Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

| Centre name: | Bramleigh Lodge Nursing Home |
| Centre ID: | 0204 |
| Centre address: | Cashel Road, Cahir, Co Tipperary |
| Telephone number: | 052-7442129 |
| Email address: | webbmilli@gmail.com |
| Type of centre: | ✔ Private | ☐ Voluntary | ☐ Public |
| Registered provider: | Mildred Webb |
| Person in charge: | Mildred Webb |
| Date of inspection: | 13 July 2010 and 14 July 2010 |
| Time inspection took place: | Day-1 Start: 11:30hrs  Completion: 20:00hrs  
Day-2 Start: 09:00hrs  Completion: 13:00hrs |
| Lead inspector: | Noelene Dowling |
| Support inspector(s): | Catherine O Keeffe |
| Type of inspection: | ✔ Registration  
☐ Scheduled  
☐ Announced  
☐ Unannounced |
About 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 under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice - this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required - this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required - this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.
About the centre

Description of services and premises

Bramleigh Lodge Nursing Home is a single-storey building which first opened as a nursing home in 1994. The present provider took ownership of the centre in 1996. The provider offers long-term care to 20 persons of 55 years old and over, some of whom have dementia. There were no residents under 65 years living in the centre at the time of the inspection.

The accommodation is accessed via an entrance door which leads to a lobby which contains the nurse’s office and soft seating for visitors. There are two living rooms for residents’ use, and a large dining room. The recently completed extension consists of six single en suite bedrooms each of which contains an assisted shower, a wash-hand basin and a toilet. The residents in the remaining seven single and six twin bedded rooms share three assisted bathrooms with shower or bath, wash-hand basin and toilet. There is an additional single toilet for residents use.

There is a small enclosed secure garden area which is easily accessible by residents and contains garden seating. There is small car park to the front of the building. There were 17 residents present on the day of inspection and all were over 65 years old.

Location

Bramleigh Lodge is located in the town of Cahir County Tipperary. It is within walking distance of the local shops, churches and amenities.

<table>
<thead>
<tr>
<th>Date centre was first established:</th>
<th>1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection</td>
<td>17</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependency level of current residents</th>
<th>Max</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents</td>
<td>6</td>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Management structure

Mildred Webb is the registered provider and the person in charge. Nurse Liz O’Donnell deputises for her in her absence. All nursing care assistants and catering and household staff report to the Provider.

<table>
<thead>
<tr>
<th>Staff designation</th>
<th>Person in Charge</th>
<th>Nurses</th>
<th>Care staff</th>
<th>Catering staff</th>
<th>Cleaning and laundry staff</th>
<th>Admin staff</th>
<th>Other staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff on duty on day of inspection</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>


Summary of findings from this inspection.

This was the first inspection of this centre by the Health Information and Quality Authority and it was an announced inspection. The provider had been registered by the Health Service Executive to accommodate 20 residents and this registration expired on 20 May 2010.

The existing provider had extended the premises by the addition of six additional single bedrooms with en suite, which would increase the capacity to 26 residents. The existing provider was in the process of completing the sale of the nursing home as a going concern to Selma Kelly and Laura Myers who are the applicants for registration. Selma Ryan is the registered provider of Sacre Coeur Nursing Home which is located in Tipperary town. This inspection was carried out in order to ascertain the suitability of the additional six bedrooms for use prior to the sale of the centre.

The assessment of fitness of the applicant / new provider and the new person in charge was also undertaken at this time. This is reported on separately as part of the application for registration.

The inspection found that the new extension to the premises is in compliance with all relevant legislation and that overall the premises are fit for purpose.

The centre was domestic and homely. While the provider strove to provide a quality care service for residents’ practices failed to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres For older People Regulations (as amended) in a number of areas. There were requirements for significant improvements in relation to risk management, care planning, consultation with residents, policy development and review of the quality and safety of care of the residents. These findings are outlined in the report and the Action Plan at the end of the report.

Comments by residents and relatives

Inspector received completed questionnaires from four residents and three relatives prior to the inspection. During the inspection inspectors met with four relatives and spoke with seven residents. Comments included “this is a home from home“ and that the atmosphere is warm and welcoming. One resident said the matron and staff are very kind, easy to talk to and “have a good listening ear“. Relatives said that they visited at various times of the day and always found their relatives well looked after. Some had visited the centre prior to admission and had chosen the centre based on the atmosphere and the homeliness of the centre. They were appreciative of the fact that the location enabled them to visit their relatives regularly. One resident informed the inspectors that when she had made a small complaint in relation to her bedroom she was offered an alternative room.
Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

The existing provider is qualified and experienced. She was observed to be involved in the day-to-day management of the centre and care of the residents. A senior nurse acts up on the occasions when the person in charge is absent. Staff and residents expressed their confidence in the provider and in her ability to care for them and inspectors observed her interacting consistently with the residents and relatives during the inspection.

The existing provider had recently developed a statement of purpose which inspectors found contained all of the required information. Inspectors saw a copy of the centres health and safety statement which was centre-specific. The directory of residents was seen by inspectors and found to contain the required information. All residents had contracts of care signed by them or on their behalf and inspectors saw evidence of up-to-date insurance.

The existing provider was acting as agent for one resident. Inspectors saw records of all financial transactions and the resident involved confirmed that she is satisfied with how this arrangement is managed. The existing provider had fulfilled her obligations to notify the office of the Chief Inspector of incidents which occurred in the centre.

Significant improvements required

While all the required polices were available they were found not to be centre-specific to Brameigh House and had not been implemented.

The complaints log was reviewed by inspectors and this provided evidence that the provider had acted to resolve issues which arose. However, the complaints procedure did not meet the requirements of the regulations, it was not displayed in a prominent place in the centre or given to residents and it did not contain an adequate appeals process.
There was no system for reviewing the quality or safety of care for residents. The accident an incident logs recorded incidents such as falls but these had not been utilised to support changes in practice for the residents. The provider had a fire evacuation procedure. However, there was no planning for emergencies such as loss of electricity or water.
2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

Inspectors observed staff promoting the privacy of residents by closing doors and screening curtains when carrying out personal care and residents confirmed this practice. The inspectors joined the resident's for lunch. The food was nutritious, fresh and well presented and the table was laid with condiments and flowers. Staff supported residents who needed this in a sensitive and unhurried manner. Pureed food was well presented. The cook was knowledgeable in regard to the residents' likes and dislikes.

Special dietary needs are communicated to the catering staff by the nursing staff and this is recorded in the kitchen to avoid any errors. Inspectors saw a list of residents birthdays in the kitchen and the cook stated that she ensured a cake was made. Residents were observed partaking of regular snacks and home baking throughout the day.

Activities are organised a number of times in the week with support from members of the local community. These activities included a twice weekly bingo game, visits from the transition year students, and regular music sessions. Sit fit exercises take place each morning where residents’ themselves use a DVD and exercise in the day room. Inspectors saw books and magazines available in the living rooms and residents were reading these. Residents’ religious practices are supported and mass takes place twice weekly. A member of the local community comes up to help with this and one resident informed that she was responsible for making the necessary preparations.

Residents stated that they can get up and go to bed when they wish and some go out to the local village. Staff were seen to be attentive to residents and from conversation with inspectors staff knew the residents history and their likes and dislikes. Inspectors observed constant visitors to the residents centre during the inspection. Relatives informed inspectors that they can visit when they wish, are always welcomed and offered refreshment.
Inspectors observed that resident’s bedrooms were personalised with family photographs, rugs and other personal belongings.

Staff training records were reviewed and showed that care assistant staff have undergone training in the prevention, detection and reporting of elder abuse. Staff interviewed stated that this training had made them more aware of what might constitute abuse of a resident. They also stated that they were confident that the existing provider would not tolerate any poor behaviour towards residents.

Residents told inspectors that they felt safe living in the centre and relatives stated that they were confident that their relative was safe. Consultation regarding care planning is undertaken informally, and while relatives or residents were not aware of the formal planning process all stated to inspectors that they are involved in planning and decision making.

### Some improvement required

Residents when asked by inspectors stated that they enjoyed their meals and the cook did take note of preferences. However, on the day of the inspection, the menu was set and there was no choice offered to residents. Staff confirmed that this is always the case, and meals are planned well in advance.

### Significant improvements required

Activities for those residents with cognitive impairment or communication difficulties were not included in the care planning process. While staff were in the process of training in working with resident’s who have dementia, this was not translated into guidelines for practice. No signage or other communication tools were utilised and no specific planning was undertaken for residents who became agitated or had limited mobility and communication skills. One staff member stated to an inspector that occasionally she did hand massage with residents who are highly dependant. However, she stated that the opportunity to do so was limited due to lack of time and insufficient numbers of staff on duty.

Inspectors saw consent forms signed by relatives for the use of methods of restraint such as bedrails. However, there was no evidence that the risk of their usage had been clearly outlined to relatives or alternatives sought prior to usage. One resident was observed seated with the bed table placed in a manner which prevented her from getting up. This action had been agreed with relatives as the provider felt the lady was in danger of falling and due to incessant walking was also loosing weight. No alternative strategies had been explored prior to taking this decision, and no written details of the timeframes for the removal of this method of restraint were evident. Inspectors noted that this occurred in the afternoon when staff numbers were reduced.
3. Healthcare needs

Outcome: Residents’ healthcare needs are met.

Healthcare is integral to meeting individual’s needs. It requires that residents’ health, personal and social care needs are assessed and reviewed on an on-going basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

The resident's healthcare needs were seen to be met on a day-to-day basis. Resident's could maintain their own general practitioner (GP). Out of hour’s service is provided by Mid-Doc. The records and interviews confirmed that the existing provider was proactive in calling the GP and staff were observant of any changes in residents’ health. The medication round observed by inspectors was found be in accordance with best practice with photo identification and good recording of administration observed. All prescriptions were signed by the GP assigned.

There was evidence that health was promoted and residents were encouraged to take drinks. Residents were supported by staff to walk rather use a wheelchair in order to maintain their independence. Nutritional care for residents was found to be good, and there were good guidelines on wound care and prevention of bedsores noted in resident records.

Inspectors reviewed six resident records’ and found that a range of recognised assessment and monitoring tools were utilised.

A new care planning system had been introduced by the existing provider and inspectors found that these were very detailed and included social and biographical information on residents. For example, one resident had dementia and a sight problem, her plan contained directives for staff as to how to communicate with the resident and that she should be supported to walk with the aid of two staff. This was observed in practice by inspectors. Inspectors also found that residents had support from psychiatric services as required.

Significant improvements required

Inspectors found that access to multidisciplinary services such as chiropody, dietician occupational therapy or physiotherapy was poor and lengthy delays were noted in accessing such services.

Inspectors reviewed records and found that adequate reviews of residents’ healthcare had not taken place within the required three-monthly intervals.
Resident’s interviewed and medical records examined showed that one (GP) in particular was reluctant to visit unless specifically requested to do so and did not undertake medication or healthcare reviews regularly.

No audits of medication are undertaken. The policy on medication management policy did not conform with the Bord Altranais guidelines for 2007. There was no policy on the use of PRN (as required) or on medication errors and the medication trolley was not secured when not in use. Staff interviewed did not know of any procedure to be used in the event of an error occurring which could place residents at risk.
4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents’ individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

Inspectors found that the overall centre was bright, well maintained, decorated and very clean. Prints and pictures, flowers and other ornaments were evident and a range of soft furniture was available in the day rooms, bedrooms and lobby which added a homely atmosphere. Grab-rails and non-slip flooring were provided.

All bedrooms without en suites contained a wash-hand basin. Shared bedrooms contained curtain screening to ensure the privacy of residents.

Kitchen staff and care assistant staff have separate washing facilities. The new extension also contains a fully equipped sluice room. The kitchen and laundry were found to be suitable equipped. A staff room, nurses office and equipment storage room completes the accommodation. There is a small secure paved patio area which contains a ramp, grab-rails and seating for residents’ use. A call bell system is provided and inspectors tested this and found that staff responded promptly.

Inspectors observed good practice in the management of clinical waste. The catering staff had completed Hazard Analysis Critical Control Points (HACCP) training. Inspectors saw food safety policy and management systems. A health and safety statement was available and was centre-specific.

Inspectors reviewed records and found that assistive equipment such as hoist, beds, and call bells were serviced regularly. Written evidence was provided from a suitably qualified person, stating that the centre is in compliance with the requirements of the statutory fire authority have been complied with. Inspectors viewed documents relating to the installation and servicing of the fire safety equipment including extinguishers, fire alarm and emergency lighting and found that this up-to-date. The extinguishers were last serviced in January 2010. Fire training had taken place for all staff in January 2010, Inspectors reviewed the last environmental health report provided and found that the existing provider has completed all of the actions required by the officer.
Some improvements required

Five of the existing bedrooms had windows which, due to their height from floor level, did not allow residents to have an eye level view of the outside and created shade in the rooms. Only six of the bedrooms contained a lockable space for resident’s valuables.

While the laundry was found to be well equipped, soiled and washed clothes were not adequately separated and there were no temperature guidelines for laundering which would support good infection control practices. All bedrooms and bathrooms contained hand sanitizers and staff were observed using them. However, inspectors observed that sanitizers were not available in the lobby or hallway for visitors use.
5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents’ and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents’ privacy is respected.

Evidence of good practice

Residents and relatives told inspectors that the existing provider and staff keep them informed of any changes or developments which take place in a timely manner. Inspectors observed staff communicating freely with residents during the inspection and addressing them by their names.

Resident records required by legislation were found to be in good order, stored in individual folders and securely stored when no longer required. Inspectors observed copies of the National Quality Standards for Residential Care Settings for Older People in Ireland in the centre and staff were aware of these standards.

Significant improvements required

Inspectors reviewed the residents’ guide. This had not been distributed to residents or relatives and did not contain all of the information required by law, such as a summary of the purpose and function, a summary of the complaints process, or the contact number of the Chief Inspector of the Social Services Inspectorate.

No menu was available for residents and no list of activities was available in a format or print size that residents with sight difficulties could see.

A nursing handover report takes place at 08:00hrs and 20:00hrs each day. Inspectors observed the evening report and found it did not provide sufficient information to incoming staff, on the resident’s day and made no reference to the residents care plan.

There were no formal staff meetings held which would support practice development and communication with staff, though staff informed inspectors that the provider keeps them informed of issues as they take place.
6. **Staff: the recruitment, supervision and competence of staff**

**Outcome: Staff are competent and recruited in sufficient numbers to meet residents’ needs**

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

**Evidence of good practice**

Inspectors observed staff spending time with residents and being attentive to their needs. Inspectors saw record of a staff training programme consisting of core training such as manual handling and relevant training provided by accredited trainers in challenging behaviour, recognising and responding to elder abuse which has been implemented in the past year. All care assistant staff have attended. The functions of care assistant and cleaning staff have been clearly defined to support resident care.

**Significant improvements required**

The existing provider employs eight care assistant staff, 6 nursing staff, three catering staff and four cleaning laundry staff. Inspectors examined the roster and found that from 14:00hrs until 20:00hrs only one nurse and one care assistant were on duty. Inspectors observed that the staffing levels were not sufficient to meet the needs of the residents during this time, with residents alone for long periods. Staff interviewed confirmed this.

There is no formal induction or supervision programme for new staff though staff informed inspectors that the provider does undertake informal mentoring and guidance with staff.

Inspectors reviewed personnel files and found that while all nursing staff had up-to-date An Bord Altranais registration numbers the recruitment practices in general were poor. The provider had tried to remedy this by applying for Garda Síochána vetting retrospectively in 2010. However, staff files did not contain the required three written references for staff. Inspectors noted that there was a considerable delay between application being made for Garda Síochána vetting and return of the outcome. There were no checks carried out on any of the local volunteers who undertook activities with the residents.
Closing the visit

At the close of the inspection visit a feedback meeting was held with Mildred Webb, the existing provider, Selma Kelly, Laura Myers and Lelia Considine the intended purchasers 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
Noelene Dowling
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

19 July 2010

<table>
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<th>Chronology of previous HIQA inspections</th>
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<tr>
<td>Date of previous inspection</td>
</tr>
<tr>
<td>None undertaken</td>
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<tr>
<td></td>
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<tr>
<td></td>
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</table>
Provider's response to inspection report

<table>
<thead>
<tr>
<th>Centre:</th>
<th>Bramleigh Lodge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>0204</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>13 July 2010 and 14 July 2010</td>
</tr>
<tr>
<td>Date of response:</td>
<td>6 September 2010</td>
</tr>
</tbody>
</table>

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:

Failure to provide suitable and sufficient care to maintain the residents welfare and wellbeing having regard to the nature and extent of the residents dependency

Action required:

Implement evidence based practice guidelines for the support of residents with communication difficulties or cognitive impairment.

Action required:

Put in place procedures for managing residents whose behaviour poses a risk to him or herself in an environment that promotes wellbeing and with the least restrictions.

Action required:

Ensure that any methods of restraint have been adequately assessed and alternatives
explored prior to any such measures being taken.

**Action required:**

Record all occasions when restraint is used, its duration and the timeframe when the restriction is removed.

**Action required:**

Aim for restraint free environment.

**Reference:**

Health Act, 2007  
Regulation 6: General Welfare and Protection  
Standard 21: Responding to Behaviour that is Challenging

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

**Provider's response:**

The intended providers will draft and implement centre-specific practice guidelines for the support of residents with communication/cognitive difficulties as per the timetable submitted to HIQA during the course of the inspection.

In the meantime, the existing provider will review existing procedures for managing residents with regard to the use of restraint and will ensure that any methods of restraint are pre-assessed, alternatives are considered and that a record is kept.

**Timescale:**

This will be completed within six to eight months of takeover following initial care plan reviews, assessments and interviews with residents/families.

**Immediate**

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

There was no risk management policy implemented in the centre.

**Action required:**

Implement a risk management policy governing all matters required by the regulations.
**Action required:**

Put in place arrangements for the identification, recording, investigation and learning from serious untoward incidents or adverse events involving residents.

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**Action required:**

Put in place a plan to respond to emergencies including loss of power and light.

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**Reference:**

Health Act, 2007  
Standard 26: Health and Safety

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

**Provider’s response:**

<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>The intended providers will draft and implement centre-specific risk management policy as per the timetable submitted to HIQA during the course of the inspection.</td>
<td>Immediately upon takeover.</td>
</tr>
<tr>
<td>The existing provider will amend existing procedures for the recording of incidents to support changes in practice where required.</td>
<td>Immediate</td>
</tr>
<tr>
<td>The existing provider has put an emergency plan in place to cover incidents such as loss of electricity or water.</td>
<td>Now in place</td>
</tr>
</tbody>
</table>

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

The policy on medication management was not compliant with the requirements of an Bord Altranais guidelines 2007:

Deficits include.

- there is no PRN s (as required) policy
- there is no policy on management of drug errors
- the medication trolley was not secured when not in use

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**Action required:**

Update the policy and practice in relation to medication management to ensure that all requirements of An Bord Altranias guidelines are adhered to.
**Action required:**
Implement a policy on the uses of PRN s (as required) medication.

**Action required:**
Implement procedure for the management of drug errors.

**Action required:**
Secure the drugs trolley when it is not in use

**Reference:**
Health Act, 2007  
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines  
Standard 14: Medication Management

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take following the inspection with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
</table>
| Provider’s response:  
The intended providers will draft and implement a centre-specific medication management policy which meets the requirements of An Bord Altranais Guidelines 2007 which will include a policy on the use of PRNs and management of drug errors.  
The existing provider will ensure that the drugs trolley is secured when not in use. | Immediately upon takeover  
Immediate |

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

Staffing numbers were not adequate to meet the assessed needs of the residents

**Action required:**
Put sufficient numbers of staff in place in the afternoons and evenings to meet the needs of the residents.

**Reference:**
Health Act, 2007  
Regulation: 16 Staffing  
Standard 23: Staffing Levels and Development
**Please state the actions you have taken or are planning to take with timescales:**

**Provider’s response:**

An extra care assistant has been rostered between 15:00hrs and 20:00hrs.

**Timescale:** Now in place

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

The residents’ care plans were not adequately reviewed as resident’s needs change and within the required timeframes.

**Action required:**

Keep the resident's care plan under review as required by the resident’s changing needs and no less frequently then at three-monthly intervals.

**Action required:**

Revise and implement the resident's care plan in consultation with the resident.

**Action required:**

Make the care plan available to the residents and his or her representative.

**Reference:**

Health Act, 2007  
Regulation 8: Assessment and Care Plan  
Standard 11: The Residents Care Plan

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

**Provider’s response:**

The intended providers will review the care plans in consultation with the resident and/or the resident's representative initially as per the timetable submitted to HIQA and ongoing as appropriate on a minimum three monthly basis.

**Timescale:** Immediately upon takeover
6. The provider has failed to comply with a regulatory requirement in the following respect:

There was no adequate centre-specific procedure for the making, investigating and handling of complaints.

**Action required:**

Put in place an operational policy and procedure which outlines the process for making, investigating and handling of complaints.

**Action required:**

Identify a source of appeal of the outcome of any complaint made

**Action required:**

Make the procedure available to residents’ and relatives.

**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:**

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
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</thead>
<tbody>
<tr>
<td>The provider has implemented a centre-specific operational procedure for the making, investigating, handling and appeal of complaints and this policy is now displayed prominently in the centre.</td>
<td>Now in place.</td>
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</tbody>
</table>

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

The operational policies and procedures were not specific to the centre and had not been implemented.

**Action required:**

Develop and implement centre-specific operational policies and procedures required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and detailed in Schedule 5.
### Reference:
Health Act, 2007  
Regulation 27: Operating Policies and Procedures  
Standard 29: Management Systems

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
</table>
| Provider’s response:  
The intended providers will develop and implement all centre-specific operational policies and procedures required by the relevant regulations as per the timetable submitted to HIQA during the course of the inspection. | Operational healthcare policies and procedures will be drafted and implemented within eight months of takeover. All other operational policies and procedures will be implemented within eight to 12 months of takeover. |

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

There is no system in place for the supervision of staff.

**Action required:**
Put in place a system for supervision of staff appropriate to their role.

**Reference:**
Health Act, 2007  
Regulation 17: Training and Staff Development  
Standard 24: Training and Supervision

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
</table>
| Provider’s response:  
The intended providers will draft and implement procedures for the | Immediately upon |
10. **The provider has failed to comply with a regulatory requirement in the following respect:**

The existing provider did not have all the information relating to staff specified in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

**Action required:**

Ensure the centre has all the information relating to staff specified in Schedule 2 of the regulations.

**Action required:**

Source all missing documentation for current staff.

**Reference:**

Health Act, 2007  
Regulation 18: Recruitment  
Standard 22: Staffing

<table>
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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The existing provider will source all missing documentation for current staff.</td>
<td>Immediate</td>
</tr>
</tbody>
</table>

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

The physical design and layout of the building did not meet the needs of residents in the following areas:

- windows in five bedrooms do not allow for adequate light for residents.  
- a suitable space to meet visitors in private was not provided.  
- suitable lockable storage space was not provided for all residents.

**Action required:**

Provide suitable windows.

**Action required:**

Provide safe lockable storage space for resident's valuables.
**Action required:**

Provide a suitable space for residents to meet with visitor’s in private.

**Reference:**

Health Act, 2007  
Regulation 19: Premises  
Standard 25: The Physical Environment

<table>
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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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</table>
| Provider’s response:  
The intended providers will change the physical design and layout of the building to provide adequate light for residents by making the relevant windows bigger and providing a private visiting space. The intended provider is currently awaiting costings in relation to this project.  
The existing provider will provide safe lockable storage space for each resident. | Within 24 months of takeover |
| | Immediate |

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

There is no system for reviewing the quality and safety of care provided to residents and the quality of life of residents.

**Action required:**

Implement a system for reviewing the quality and safety of care provided to residents and the quality of life of residents.

**Reference:**

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

<table>
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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
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</table>
| Provider’s response:  
The intended providers will develop and implement a system for | Immediately upon |
| reviewing the quality and safety of care provided to residents and the quality of life of residents as per the timetable. | takeover |
## 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.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Best practice recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 18 Routines and expectations</td>
<td>The resident is given opportunities for participation in meaningful activity that suit his or her needs. Particular consideration is given to residents with dementia and other cognitive impairment and residents with communication difficulties</td>
</tr>
</tbody>
</table>
Provider’s response:

As referred to in the report, the property has been sold and completion of the sale has been held up for almost a year awaiting HIQA inspection. I therefore earnestly request the immediate finalisation of registration as I am approaching 70 and wish to retire as soon as possible.

Thank you,

Mrs. Mildred Webb

Provider’s name: Mildred Webb
Date: 6 September 2010