Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	St. Camillus Nursing Centre
Centre ID:	0098
Centre address:	Killucan Mullingar Co Westmeath
Telephone number:	044-9374196
Fax number:	044-9374309
Email address:	riverstown@eircom.net
Type of centre:	☐ Private ☒ Voluntary ☐ Public
Registered providers:	Fr. Frank Monks, Order of St. Camillus
Person in charge:	Brother John O'Brien
Date of inspection:	17 September 2010
Time inspection took place:	**Start:** 09:00 hrs **Completion:** 13:30 hrs
Lead inspector:	Catherine Connolly Gargan
Support inspector:	Brid McGoldrick
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit	☐ **Application to vary registration conditions** ☐ **Notification of a significant incident or event** ☐ **Notification of a change in circumstance** ☐ **Information received in relation to a complaint or concern** ☒ **Follow-up inspection**

About the inspection

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

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

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

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

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

About the centre

Description of services and premises

The order of St. Camillus has been providing health services in the area since the 1930's and the St. Camillus Nursing Centre provides care to a maximum of 57 residents.

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, 13 of which have en suite toilet and hand-washing facilities, eight twin bedrooms, seven of which have en suite toilet and hand-washing facilities. There are also three rooms accommodating five residents in each and two rooms accommodating six residents in each. Residents in five and six bedded rooms have access to a shower, toilet and hand-washing facility in each. The centre has two palliative care beds. The Westmeath Hospice offices are located in the centre. There is a spacious modern oratory linked to the centre that is used by residents and the local community.

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.

Location

The centre is located adjacent to Killucan Village. It 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.

Date centre was first established:	01 January 1976
Number of residents on the date of inspection	56
Number of vacancies on the date of inspection	1

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	34	16	6	0

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. Brother O'Brien was on leave on the day of inspection.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1 staff nurse deput-ising for the person in charge	1	8	6	4	1	1*

*The provider works as an administrator in the centre on a day-to- day basis.

Background

This was a follow-up inspection of completion of actions required as a result of a scheduled inspection by the Health Information and Quality Authority of the centre on the 15 September 2009. Inspectors found that although improvements were required in some areas, most areas were of a satisfactory standard. Areas identified as requiring improvement included complaints management, Garda Síochána vetting procedures, address of narrow corridors, maintenance of records and refurbishment of an internal garden and seated area to the exterior of the centre.

Summary of findings from this inspection

There were eight action plans, five of which were satisfactorily completed. While the remaining actions were partially completed, one action was not satisfactorily completed. This uncompleted action referenced notifying residents and relatives of the procedures they can follow to appeal complaints that are not resolved to their satisfaction.

Residents and their relatives were very satisfied with the care given to them in the centre. Very positive and complimentary comments about the management and staff were shared with the inspectors by residents and relatives alike.

The inspectors reviewed a number of other areas including the statement of purpose, staffing, directory of residents, risk management procedures including fire safety, notifications, health care, general welfare and protection and laundry procedures.

While there were satisfactory practices observed in these areas, most required some improvement and in the case of risk management, emergency procedures and protection of vulnerable residents, significant improvements are necessary.

All notification required by the Authority were not up to date. The provider and person in charge were requested to provide a report detailing an investigation into the

occurrence of pressure related skin damage to some residents and to evaluate the appropriateness of care provided for each of these residents. A review was also requested by the Authority from the provider of a serious injury sustained by a resident following a fall.

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

Issues covered on inspection:

A follow-up inspection was carried out on the actions required from the inspection by the Authority on the 15 September 2009. Other areas were reviewed on this inspection and included the statement of purpose, staffing, directory of residents, risk management procedures including fire safety, notifications, health care, general welfare and protection and laundry.

The statement of purpose for the centre, although available did not reference all the requirements of the legislation. For example, there was no organisational chart available, no reference to how dependency levels are measured or the nursing care provided to meet the needs of residents in each dependency level.

Each grade of staff had an individual duty rota, resulting in a number of rotas needing to be reviewed to reference all staff on duty on any one day. The catering rota was kept in the kitchen. None of the rotas recorded the full name of staff, recording first names only and the first letter of the surname to distinguish between staff with the same first names. A group of staff nurses and carers worked on night duty only. As there was only one staff nurse on night duty at any time, there were no supervisory arrangements in place for this group of staff. Although a document recording completion of a training needs analysis was not available for inspection. 100% of care staff had completed the Further Education and Training Award Council (FETAC) level five. Staff had also completed venepuncture training, palliative care and care planning training.

The directory of residents was not complete. It did not record the times when the resident was not living in the centre due to hospitalisation. The register document was in a poor condition and was not adequately bound to ensure that loss of records did not occur.

Risk management procedures required improvement in a number of areas. The risk management policy was not comprehensive and did not record risks in the centre or reference all risks and adequate controls to mitigate their occurrence. Near misses were not recorded as part of the risk management procedure.

The emergency policy was not adequate and although there was a generator on site in the event of loss of light, this was not referenced in the emergency policy. There was no information in the emergency policy to reference flooding (a canal runs through the site), loss of heat or procedures to be followed in the event of a resident leaving the centre unaccompanied. A missing resident drill had not taken place and profiles were not in place for each resident to assist the emergency services to find them as soon as possible. There was no contingency plan documented for temporary accommodation arrangements if residents had to be evacuated from the centre. While two residents smoke, they do not have a suitable smoking area with permanent ventilation to the external air. Their current smoking location places other residents and staff at risk of passive smoke injury. Fire drills were not carried out at a minimum of twice yearly but were completed annually and were scheduled for October 2010.

Routine fire alarm testing procedures were not in place although the provider stated that he was in the process of planning this procedure.

The Authority received quarterly notification referencing the period August 2010 to October 2010. No quarterly notifications were submitted for the period July 2009 to July 2010. An incident of a resident's money going missing, although investigated, was not recognised as possible financial abuse. The centre's policy on recognising and responding elder abuse references 'the resident complaining of money or possessions going missing'.

Inspectors viewed grade four pressure damage to skin on both heels of a resident recently admitted via the acute services. Another resident had a grade three and a grade two pressure ulcer. None of these pressure ulcers were notified to the Authority as required. Inspectors brought this to the attention of the provider and staff nurses at the feedback meeting. Further information was requested by the inspection team regarding wound management in the centre.

Procedures had not commenced to formally review the quality and safety of care and quality of life of residents through data collection, analysis and review to identify trends and areas for improvement. For example, a review of slips and falls sent to the Authority referencing the period 21 August 2010 to 19 October 2010 referenced twelve incidents. Two thirds of which occurred during night duty hours when carer staff were reduced by 75% and staff nurses were reduced by 50%. Approximately 60% of residents had maximum dependency needs including one resident on continuous oxygen therapy.

Residents had satisfactory access to occupational therapy, physiotherapy and dietetic services. Residents also have a choice of general practitioner (GP) and many residents have been able to continue to be treated by their GP. There are two rooms with specialist electric beds insitu used for residents with palliative care needs. The Westmeath hospice services offices are located in the centre. Residents with palliative care needs are well managed in the centre. Many of the staff have specialist training in palliative care skills and management of subcutaneous medication pumps for pain management.

All staff had completed elder abuse recognition and prevention training and were Garda Síochána vetted. While two residents had a diagnosis of dementia, a further one third of residents suffered from varying levels of confusion. Another 16% of residents had underlying psychiatric disorders. All procedures were not in place to protect many of these vulnerable residents from the risk of accidental ingestion of toxic chemicals or cleaning solutions. Inspectors observed that the cleaning trolley was left unattended with various unsupervised cleaning solutions insitu. Access to the cleaners' room was also not controlled; various cleaning solutions were also accessible in this room. Information relating to residents was displayed in the dining room and therefore compromised residents' right to confidentiality at all times.

While the cleanliness of the premises and cleaning procedures were of a very good standard, some improvement was required. For example, used cleaning water was not emptied in accordance with best practice infection prevention and control procedures.

The laundry did not have a means of permanent ventilation to the external air without opening windows.

Actions reviewed on inspection:

1. Action required from previous inspection:
Provide training in communication with residents with dementia to enable them to provide care in accordance with contemporary evidence-based practice.

This action was satisfactorily completed. Inspectors were told that one staff member had training in the sonas programme; other staff had attended training on dementia care and behaviour that challenges. There were five registered psychiatric nurses on staff, one of whom was on leave.

2. Action required from previous inspection:
Put a process is in place for complainants to appeal a decision if they are unhappy with the outcome of their complaint.

This action was partially completed. Although an external independent person was nominated to conduct an independent appeal if a complaint was not successfully resolved by the centre to the satisfaction of the complainant. The documented complaints procedure was reviewed by the inspectors and did not meet all the requirements of the legislation. For example, procedure for making complaints against staff, frequency of review, a second person to ensure the complaint procedures have been followed and procedures for appeal were absent. The complaints procedure is not prominently displayed in the centre. This action is restated in the action plan at the end of this report.

Action required from previous inspection:
Provide information on how to refer a complaint to the Health Service Executive, the Chief Inspector of Social Services and the Office of the Ombudsman at any stage, should he or she wish to do so.

This action was not satisfactorily completed. The complaints policy did not reference the appeals procedure for unresolved complaints. This action is restated in the action plan at the end of this report.

3. Action required from previous inspection:
Provide suitable storage facilities for residents to store their personal possessions safely and securely.

This action was partially completed. The provider told inspectors that he had sourced locks for the lockers and that they were installed. However, they do not meet the needs of all the residents as they did not all function adequately. This action is restated in the action plan at the end of this report.

4. Action required from previous inspection:
Maintain up-to-date medical records signed and dated by a medical practitioner.

This action was satisfactorily completed. Medical practitioners were referencing their review of residents in the residents' medical files.

5. Action required from previous inspection:
Make suitable adaptations to provide adequate space that meet the needs of each resident.

This action was partially completed. Although, inspectors did not have opportunity to observe this arrangement taking place at mealtimes, the corridors were also busy in the morning time with residents getting up and moving to the sitting areas. Corridors in some parts of the building did not facilitate passing a resident using assistive equipment without placing them at risk of falling. Exposed water pipe work, which ran the length of the corridors, also compromised available width. Residents and others were observed by the inspection team moving around the corridors without supervision following the one-way traffic arrangement in place to manage the narrow corridors. This action is restated in the action plan at the end of this report.

6. Action required from previous inspection:
Maintain the external grounds so they are suitable and safe for use by residents.

This action was satisfactorily completed. The internal courtyard had been refurbished and an area to the front of the building was upgraded to a good standard with sheltered seating for residents and their relatives to rest if wished.

7. Action required from previous inspection:
Provide suitable and sufficient care to maintain the resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency and needs, as set out in their care plan.

This action was satisfactorily completed. None of the residents were using wheelchairs without footplates. Residents who tended to use wheelchairs in this way were reviewed by the occupational therapist and provided with alternative suitable seating.

8. Action required from previous inspection:
Ensure Garda Síochána vetting is completed for staff members.

This action was satisfactorily completed. Staff files viewed by the inspector confirmed this.

Standard	Best practice recommendations
Standard 24: Training and Supervision	Establish a staff development and appraisal policy and train key staff in its implementation. This ensures each staff member is informed of his/her progress and strengths and has an opportunity to develop his/her capabilities and strengths.
	Inspector's review: This recommendation was satisfactorily completed. Staff appraisals are in progress.

Report compiled by:

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

Date 17 September 2010

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
15 September 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced

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Action Plan

Provider's response to additional inspection report[1]

Centre:	St Camillus Nursing Home
Centre ID:	0098
Date of inspection:	17 September 2010
Date of response:	3 February 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider has failed to comply with a regulatory requirement in the following respect: The statement of purpose available did not contain all the required information as outlined in the legislation.
Action required: Redraft the statement of purpose to include all the information required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).
Action required: Make a copy of the revised Statement of Purpose available to the Chief Inspector of Social Services.

[1] 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 redrafted in line with legislation contained in Health Act, 2007 and Regulations 2009.	Completed on 2 February 2011

2. The person in charge has failed to comply with a regulatory requirement the following respect: The directory of residents was not adequately maintained.	
Action required: Put procedures in place where all information relating to residents is recorded in the directory in line with the legislative requirements.	
Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: New register now in place. We will commence transcribing on 4 February 2011, all current residents' information and it will be kept up-to-date with all information relating to residents.	To be completed by 28 February 2011

3. The person in charge has failed to comply with a regulatory requirement in the following respect: The number of staff on duty from 22:00 hrs until 08:00 hrs was not appropriate to meet the assessed needs and dependencies of the residents and the design and layout of the centre.

Action required: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents and the size and layout of the designated centre at all times.	
Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Having assessed the staffing levels in conjunction with the constantly changing dependency levels of the residents between 22:00 hrs and 08:00 hrs, we have decided on an action plan. It is our intention to divide the building into two sections and each section will have a qualified nurse and a carer. We are actively recruiting to have this plan in place by 31 March 2011. During the recruitment process we are also devising a method of continuity of care whereby staff will rotate to all sections of the facility to ensure all are familiar with the needs of all the residents.	31 March 2011

4. The person in charge has failed to comply with a regulatory requirement in the following respect: All staff members were not adequately supervised on night duty.	
Action required: Put procedures in place to ensure that all staff members are appropriately supervised.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The night staff are currently engaging in mandatory training. It is our aim to have complete internal rotation of staff in place by 30 May 2011. We have begun the process of sensitisation of staff.	30 May 2011

In the interim, the director and deputy director will work a number of night shifts to monitor staff competence and to oversee the implementation of the new staffing regime.	

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

The fire safety in the centre was not of an adequate standard. Safety was compromised by the location of the area for residents who smoked. Inadequate fire drills and no procedure for checking fire alarms were in working order were in place.

Action required:

Ensure by means of fire drills and practices at suitable (at least twice each year) intervals that all staff participate in and are aware of the evacuation procedures.

Action required

Make arrangements for reviewing fire precautions and testing fire equipment at regular intervals to ensure it is always in working order.

Action required:

Review the arrangements for residents who wished to smoke in the centre in light of required fire prevention and fire safety regulations.

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: The old firm alarm system is presently being substituted by a more modern system compliant with fire regulations. The stand by generator is serviced annually and checked and run once a fortnight. A record of this test is maintained. The fire alarm is now being checked and recorded weekly. Fire drills are held annually. Two fire drills were held: one on the 14 and one on 19 October 2010. The next fire drill is scheduled for April 7 and to be repeated on April 14 (This facilitates the participation of all staff). It is present policy to have a fire drill on a six monthly basis.	 Completed on 20 February 2011 Completed Completed Completed

A smoking room is part of our new upgrading plans. In the interim we will use the first sitting room, which in fact is rarely used during the day. We have consulted with the fire office and will install an expel air device which can be switched on and off.	Hope to start building in April. Temporary smoking facility to be ready by 1 March 2011

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

The risk management policy was not adequate. There was no missing person policy and there was no missing person profiles completed.

The emergency policy did not adequately address procedures for responding to all emergencies.

Did not put adequate risk management procedures in place where recorded incidents and accidents were analysed and used for learning and as a proactive risk management tool.

Near misses were not recorded or analysed in the centre.

Did not adequately identify and assess all risks in the centre and put precautions in place to control risks.

Did not take all reasonable measures to prevent vulnerable residents being placed at risk of possible ingestion injury due to accessibility of toxic chemical and cleaning solutions.

Action required:

Redraft the risk management policy to reflect all areas of risk in the centre.

Action required:

Establish a system where all near misses are recorded as part of the risk management documentation procedures.

Action required:

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

Action required:

Evaluate all risks in the centre and put precautions in place to control risks identified.

Action required:

Revise the emergency plan to reference contingency plans for all possible emergencies in the centre.

Action required:

Secure access by vulnerable residents or visitors to toxic chemicals in the cleaners' room and on the cleaners, trolley.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 25: Physical Environment
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Emergency policy is now is place.	Completed on 30 January 2010.
Risk management policy is in place and operational.	Completed
Cleaning staff are now aware of need for safe storage and use of cleaning materials. A locked area for the cleaning trolleys provides a safe area for materials in current use.	Completed on 31 January 2011
Missing person policy has been updated.	Completed on 30 January 2010
Missing person profiles of the residents have now been produced for each resident. Each new resident will have such a profile.	Completed on 30 January 2010
Recording of near misses to be instituted. A near miss form is being prepared and will be completed in each case.	28 February 2011
We will organise a missing person's drill before 31 March 2011.	31 March 2011

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

Permanent ventilation to the external air was not adequate in the laundry or smoking area.

Procedures for disposing of waste cleaning water were not of an adequate standard.

Action required: Install permanent ventilation to the external air in the laundry and smoking area.	
Action required: Implement adequate procedures and practices for disposal of waste water in line with waste management guidelines.	
Action required: Review width of corridors in the centre and their adequacy in meeting the needs of residents to move safely around the centre.	
Action required: Provide residents with suitable lockable facilities to secure their own valuables and possessions if they wish.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Ventilation was improved in laundry by transferring the location of the ironing facility and the introduction of an air vent. Waste water facilities will be included in the upgrading and building which begins in April 2011. In the interim we have arranged with the housekeeping staff to dispose of waste water via the outside sluice. A smoking room is planned with the April upgrading. In the interim we will use first sitting room as stated above action five. The only time that the corridors at the old end may cause a problem is at meal times – since the end of September 2010 a one way policy of movement has been successfully introduced. All residents have a lockable storage area.	 Completed on 1 Dec 2010 Work due to commence in April 2011 April 2011 Completed 30 September 2010 Completed on 30 September 2010

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

There was no quality and safety review of service provision referencing such areas as the medication management process, falls, recreational activities and wound management.

Action required:

Commence a process of measuring, analysing and evaluating the quality and safety of care and quality of life for residents in the centre.

Reference:

Health Act, 2007
Regulation 35: Review of the 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: An auditing process will be introduced for medication management, falls, recreational activities and wound management. To do this we intend setting up an auditing tool specific to each category. A series of meetings with members of staff will then be held.	To be operational by the end of March 2011

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

The complaint policy does not contain all the procedures outlined in the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

Action required:

Redraft the complaints policy to ensure all aspects of the complaints procedure are implemented and operational in the centre.

Action required:

The redrafted policy must be displayed in the centre.

Action required:

Ensure residents are fully informed of the redrafted complaints procedure.

Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Regulation 39: Complaints Procedures Standard 1: Information	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A complaints policy has been drafted and publicly displayed in the centre. It is also available to all residents and their relatives.	Completed and implemented 30 January 2011

10. The person in charge has failed to comply with a regulatory requirement in the following respect: Did not submit notifications of incidents as required by the legislation within the time frames stipulated.	
Action required: Submit all notification of incidents as required the the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Notification required by legislation will be submitted as required of us. All notifications now up to date.	Completed on 31 January and ongoing as per requirements of the legislation

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

Did not provide suitable and sufficient care to maintain the resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency and needs as set out in their care plan.

Action required:

Put procedures in place to ensure pressure area care is managed to a high standard based on evidence based risk assessment tools, multidisciplinary input and informed by contemporary wound care guidelines.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 7: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We use the Waterlow Score, a known international tool, to evaluate risk of pressure area damage and also to score grades of wounds. This tool includes the grade of the mattress to be used. We follow current wound-care management guidelines. Staff nurses have training in wound care management. Our key senior manager is a member of the wound management association. Members of the MDT include nursing Staff, GP, and HSE tissue viability nurse. They are involved in the assessment and care planning for wounds. If assessed as necessary by MDT the wound is referred to a surgical team at Mullingar Regional Hospital for further assessment and intervention. Community dieticians are not available to nursing homes but the team based at Mullingar Regional Hospital will give advice in individual cases over the telephone. If the resident is deemed fit enough to travel by the MDT the dieticians will assess a resident in their clinic. The MDT is particularly mindful that resident may be lying on a trolley with no pressure relief while awaiting examination. A MDT will always try and coordinate this assessment with the clinic team. Wound assessment charts and wound treatment charts designed to reflect evidence based practice are used in the ongoing management of wounds. They include the measurements of wounds to tract their progress. If deemed necessary by the MDT a wound may be photographed. We have current wound care policy in operation in the centre.	Completed 30 September 2010

Recommendations

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

Standard	Best practice recommendations
Standard 32: Register and Residents Records	Ensure that the Directory/Register of Residents is maintained in good order **Providers Response:** Completed
Standard 32: Register and Residents Records	Put procedures in place to protect resident's personal information displayed in the dining room. **Providers Response:** Completed 19 September 2010 – There is no information presently on display in the dining room.
Standard 23: Staffing Levels and Qualifications	Amend the duty rota to include details of all staff on duty in one document at one point of reference and document the full names of staff working in the centre on the duty rota. **Providers Response:** Completed 27 December 2010 – All staff duty rotas are now held in one file at the nurses' station.

Any comments the provider may wish to make:

Provider's response:

Thank you for the report and for the opportunity to comment, which you will find above in the spaces provided. This was carried out in consultation with the Director and Assistant Director of Nursing.

I would like to make the following personal observation. We have always from the setting up of our nursing centre sought to cooperate fully with the Authority and the requirements of the law and this will always continue. We were one of the advocates of the need for regulation of nursing homes and welcomed its arrival. But we do feel that the paperwork demands as presently required is excessive. This is causing stress particularly to the management team and staff nurses in so far as they are consuming so much time that heretofore was employed in animating the residents.

Provider's name: Fr. Frank Monks, MI (Order of St. Camillus)

Date: 3 February 2011