<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Strathmore Lodge Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>0281</td>
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<tr>
<td>Centre Address:</td>
<td>Friary Walk</td>
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<td></td>
<td>Callan</td>
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<tr>
<td></td>
<td>Co Kilkenny</td>
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<tr>
<td>Telephone number:</td>
<td>056-775515</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:info@strathmorelodge.ie">info@strathmorelodge.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>Private</td>
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<tr>
<td></td>
<td>Voluntary</td>
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<td></td>
<td>Public</td>
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<tr>
<td>Registered provider:</td>
<td>Liam Harvey</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Sarah McGrath</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>3 November 2010 and 4 November 2010</td>
</tr>
<tr>
<td>Time inspection took place:</td>
<td><strong>Day-1 Start:</strong> 10:15hrs   <strong>Completion:</strong> 20:15hrs</td>
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<tr>
<td></td>
<td><strong>Day-2 Start:</strong> 09:30hrs   <strong>Completion:</strong> 15:00hrs</td>
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<tr>
<td>Lead inspector:</td>
<td>Noelene Dowling</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Mary Moore</td>
</tr>
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<td>Type of inspection:</td>
<td><strong>Registration</strong></td>
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<td><strong>Announced</strong></td>
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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.

**Registration inspections** are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.
In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is a statutory discretion to refuse registration if the Chief Inspector 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 inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.
About the centre

Description of services and premises

Strathmore Lodge Nursing Home commenced operations in 2005. It provides long-term, respite and convalescent care for 58 older persons and two residents who are under 65 years of age. The centre also offers day care service respite for a small number of people who come and participate in the activities programme and have a meal.

The premises are purpose-built over two storeys with accommodation for 35 residents on the first floor and 25 residents on the ground floor. There are two lifts installed, one primarily for service use and one for residents' use.

The entrance hallway leads to a spacious lobby and reception area with a stove fire and comfortable seating. Two dining rooms, three day rooms and a general room used for visitors, activities and hairdressing are located downstairs along with the kitchen and storage areas. Two visitors' toilets and a separate staff toilet is also located on the ground floor. There is a treatment room which also contains secure storage for all drugs and medications.

All bedrooms are single and en suite with assisted shower, wash-hand basin and toilet. A separate bathroom containing a hydro-bath is available and a separate shower room containing assisted shower, toilet and wash-hand basin is also available for residents who prefer this.

The second floor is similar to the first with the exception of the secretary's office and has one large day room, smoking room and staff changing room. Both floors contain a centrally located nurses' station.

There is ample car parking space to the front of the building and a large secure landscaped garden to the rear which has regularly spaced seating for residents. This is easily accessed from the living room on the ground floor. The premises are well maintained and brightly decorated with a good standard of furnishing throughout.

Location

Strathmore Lodge Nursing Home is located in the village of Callan Co. Kilkenny adjacent to all local amenities.

<table>
<thead>
<tr>
<th>Date centre was first established:</th>
<th>1995</th>
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<tr>
<td>Number of residents on the date of inspection</td>
<td>60</td>
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<td>Number of vacancies on the date of inspection</td>
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<tr>
<td>Dependency level of current residents</td>
<td>Max</td>
</tr>
<tr>
<td>--------------------------------------</td>
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<td>Number of residents</td>
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**Management structure**

Liam Harvey is the Registered Provider. Sarah McGrath is the Person in Charge. Shanley Mathew is a senior nurse and deputises in the absence of the Person in Charge.

All nursing and care assistant staff report to the Person in Charge. Catering staff report to the Household Supervisor. Maintenance staff report to the Registered 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>
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<tbody>
<tr>
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<td>9</td>
<td>4</td>
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Summary of findings from this inspection

This was the second inspection undertaken by the Health Information and Quality Authority in Strathmore Lodge Nursing Home. A regulatory monitoring inspection was undertaken on 17 August 2010.

As part of the registration process the provider has to satisfy the Chief Inspector that he is fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). As part of the application for registration the provider was requested to submit relevant documentation to the Authority including completion of the fit person self assessment. This documentation was reviewed by the inspector to inform the inspection process.

This document was comprehensive and outlined current practices as well as changes the provider wished to make having reflected on the process. Issues identified for change included the use of do not disturb signs on the residents’ bedroom doors, signage and orientation for residents, training in challenging behaviour for staff, an increase in the number of care assistant staff on duty in the afternoon, and the relocation of the nursing handover report to a location which ensured residents confidentiality was respected. These matters had been implemented prior to this inspection taking place.

Other issues identified for completion at a later date included; the sourcing of visual and audio records of resident meetings, identification of a suitable advocate for residents, the development of life story work for residents, more emphasis on the use of crosswords and other activities to support mental health, a review of routines for residents with dementia, a full training needs analysis for staff and a remembrance ceremony to be held annually for those residents who had passed away during the year.

In order to assess the fitness of the provider and the key senior manager, fit person interviews were held. The provider and person in charge demonstrated an adequate knowledge of the National Quality Standards for Residential Care Settings for Older People in Ireland and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Other documentation reviewed by inspectors included operational policies, residents’ records, staff rosters and training records, meeting records and maintenance logs. Inspectors met with residents, relatives and staff.

Findings from this inspection indicated that there was good management and governance systems in place, adequate staffing levels and a commitment to ongoing training for staff, good practice in relation to complaint management, and residents’ participation in the running of the nursing home. Medical care was found to be of a good standard with systematic reviews and monitoring of residents’ health needs, and access to allied and multidisciplinary health services.
Improvements were required in the consistent implementation of risk management strategies, policies on elder abuse and methods of restraint used, and staff responding to residents’ call-bells.

The Authority had received a concern in relation to the centre prior to the inspection and the details of this concern also informed the inspection process.

The Authority was informed by the provider prior to the inspection that the person in charge was rescinding the post to concentrate on the clinical care of residents. A new person in charge had been appointed but had not taken up position at the time of the inspection.

**Comments by residents and relatives**

The inspector received eight completed questionnaires from residents and eleven from relatives. Inspectors interviewed eight residents and four relatives during the inspection.

Residents expressed their satisfaction with the accommodation and the care they received, and stated that they enjoyed their lives in the centre, the open visiting times, the activities and the support of the staff including the person in charge and the provider. Three residents stated that they felt very much at home, and one said she felt very safe living there.

Relatives stated that they had made extensive enquiries prior to their relatives’ admission and had chosen the centre specifically because of its reputation and the information they had received from the person in charge. They said they visited at flexible times and always found their relatives well cared for, and that staff were very attentive.

One relative said she observed staff using the appropriate resident transfer techniques at all times with her relative. Another stated that she observed staff ensuring that her relative had access to different parts of the premises to vary her environment during the day. However, two residents stated that there was occasional delays in staff responding to call-bells.
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

Inspectors found effective management systems in place and resources such as staff were well deployed. The person in charge is appropriately qualified and experienced and demonstrated a detailed knowledge of the residents and their day-to-day care needs. A suitably qualified and experienced nurse has been appointed to cover in the absence of the person in charge. Inspectors were shown the documentation in relation to the incoming person in charge and found that she was suitably qualified and had the required three years experience in the previous six years to undertake this role.

Legal requirements such as the statement of purpose, contracts of care, adequate insurance, compliance with environmental health requirements, written evidence of compliance with the requirements of the statutory fire authority were provided. An emergency plan had been devised since the regulatory monitoring visit.

Records of residents' personal monies held for safe-keeping by the provider were detailed and the resident's or relative's signature is required and was evident. Expenditures were receipted and the amounts were found to tally. The provider and the person in charge had complied with their responsibility to notify the Chief Inspector of significant occurrences within the centre.

Inspectors found that admissions were congruent with the statement of purpose and the individual needs of residents under the age of 65 were managed appropriately with access to supports from external allied services.

Some improvements required

Risk management strategies had been developed and there was evidence that the person in charge monitored incidents and took remedial action to prevent reoccurrences. This process included multidisciplinary assessments, environmental awareness to prevent injury to residents, and remedial actions to prevent injury to residents and safeguarding residents with dementia. However, inspectors found that
in two specific areas these identified risks were not supported by the consistent implementation of the proposed management strategies. These were; the monitoring of methods of restraint used and the consistent application of supervision strategies implemented to safeguard residents.

Systems in place to monitor the quality of life and care for residents include ongoing feedback from the residents’ forum, one-to-one feedback from residents and relatives, information gleaned from the regular staff meetings, medication monitoring and review and incident and accident reviews were evident. A formal auditing system had not been implemented.
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 found that the staffing levels, training of staff, division of roles and robust management system contributed to the wellbeing and overall quality of life of the residents. Inspectors observed that staff respected the privacy and dignity of residents when carrying out personal care and in how residents were addressed by staff. Do not disturb signs were provided for use on bedroom doors when this was taking place.

Staff were very knowledgeable regarding residents’ biographical information, preferences and care needs. This knowledge was seen to be transferred into the day-to-day life of the residents. For example, one resident did not wish to get up before lunchtime and this choice was respected. There is choice as to how and where the residents spend their time during the day and staff facilitate this. Residents were observed reading, and making use of the various living rooms and seating areas which offer space for quite time or for visitors. Residents confirmed that they enjoyed the activities provided and that the provider is open to any suggestions they make. They have regular and easy access to the garden in fine weather and residents said they enjoyed this.

There are six male carers employed and staff and residents confirmed that they have choice in relation to the gender of carers who provide personal care for them and this was reflected in care plans. Rosters seen by inspectors demonstrated that there was an appropriate mix of male and female carers on duty.

The activities coordinator was on leave on the day of the inspection. However, a local musician held a sing-along session in the afternoon, fit for life exercise was also provided weekly and pet therapy was available. The activities coordinator had been observed on the previous inspection spending individual time with residents, reading with them or supporting them to walk outside, giving hand massages as well as organising group activities. Reminiscence tools are provided for residents. The activities coordinator was scheduled to undertake training in order to better support residents who have cognitive impairment.

Inspectors joined residents for lunch and those residents who needed assistance were supported in an unhurried and respectful manner. Independence was promoted
by staff offering minimal assistance to residents when required. A menu is available but residents are offered a choice when they are seated at the table, thus ensuring they have the meal they choose at that time.

The food was freshly cooked and the meal was a social and unhurried occasion. Since the issue of support for residents at mealtimes was identified by the regulatory monitoring inspection, the provider has made changes to how meals were served to ensure they are hot. This included the redeployment of staff at lunchtime to ensure there are enough staff to assist residents and ensuring that meals were only served when residents are seated and ready to partake of them. Residents were observed coming into the dining room at various times, and there was flexibility regarding the mealtime. Inspectors observed open and positive interaction between staff and residents.

Religious preferences are provided for and the presence of the oratory supports this. Residents were observed participating in a service which they said they appreciated was available to them. Social relations were supported by an open visiting policy and relatives were observed visiting at all times of the day. Inspectors observed that staff, the person in charge and the provider were well known to relatives and visitors.

There was a written operational policy for the making and management of complaints which included a timeframe for response and an appeals process. A synopsis of this was displayed in a prominent position in the centre. The inspector reviewed the complaints log and found that complaints made were appropriately and satisfactorily resolved by the person in charge. Residents and relatives informed the inspectors that they were confident the person in charge, staff or the provider would address any issues they might have.

The residents’ forum is another avenue whereby residents can make suggestions and raise issues. Inspectors reviewed the monthly forum records which are chaired by the activities coordinator. These showed evidence of how residents influenced practices and how the provider responded positively to issues raised. For example, the issue of inadequate staffing levels between 20:00hrs and 00:00hrs was raised by residents. This matter was resolved by the addition of a care assistant during those times.

Staff have undergone training in the protection of vulnerable adults and reporting of elder abuse. Staff interviewed were able to define what would constitute abuse of a resident and were unequivocal that they would report this to the person in charge or the provider. They also expressed confidence in how the provider would respond to such an issue.

**Significant improvements required**

Since the previous inspection the Authority was notified of a second incident of concern which had occurred between two residents. All appropriate steps had been taken by the provider, which included sourcing specialist consultation and advice, family meetings and internal strategies such as increased supervision of residents.
However, on review of the records in relation to this matter inspectors found that two strategies implemented had not been adhered to. The provider had devised a system of close supervision and in particular that the residents would not to be alone and unsupervised. While staff were able to outline this strategy to the inspectors, the supervision plan had not been adhered to and this contributed to the second incident occurring. The records of this monitoring programme were poorly dated and maintained.

A further aspect of the strategy to manage this behaviour included a consultant psychiatrist who, following assessment of a resident had prescribed a course of medication which was to be reviewed following a specific timeframe. However, on examination of the medical records inspectors found that this prescription and its duration had been altered by another clinician. Inspectors could find no evidence of interdisciplinary consultation or review prior to this decision being made.

Although staff were observed monitoring the residents regularly, inspectors noted that two residents, one in a bedroom and one in a living room could not access their call-bells easily. Two residents also reported that there was a delay in staff answering the call-bells and inspectors observed this on one occasion during the inspection.
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 ongoing 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

Residents may retain their own general practitioner (GP). However, residents usually transfer to one of three GPs who are within the local catchment area. One GP calls to the centre daily and an out-of-hours service is provided. Inspectors reviewed six residents' files. Medical records examined showed that residents’ medical care and medications were reviewed regularly and well within the required three-monthly timescale. The GP, pharmacist and person in charge undertake a formal three-monthly audit of medication to ensure that medication and its impact on or benefit to the resident was evaluated. Records and interviews confirmed that the person in charge was rigorous in contacting the GP when any change occurred in a resident’s health or when she felt advice was needed.

Inspectors saw dietary communication tools outlining residents' likes and dislikes, special dietary needs and foods to be liquidised. Fortified drinks and supplements were observed being served to residents during the day. Jugs of fluids with ice were observed in all areas and inspectors observed staff encouraging and supporting residents who could not access these themselves. Inspectors observed two GPs visiting residents during the inspection.

Records and interviews confirmed that allied health services such as speech and language therapy and chiropody are accessed as needed. The inspector observed the written directions of the speech and language therapist being implemented with residents at mealt ime. Physiotherapy is available privately on a weekly basis.

Other allied disciplines such as mental health or disability specialists were accessed and available for residents when required. Inspectors noted good communication in records and from interview with the person in charge and staff between these services to support consistent care for residents. End-of-life care is supported with combined planning between the local GP, the home care team and the person in charge. Inspectors observed this process being implemented during the inspection and monitored consistently by the person in charge.

Nursing care records reviewed indicated that residents’ needs are assessed on admission and regularly reassessed using appropriate assessment tools to assess residents’ risk of falls, nutrition and dependency levels. Vital signs were monitored regularly. Inspectors saw evidence of referrals to wound management specialists and
observed that the treatment plans outlined were carried out by staff. Manual handling techniques for residents who require support were detailed and concurred with the observations of inspectors and the information given by relatives.

The person in charge has implemented the new care planning system and related documentation and were mainly reflective of the work undertaken on a day-to-day basis on behalf of residents. While they showed no evidence of consultation with residents and or relatives, both groups stated that they were always consulted and that information was elicited before and following admission to guide the care-planning process. They confirmed consistently being informed and consulted with regard to all interventions.

The inspector found that all medications, including controlled drugs are prescribed, administered, stored, disposed of and accounted for in accordance with An Bord Altranais Guidelines 2007. The medication policy is up to date and adequate.

Health promotion strategies were observed in records and practice. Residents were encouraged to walk and remain mobile, with many using appropriate walking aids or being supported by staff. Fluids were encouraged.

**Significant improvements required**

Inspectors found limited use of methods of restraint such as bedrails and observed that the resident's choice regarding their usage is respected. A wandering tag system was used for a short period of time while a resident with dementia was acclimatising to living in the centre. This was then removed with guidelines for staff to redirect the resident as the surrounding became more familiar. This strategy was effective.

However, another resident was also using a wandering tag. Assessment of the need for this had been undertaken and the tag was to be monitored daily to ensure it was in working order. Records showed this monitoring was not undertaken consistently which could have placed this resident at risk. The detailed policy on restraint states that restraint will not be utilised for wandering behaviours and does not refer to the use of wandering tags.

While there was comprehensive documentation available outlining the need for restraint and measures which should be implemented as an alternative, these assessment tools were not adequately implemented. No written consent for the use of restraint was obtained from residents or relatives. Although, relatives confirmed they were consulted with in relation to this.
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

The centre is bright, spacious, well decorated, ventilated, maintained and fit for purpose. The communal space was adequate and the design of the building allows for soft seating to be placed in a number of alcoves throughout the premises allowing residents’ freedom of movement and privacy. There is a smoking room, and a small oratory for residents’ use. The large sitting room upstairs was used for celebrations, family parties and religious ceremonies. Sluice rooms and storage areas were found to be adequate and suitable equipped.

The furnishings are comfortable and suitable for residents’ use and the bedrooms were found to be personalised with photos, flowers, and rugs. All rooms have telephone access points and televisions. While the residents had good personal storage space in their bedrooms, this could not be locked and the provider is examining ways to facilitate this.

The garden to the rear is secure, wheelchair accessible, well landscaped with circular walk-ways to support residents who have dementia. Seating is strategically placed at regular intervals.

Inspectors found good practice in relation to infection control, and observed staff taking the necessary precautions. The premises were clean with a rigorous cleaning schedule including the washing of all carpets carried out daily. The laundry room was well equipped and linen is appropriately segregated. The catering staff have completed the required Hazard Analysis Critical Control Points (HACCP) training. Observation in the centre and examination of the maintenance logs showed that repairs are attended to in a timely and effective manner.

A good range of high specification profiling beds, hoists and other assistive equipment is provided for residents. The provider gave the inspector a written contract for the servicing of this equipment from a new contractor as the previous company had not been found satisfactory. Grab-rails and non-slip flooring are provided in appropriate areas. A call-bell system is in place and CCTV cameras are used only on corridors and the external access to the premises and the presence of this monitoring system is highlighted by signage in the lobby.
The inspector examined records in relation to the servicing of all fire safety equipment and found good practice was adhered to. The fire alarm and emergency lighting systems were last serviced in May 2010 and July 2010 respectively. Fire extinguishers were serviced in June 2010. A monthly fire alarm test is recorded and daily checks on escape routes are undertaken and recorded.

Inspectors found that the induction procedure for new staff included fire safety and fire training. This training was provided to staff in 2010 with further training scheduled for the autumn. This training was detailed and included directions as to how to move both mobile and immobile residents utilising the fire compartments within the premises. The procedures in the event of a fire are clearly displayed both upstairs and downstairs. Staff interviewed were knowledgeable on these procedures.
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

A number of mediums, both formal and informal are utilised to support communication.
Relatives stated that they had received the residents’ brochure and they always had access to the staff, the person in charge or the provider should they require. They stated that they were confident of been promptly informed and consulted in regard to changes to their relatives’ health. Residents’ opportunities for expression were well supported through the resident’s forum, which they confirmed attendance at, and by informal day-to-day communication with the staff. In order to support communication and orientation for residents who have cognitive impairment, the provider has commenced using some signage and orientation boards.

Head of section meetings took place at least once per week. Records reviewed show that these meetings informed practices and identified necessary changes. For example, new non-slip place mats were provided once the need was identified. Inspectors attended the evening report on both floors and found that this was comprehensive, and included both the health and social needs of residents. Care assistants and nursing staff attended this handover and incoming staff participated proactively. Management meetings also take place and records reviewed showed evidence that actions were identified and acted upon in order of priority. Team meetings were scheduled regularly so that all staff are familiar with changes to practices as a result of policy development.

A comprehensive schedule of policies in relation to clinical matters has been completed and signed by staff. These are up to date and contain appropriate references. In general these are centre-specific and concur with practices as outlined by staff, for example in relation to Methicillin-resistant Staphylococcus Aureus (MRSA) and wound management.

Inspectors observed that a broad range of educational reading material specific to older persons including literature on end-of-life care and nutrition were available for all staff.
Since the regulatory monitoring visit, the development of policies has continued and the provider has the policies required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Staff were familiar with the policies. However, the detailed policy on the use of restraint is not implemented in practice. Additionally, the policy on detecting and responding to allegations of abuse does not outline sufficiently the range of circumstances which may require intervention and the subsequent actions to be taken by the provider.
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

The provider employs 10 nursing staff and 20 care assistants who are dedicated to resident care only. Cleaning catering and laundry staff are separate to this allocation. On the day of the inspection there were two nurses and between nine and five carers depending on the time of day. Staff are allocated to the ground or first floor. There is an additional care assistant assigned between 10:00hrs to 16:00hrs seven days per week to support residents with mobility and personal care. There are two nurses and three care assistants on duty overnight. The skill mix is deemed suitable for the needs and the numbers of residents who live in the centre.

Inspectors viewed staff training records and found that the provider and staff have committed to a significant training schedule including mandatory training such as manual handling, fire safety, and elder abuse, along with infection control and nutrition for the older person. Five of the care assistant staff have completed all modules of the Further Education and Training Awards Council (FETAC) Level 5. A training schedule is in place and three staff are scheduled to commence Further Education and Training Awards Council (FETAC) in 2011.

As required by the regulatory monitoring inspections in August, staff have undergone training in supporting residents with challenging behaviours and in understanding the needs of residents with dementia. The provider stated that this training schedule will be further developed once the new person in charge has taken up post. Staff informed inspectors that they benefited from this training and could outline how it helped them to engage with the residents and to understand the underlying causes of residents' behaviours. Inspectors observed that good manual handling techniques were utilised by staff.

The person in charge has undergone the “Train the Trainer” course for the prevention detection and reporting of elder abuse and has provided regular and updated training for staff in this subject.
Some improvements required

The person in charge and senior nurse support staff and monitor practice by a system of informal mentoring and day-to-day direction and education. The post of senior carer also helps to ensure that care assistant staff are monitored. Staff confirmed the support and direction of the person in charge. However, there is no formal appraisal and supervision system in place for staff.

Significant improvements required

Current registration details were available for nursing staff. However, staff files examined by the inspector did not contain all the documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Items missing included three references and police clearance for staff employed from abroad. The provider had commenced the process of sourcing the missing documents. However, the inspectors found that the staff member employed since the regulatory monitoring inspection was undertaken was not recruited in line with best practice and the regulations. The information in the curriculum vitae was not utilised, only one reference was sourced and this was not sourced from the most recent employer.
At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, care assistant supervisor, the administrator and the senior nurse 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

3 November 2010

<table>
<thead>
<tr>
<th>Date of previous inspection</th>
<th>Type of inspection:</th>
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<tbody>
<tr>
<td>17 August 2010</td>
<td>☒ Unannounced</td>
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<tr>
<td></td>
<td>☐ Registration</td>
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<td>☐ Follow up inspection</td>
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Provider’s response to inspection report*

<table>
<thead>
<tr>
<th>Centre:</th>
<th>Strathmore Lodge Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>0281</td>
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<tr>
<td>Date of inspection:</td>
<td>3 November 2010</td>
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<tr>
<td>Date of response:</td>
<td>17 December 2010</td>
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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 policy and procedure in place for the prevention, detection and response to abuse is inadequate.

   **Action required:**

   Put in place an adequate policy and procedure for the prevention, detection and response to abuse.

   **Action required:**

   Make all necessary arrangements which are aimed at preventing residents being harmed or being placed at risk of harm.

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

Health Act, 2007  
Regulation 6: General Welfare and Protection  
Standard 8: Protection

### 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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<tr>
<td>There is now a rigorous policy in place that clearly reflects the requirements within the Health Act 2007, Regulation 6 in respect of general welfare and protection and care Standard 8 relating to protection. All staff within the centre have completed the Elder Abuse awareness training.</td>
<td>17 December 2010</td>
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### 2. The person in charge has failed to comply with a regulatory requirement in the following respect:

Records in relation to the assessment of the need for the use of wandering tags, and other methods of restraint were not adequately completed and reviewed.

### Action required:

Maintain a complete record that documents the specific medical symptom to be treated by the use of any methods of restraint, the alternative measures taken, evidence that such use would benefit the symptom and the resident’s or relative’s consent for such use.

### Reference:

Health Act, 2007  
Regulation 22: Maintenance of Records  
Standard 21: Responding to Behaviour that is Challenging  
Standard 3: Consent

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
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<tr>
<td>All care planning procedures are currently under review. The restraint policy is a comprehensive policy, however the 'person-centred' recording of reviews that involves family, GP and any other persons will be implemented and documented more thoroughly. This will include risk assessments, antecedents to behavioural records and management of the same.</td>
<td>31 May 2011</td>
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<td><strong>3. The provider has failed to comply with a regulatory requirement in the following respect:</strong></td>
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<td>The risk management policy was not implemented.</td>
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<td><strong>Action required:</strong></td>
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<td>Implement a risk management policy to cover all of the risk identified in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and ensure that any strategies used to maintain residents’ safety are implemented.</td>
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<tr>
<td><strong>Reference:</strong></td>
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| Health Act, 2007  
Regulation 31: Risk Management Procedures  
Standard 26: Health and Safety |   |   |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |   |
| Provider’s response:  
The health and safety policy is currently under review. The implementation of a more rigorous, evidence-based protocol will commence in January 2011. This will include further training for staff, including risk assessment training and the commencement of weekly health and safety meetings for all areas of the centre with recorded minutes available. Our emergency contingency plan will also be completed. | Commencing January 2011 |   |

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<td><strong>4. The provider has failed to comply with a regulatory requirement in the following respect:</strong></td>
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<td>Residents’ call-bells were not answered in a timely manner.</td>
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<td><strong>Action required:</strong></td>
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<tr>
<td>Establish a system for reviewing the quality of life and safety of care provided to residents.</td>
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<td><strong>Reference:</strong></td>
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| Health Act, 2007  
Regulation 35: Review of Quality and Safety of Care and Quality of Life  
Standard 30: Quality Assurance and Continuous Improvement |   |   |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |   |
|   |   |   |
Provider’s response:

The commencement of internal auditing to evidence quality assurance will commence January 2011. This will encompass: care plans, medication, infection control, health and safety, general home maintenance. Along side these quality benchmarkers there will be a review of time management in all areas and an improved deployment of staff. A service user and family quality questionnaire will be delivered to them quarterly and our transparent management style will continue. Discussion is ongoing in respect of the recording of ‘call-bell’ durations and is something we need further advice from the manufacturers on.

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

Staff files did not have the required documents as set out 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 that staff employed to work at the designated centre are fit to do so by sourcing all of the documentation set out in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

**Reference:**

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

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

Provider’s response:

The inspection team reviewed only one personnel file and as such did not appreciate a true reflection of the high standards of the recruitment protocol within Strathmore Lodge. We continue to endeavour to recruit within the national guidelines despite the national constraints.

**Timescale:** 17 December 2010

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

Staff are not formally supervised according to their role.
**Action required:**

Put in place a formal system for the supervision of staff pertinent to their role.

**Reference:**

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

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<th>Provider’s response:</th>
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<td>The formal supervision of staff commenced on 29 November 2010. There will be at least six supervisions yearly and an annual appraisal. Within the supervision, training needs and requirements are reviewed and actioned. The director of nursing has undertaken all the initial supervisions. Going forward the pertinent managers and nurses of each area will also be involved in the process with the director reviewing these personally.</td>
<td>29 November 2010</td>
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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>
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<td>Standard 3: Consent</td>
<td>Ensure that the residential care setting has a policy that outlines the procedures for seeking consent from residents prior to any treatment or care given. The policy addresses when the resident lacks the capacity to give consent.</td>
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<td>Standard 21: Responding to Behaviour that is Challenging.</td>
<td>Ensure that all interventions in response to behaviour that is challenging are reviewed regularly, inform learning and practice development. Reviews take place in a spirit of support.</td>
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Provider’s response:

This first registration inspection was an interesting experience for all the staff at Strathmore Lodge Nursing Home.

While we are delighted that the inspection team have recognised and recorded many of the excellent standards of care in the nursing home, I would like to comment on one negative aspect of the report and that is the answering of the nurse call-bells. We are disappointed that the inspection team felt that some bells were not answered in a timely manner. All staff are aware of the importance of responding to the residents call-bells promptly. If the inspectors felt that the call-bells could have been responded to more quickly on the days of their inspection, it would have been appreciated by management to have been told on the day, during the feedback session. We then would have had the opportunity to deal with the concern immediately and/or discuss what the inspectors perception of 'delays' in answering the call-bells were.

We would like to thank the members of the inspection team for the courtesy that they showed to the residents, relatives and the staff during the inspection process.

Provider’s name: Liam Harvey
Date: 17 December 2010