reference:

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

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All information gathered through continuous quality and safety audit will be discussed and analysed for trends and the effectiveness of interventions. An appropriate feedback mechanism will be put in place to ensure the information gathered from the continuous quality improvement audit is analysed and disseminated in order to further improve and enhance care delivery. Interventions undertaken will be evaluated to assess the impact on care outcomes. A resident's satisfaction survey will be undertaken each year in January.	 31/12/2011 31/01/2012

Outcome 3: Complaints procedures

2. The provider is failing to comply with a regulatory requirement in the following respect: The complaints policy did not fully comply with the requirements set down in the Regulations. A second nominated person had not been appointed as required in the Regulations to ensure complaints were properly recorded.
Action required: Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).
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: The complaints policy has been updated and now complies with the Regulation. A person has been identified, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under the Regulations.	 Completed

Outcome 5: Health and safety and risk management

3. The provider is failing to comply with a regulatory requirement in the following respect: Written confirmation from a competent person confirming that the centre was in substantial compliance with all fire and building control Regulations was not submitted.	
Action required: Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.	
Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Estates Management has confirmed that the required written confirmation of fire compliance will be submitted by March 2012.	31/03/2012

4. The provider is failing to comply with a regulatory requirement in the following respect: During the morning access and egress to the centre was not adequately monitored. The entrance door was left open and this enabled direct access and egress to and from Unit 5.	
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: Awareness has been raised in relation to the need to monitor and ensure the entrance door is secure at all times.	November 2011

Outcome 6: Medication management

5. The provider is failing to comply with a regulatory requirement in the following respect: Some aspects of the medication management policy and practices were not in line with Regulations, the Standards and An Bord Altranais guidelines.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A review of medication management policy is currently taking place. The following policies will be developed: (a) Prescribing of medications that require to be crushed (b) PRN medication management. (c) Self administration to be developed by the MDT	Ongoing due for completion February 2012

Outcome 7: Health and social care needs

6. The person in charge is failing to comply with a regulatory requirement in the following respect: Some deficits were identified in the care planning process. ▪ specific care plans were not in place for residents who received end-of-life care ▪ some residents' care plans were not updated in line with residents' changing needs as required by the Regulations ▪ residents or their representative were not consistently involved in the care plan review.

Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Action required: Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances as and no less frequent than at three-monthly intervals.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Regulation 14: End of Life Care Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 16: End of Life Care Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Each resident's needs will be set out in an individual care plan developed and agreed with the resident/representative. In particular, care plans will reflect changing needs of residents. Specific care plans for residents who receive end of life care will be documented. Residents and representatives will be consulted when care plans are reviewed and updated.	February 2012

7. The provider is failing to comply with a regulatory requirement in the following respect: The management of restraint did not fully promote a restraint free environment. The behaviour management policy had not been implemented and improvements were required to the care planning for behaviours that challenge.
Action required: Provide a high standard of evidence based nursing practice.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All residents have been re-assessed in relation to restraint management and the risk assessments now indicate why a specific form of restraints are used and supported by appropriate documentation. A request for resources i.e., low-low beds has been submitted as an additional means to promote a restraint free environment. The behavioural management policy will be completed and signed off. The completed policy will be disseminated and discussed with all staff.	 Complete Complete 31/12/2011 31/01/2012

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

Adequate staffing arrangements were not in place for the supervision of residents during some parts of the day.

Action required:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A risk assessment has been completed regarding the impact the staffing moratorium on the delivery of care. Risk controls include: Local Controls - Roster review has commenced. This review will focus on putting in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.	 Complete

Additional hours and overtime are utilised to support staff rosters to maintain each resident's welfare and wellbeing. Business cases submitted for staff replacement including CNM2 and named Person In Charge No new long-stay admissions to Unit 5 and Unit 6 until staffing situation is addressed.	31/12/2011 Complete Complete

Outcome 10: Contract for the provision of services

9. The provider is failing to comply with a regulatory requirement in the following respect: Contracts of care did not meet all the requirements outlined in the Regulations.	
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:**
Provider's response: Each resident's contract will deal with the care and welfare of the resident in the designated centre and will includes details of the services provided to that resident and the fees to be charged.	February 2012

Outcome 12: Residents' clothing and personal property and possessions

10. The provider is failing to comply with a regulatory requirement in the following respect: Property lists of residents' belongings were not kept up-to-date.
Action required: Maintain an up-to-date record of each resident's personal property that is signed by the resident.

Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An up-to-date record of each resident's personal property that is signed by the resident/representative will be maintained.	January 2012

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

11. The provider is failing to comply with a regulatory requirement in the following respect: Some records and documents did not comply with all the requirements set down in the Regulations. Some policies were not implemented while other policies did not give adequate direction to staff on the specific arrangements for this centre.
Action required: Produce a resident's guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.
Action required: Ensure that the directory of residents includes the information specified in Schedule 3 of the Regulations.
Action required: Ensure that the designated centre is adequately insured against accidents or injury to residents, staff and visitors.
Action required: Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.

Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Regulation 23: Directory of Residents Regulation 26: Insurance Cover Regulation 27: Operating Policies and Procedures Standard 1: Information Standard 29: Management Systems Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The Residents' Guide will be updated to includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.	January 2012
The directory of residents has been updated to include the information specified in Schedule 3 of the Regulations.	Completed
The nutritional policy will be amended to reflect the current practice which includes referral to dietician and speech and language therapists when indicated.	January 2012
All remaining policies listed in Schedule 5 to be signed off and implemented. The dissemination of policies will involve staff discussion so as to ensure there is clear guidance to underpin practice.	February 2012

Outcome 17: Notification of incidents

12. The person in charge is failing to comply with a regulatory requirement in the following respect: Some occurrences had not been notified to the Chief Inspector within the required timeframe.
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Chief Inspector is now notified without delay of the occurrence in the designated centre of any injury to a resident.	Completed

Any comments the provider may wish to make:

Provider's response:

We welcome this report which acknowledges the quality of care provided by a team of committed and caring staff. We are pleased that so many areas of good practice was observed and acknowledged during inspection.

We wish to thank our resident, relatives and volunteers for their objective and positive feedback. We thank all staff and acknowledge that through their dedication and hard work residents are cared for in a way that is person-centred.

Finally we thank both inspectors for the professional and courteous manner in which they carried out the inspection.

Provider's name: Dr. David O'Keefe
Date: 15 November 2011