### Centre name:
- St Anne's Private Nursing Home

### Centre ID:
- 0387

### Centre address:
- Sonnagh
- Charlestown
- Co Mayo

### Telephone number:
- 094-9254269

### Fax number:
- 094-9255093

### Email address:
- kathsmyth@eircom.net

### Type of centre:
- ☒ Private
- [ ] Voluntary
- [ ] Public

### Registered provider:
- Kathleen Smyth

### Person in charge:
- Audrey Harrington

### Date of inspection:
- 4 and 5 March 2010

### Time inspection took place:
- **Day 1**
  - Start: 10.00 hrs
  - Completion: 17:50 hrs
- **Day 2**
  - Start: 09:00 hrs
  - Completion: 16:45 hrs

### Lead inspector:
- Jude O’Neill

### Support inspector(s):
- Marie Matthews

### Type of inspection:
- ☒ Registration
- [ ] Scheduled
- [ ] Announced
- [ ] Unannounced
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

St Anne’s Private Nursing Home was established in 1983. The centre provides accommodation for up to 36 residents and offers long term, respite and convalescent care. It caters for residents who mainly have physical problems as a result of aging and also provides care to people with cognitive impairment and / or dementia.

The centre has been converted from a residential dwelling. It is two-storey to the front and contains three twin rooms upstairs which have been converted for use by staff and visitors. All accommodation for residents is on the ground floor in a purpose built extension. There are 18 twin and 2 single bedrooms, each with an en suite toilet and wash hand basin. Communal accommodation consists of a dining area adjacent to the kitchen, three sitting rooms (including the foyer), a smoking room, an oratory, three toilets and one assisted bathroom. Office space, storage space, staff changing facilities, an overnight guest room, a visitors’ room and toilet complete the layout.

Location

The centre is located in Sonnagh, on the outskirts of Charlestown, Co Mayo. It is also close to the town of Swinford and within 6 kilometres of the Ireland West Airport.

| Date centre was first established: | 1983 |
| Number of residents on the date of inspection | 22 |
| Number of vacancies on the date of inspection | 15 |

| Dependency level of current residents | Max | High | Medium | Low |
| Number of residents | 8 | 6 | 5 | 3 |

Management structure

The provider is Kathleen Smyth and the person in charge is Audrey Harrington.

The person in charge is supported by staff nurses, care assistants and a range of administrative, clerical and ancillary staff.
Summary of findings from this inspection

This was an announced registration inspection and the first inspection carried out by the Health Information and Quality Authority. The provider had applied for registration under the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009. As part of the registration process, the provider has to satisfy the Chief Inspector of Social Services of the Health Information and Quality Authority (HIQA) that he / she 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). The provider applied for registration for 36 residents to include the categories of older person, dementia, physical disability, intellectual disability, respite and convalescence care.

Inspectors met residents, relatives, the provider, the person in charge, staff nurses, an administrator, the chef and other members of staff. A range of documents were reviewed which included care plans, medical records, the accident and incident log, fire safety records, staff records and policies and procedures.

Separate ‘fit person’ interviews were carried out with the provider, the person in charge and a senior staff nurse who deputised in the absence of the person in charge. Inspectors read the ‘fit person’ self assessment document in advance of the inspection along with all the information provided in the registration application form and supporting documents.

Inspectors were satisfied that the medical and healthcare needs of residents were met. The provider, the person in charge and all staff demonstrated a commitment to the provision of good quality, person-centred care. Staff were knowledgeable of residents’, likes, dislikes, needs and preferences and were seen to attend to residents in a caring, respectful and sensitive manner.

Inspectors found that the premises, fittings and equipment were clean and well-maintained. There was a good standard of décor throughout and very high levels of personalisation evident in residents’ bedrooms and communal areas.

While the quality of care provided to residents was seen to be very good, the provider, the person in charge and staff demonstrated only limited awareness of the Health Act, 2007 and the Health Act, 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). In addition,
the standard of record keeping and availability of documentation within the centre was not in accordance with the relevant legislation.

A number of improvements were required to address deficits in the service and to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. These improvements included the need to increase staffs’ awareness of the relevant legislation, the development of a range of policies and procedures, improved record keeping, the introduction of enhanced quality assurance systems and an increased focus on social care. These requirements are set out in the Action Plan at the end of this report.

### Comments by residents and relatives

Prior to inspection, seven residents and eight relatives completed questionnaires on the quality of care provided and the quality of life experienced in the centre. During the inspection, inspectors spoke to most residents and interviewed five at length. Inspectors also had opportunity to speak to four relatives.

All residents and relatives interviewed and those who completed and returned questionnaires indicated they were happy with the care and accommodation provided and were complimentary in their comments about staff.

Residents described how they were able to exercise choice over daily routines and told inspectors that they had autonomy over their lives in the centre. Residents described what activities they liked to do which included “word puzzles”, “crosswords”, “reading newspapers”, “talking to staff” and “watching the cats outside”.

Staff were described as “approachable” and “caring” and residents told inspectors that they would be happy to talk to any member of staff if they had concerns or wished to complain.

All residents consulted said they felt safe and knew both the provider and person in charge by name. One resident said that “Kathleen (the provider) was in the home every day and is always checking to make sure we are being well looked after”.

Relatives were unanimous in their positive comments on the care provided and the good communication between staff. One relative who was interviewed said the centre was “not only a home for her mother but for me also” and told inspectors that staff treated the residents “like family”.

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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 philosophy of care as described in the statement of purpose was observed throughout the inspection. Residents were afforded autonomy and choice and staff were seen to be attentive in meeting their needs.

A clear organisational structure was in place and the provider was actively involved in the day-to-day operation of the centre providing ongoing support to the person in charge. Staff interviewed were knowledgeable about their roles and responsibilities and were able to describe the staff structure and the reporting mechanisms in place.

Hoists and other equipment had been maintained and service records were seen to be up-to-date. Fire alarms, extinguishers, hoses, blankets and emergency lighting were checked and serviced by external companies. The records inspected indicated that they had been maintained in accordance with legislation and best practice. The local fire and rescue service had last inspected the centre on 27 October 2009 and the fire alarm system was last inspected on 25 September 2009. The records reviewed confirmed that staff undertake a daily inspection of all escape routes. Staff interviewed were knowledgeable of how to respond in the event of fire or other emergency.

An up to date directory of residents had been maintained by the person in charge. This was checked by an inspector and found to contain all the information required by the relevant legislation.

Inspectors viewed the reports from the last inspection by the Health Service Executive, the environmental health officer and the fire authority and confirmed that the provider had complied with the actions contained within these reports.

Inspectors were provided with written confirmation that the provider was insured against accidents and injuries to residents, staff and visitors.
Residents and relatives told inspectors that they felt comfortable at approaching the provider or person in charge if they had cause to complain. The complaints log indicated that one complaint relating to laundry had been made in recent months. A review of the documentation confirmed that this had been investigated by the provider in a timely manner and that the complainant was satisfied with the outcome from the investigation. However, while a complaints policy and procedure was in place, there was no reference made to an independent appeals process or identification of a nominated person (independent of the person responsible for investigating the complaint) to ensure that records were appropriately maintained and that all complaints were appropriately responded to in accordance with the relevant legislation.

While a statement of purpose was in place, this was seen to be very brief and did not contain the range of information required by the relevant legislation. In particular, omissions were noted in relation to the arrangements for dealing with complaints, fire precautions, emergency procedures and care plan reviews.

Discussion with residents and relatives confirmed that an information booklet known as the “residents’ guide” was available and had been provided to all residents. However, this booklet had not yet been revised to reflect the range of information required by legislation to be contained within a residents’ guide. There was no summary of the complaints procedure, or summary of the statement of purpose and function or standard form of contract contained within the booklet and the name and address of the Chief Inspector of the Authority had not been provided.

The information obtained through general discussion and during the “fit person” interviews indicated that the provider, the person in charge and the senior staff nurse were knowledgeable of the National Quality Standards for Residential Care Settings for Older People in Ireland but had only a limited awareness of their responsibilities under the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

There was no written risk management policy and limited evidence to confirm that there were arrangements in place for the identification, recording, investigation and learning from incidents involving residents. While procedures were in place to guide staff on how to deal with violence, aggression or a resident going missing, there was no specific procedure to deal with assaults, accidents / injury to residents or staff and self harm. Inspectors confirmed that individual care plans for two residents had been revised following recent falls; however, there was no indication that a more corporate approach to incidents had been adopted which considered such elements as time of day (or night), staffing levels at time of incident and location.

While the person in charge was able to describe to inspectors the various dependencies of residents, a dedicated evidence-based tool had not been used to calculate these levels and ensure that staff were on duty in adequate numbers and
with the appropriate skills and competencies to meet the changing needs of residents.

A system was in place for the management of petty cash and all transactions from residents accounts were subject to two signatures. However, the administrator confirmed that all expenditure was not routinely receipted. This practice was not in keeping with the Authority's standards.
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

Residents and relatives consulted were complimentary of the care provided and the quality of life experienced within the centre. Residents appeared well cared for and were observed to be appropriately dressed wearing clothing that was colour coordinated and season appropriate.

Residents told inspectors that they were able to exercise choice over all aspects of life and were able to participate in social and recreational activities both in the centre and the local community. A poster on the notice board in the foyer advertised a range of activities that were available which included aromatherapy, discussion groups, reading from daily newspapers and listening to music. The person in charge advised that residents were able to exercise choice over what to participate in and that planned activities often changed in response to their requests. On the day of inspection, a local musician was playing in the dayroom. Residents were seen to enjoy the music and a number were dancing and singing.

Good interactions were observed between staff and residents. Staff were seen encouraging and supporting residents to maintain their independence. Handrails were available along corridors to assist residents when walking and a choice of seating was available at regular intervals.

The choice, quality and presentation of meals were seen to be of a high standard. Inspectors joined residents for their lunch. The dining room was well laid out with adequate space noted between tables to allow residents and staff to move freely. Tables were laid with condiments, serviettes and side plates. There was a choice of hot or cold food and a selection of fresh fruit. Menu choices were clearly displayed on a notice board in the dining room. Food was served at the table providing residents with choice over portion size. The food was positively commented on by residents and found by inspectors to be tasty. Discussion with staff and residents confirmed that menu choices were also available for residents with diabetes or other conditions which required a special diet.
**Significant improvements required**

As a consequence of the poor standard of record keeping, it was not possible to confirm that all staff had been trained in elder abuse. Furthermore, while a policy on elder abuse was in place, there was no procedure setting out what staff should do in the event of abuse or suspected abuse.

**Minor issues to be addressed**

While staff were observed to be respectful to residents, Inspectors noted on one occasion that a staff member failed to knock and await permission before entering a resident’s bedroom.
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

Where possible, residents had been able to retain their own General Practitioner (GP) following admission to the centre. Where residents had been admitted from outside their GPs’ catchment area, they had been provided with a choice of GP. The centre is served by two GP practices and out of hours medical care is provided by an external provider. Discussion with the person in charge and review of the medical records confirmed that residents’ medical needs were subject to ongoing review. Inspectors noted from the records that all residents had been seen by their GP within the last three months or more frequently as required.

From the documentation reviewed, inspectors noted a proactive approach to health promotion and confirmed that staff monitored blood pressure, weight, pulse, temperature, and arranged for phlebotomy (blood analysis), and urinalysis (urine testing) as required. Staff were also observed encouraging residents to walk rather than use transport wheel chairs.

Residents with a formal diagnosis of dementia had been regularly reviewed by the psychiatry of old age team. The person in charge told inspectors that through GP referral, residents are able to access physiotherapy and occupational therapy services in the local community. A private physiotherapist was also available to residents at an additional cost.

The drug administration records for all residents were inspected. Inspectors found that medications had been prescribed and reviewed within the last three months and administered in accordance with professional guidelines.

Some improvements required

Residents’ care records were found to be disjointed with assessments, care plans and daily nursing notes filed separately. Consequently, it was difficult for inspectors to follow through the process of assessment, implementation and evaluation of care. The sample of four care records reviewed contained a number of assessments that had not been updated within the preceding three months. A formal assessment of residents’ activities of daily living had not been routinely carried out following admission. There was limited evidence that an assessment of social care needs had been undertaken and there was no emphasis or prescribed interventions within care.
plans on the need to promote social aspects of care. With the exception of the restraint proforma, care plans did not reflect any other contribution from residents or from others involved in their care.

There was no policy or procedure available to staff to inform the use of restraint. At the time of this inspection, there were 12 residents with bed rails and three subject to chemical restraint. The limited documentation in place confirmed that the use of restraint had been discussed and agreed with residents as was evidenced by their signatures on a dedicated restraint proforma. For those residents who lacked the capacity to consent, the restraint proforma had been signed by their next of kin or representative. However, there was no evidence to confirm that other measures had been considered prior to the use of restraint or that the decision to use restraint had been reached by way of a consensus view (between the next of kin and professionals involved in the resident's care) and was in the best interest of the resident.

A dedicated fridge in the clinical room was used to maintain a cold chain and ensure that medications which required cold storage were stored appropriately. However, a thermometer was not available for staff to record daily fridge temperatures.

**Significant improvements required**

While a centre-specific policy was in place entitled “Drug Administration”, this failed to reference the range of medication management procedures required to be in place by the relevant legislation. In particular, there were no centre-specific procedures for the prescribing, recording, safekeeping and disposal of medication. There was no ongoing audit of medication management and no system in place to monitor record and deal with medication errors. The centre did however maintain a register of controlled drugs although there were no controlled drugs being administered at the time of this inspection.
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 was found to be very home-like and residents and relatives commented on its warm and relaxing atmosphere. Communal areas had been tastefully decorated and provided a choice of seating for residents to relax or meet with family and friends. All radiators in communal areas had wooden decorative casings.

Residents had been empowered by staff to personalise their bedrooms which in many cases contained each resident’s own furniture and furnishings. Photographs, ornaments and other personal mementos were evident; both in bedrooms and in communal areas where residents chose to sit or spend time during the day. Inspectors noted that memorial cards had been respectfully displayed together with thank you cards and letters of commendation / thanks from relatives and former residents.

The waste management system was well-managed and secure. A contract for the removal of clinical waste was seen to be in place and all clinical waste was tagged to ensure traceability. General domestic waste was stored securely in dedicated bins to the rear of the centre.

Staff recorded details of any equipment, or item that required repair in a maintenance log and a maintenance person was employed to undertake minor repairs.

Inspectors noted that there was appropriate use of colour-coding of buckets and other cleaning materials in accordance with current infection control guidelines.

Some improvements required

While a record of resident’s property had been compiled on admission, there was no evidence in the sample of care records inspected that this had been updated throughout their stay.
The signage of fire escapes was not always obvious due to the positioning of internal doors and there were no layout plans on display showing escape routes. Fire action notices did not contain details of assembly points outside the building. Inspectors also noted that the emergency exit door opposite the laundry was locked and the key was not immediately available should the door require to be opened in an emergency. This issue was raised with the provider and person in charge who agreed to make the key immediately available. All remaining fire exits were of a push bar design which opened easily when tested by inspectors. Inspectors also found that staff responded quickly when the alarms sounded.

There were a significant number of environment issues associated with the design, layout and size of the centre which were not in accordance with the Authority’s standards. The centre has 18 twin and two single bedrooms. Three of the twin bedrooms are located upstairs and have been converted for use as a staff room, visitors room and storage area. Of the remaining 15 twin bedrooms, only two are larger than 14.8 metres square and meet the Authorities spatial standards for twin bedrooms. While there is a six-year timeframe (from February 2009) for the criteria within the standard to be fully met, the remaining twin bedrooms do not currently meet the Authority’s standards. Considerable work is also required by the provider to address the following shortcomings:

- the laundry room was shared with the sluice room which posed significant infection control risks
- the temperature of the water in a sample of taps tested was very hot and posed a potential scalding risk to residents
- there was no wash hand basin in the laundry / sluice room or space to separate clean from dirty linen
- there was no wash hand basin in the kitchen
- the wooden cupboard doors in the kitchen were worn and according to staff were difficult to clean creating a potential infection control risk
- there was no changing facilities / toilets for catering staff
- there was no dedicated cleaning room as it also doubled as a storage area
- there was only one assisted bathroom which was inadequate for the number of residents accommodated at the centre
- wardrobes were shared in some of the twin rooms
- all residents had not been provided with a lockable space to secure valuables or other personal items
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

Good relationships were evident among staff and between the provider and staff. Inspectors were told by staff that they all got on well and that there was a good team spirit which enabled them to more effectively focus on meeting the needs of residents. Staff said that the provider was approachable and available for advice and guidance.

Inspectors observed good communication between staff, residents, relatives, the provider and the person in charge. Staff were observed speaking to residents in a friendly manner and were seen to be respectful and courteous taking time to ensure that residents with dementia or cognitive impairment clearly understood before commencing any care interventions. Inspectors noted that staff acknowledged residents each time they entered communal areas and dealt with personal care requests in a sensitive manner.

An inspector took the opportunity to attend a staff handover. This was seen to be person centred and reflected a highly personalised description of the care provided to all residents during the shift. The handover was interactive and discussion took place between staff in relation to any future care planned. Residents were discussed in a professional and respectful manner and from the detail of the discussion, it was clear that staff had an in-depth understanding of the likes, dislikes and care needs of individual residents.

Some improvements required

Residents told inspectors that they were asked on a daily basis by the provider and staff their experiences of the care being provided. However, there was no residents’ forum or other formal mechanisms in place to enable residents to become involved in the operation of the centre or to capture the views of residents with communication or other cognitive impairments.

There was no contract of care in place which detailed the services to be provided for the resident and the fees to be charged. Instead, a memorandum of agreement was
seen to be in place between the provider and the resident which set out the weekly fee to be charged but made no reference to the services provided.

Inspectors observed that some residents had communication difficulties due to dementia or cognitive impairment. However, there were no alternative non-verbal methods of communication available to staff which would have enabled residents to participate more fully in the life of the centre.

**Significant improvements required**

While the policies and procedures in place were centre-specific and had been signed off by the provider and person in charge, they were seen to be very brief, had no initiation or review date and failed to reference professional and best practice guidelines where relevant. Furthermore, there were omissions in the range of policies and procedures required to be in place by the relevant legislation; the most notable relating to risk management, communication and the ordering prescribing and storage of medicines.

**Minor issues to be addressed**

The person in charge told inspectors that staff meetings take place infrequently. However, there were no minutes maintained of staff meetings and therefore it was not possible to determine if the issues discussed reflected the care needs of residents or the operation of the centre.

Inspectors overheard staff refer to continence products as “nappies” and bed rails as “cotsides” which did not reflect the person-centred care that was obvious within the centre.
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

At the time of this inspection, staff had been employed in sufficient numbers and in an appropriate skill mix to meet residents’ needs. Residents and relatives told inspectors that staff had time to attend to them in a calm and unhurried manner.

The person in charge told inspectors that annual leave and other periods of unplanned absence were appropriately managed within the current staffing complement and therefore there was no need to use agency staff. Those staff interviewed confirmed that this arrangement worked well. Adequate on-call arrangements were in place with cover provided by the person in charge and other key senior management. The provider told inspectors that she was also available and was in the centre on an almost daily basis.

An up to date record of all staff employed to work within the centre had been maintained by the person in charge. The record of An Bord Altranais personal identification numbers for registered nurses was inspected and found to be in order.

Two care staff had applied to undertake a Further Education and Training Awards Council (FETAC) Level 5 training course in care of the older person.

Some improvements required

Discussion with the person in charge and staff confirmed that all staff undertake an induction when first employed to work in the centre. While a safety induction checklist was seen to be in place, there was no other induction documentation available for inspection.

There were no formal arrangements in place for supervision or appraisal. The person in charge told inspectors that she works with all staff on a regular basis and is able to evaluate staff competencies based on her direct observation of their practices. However, there was no formal record maintained of these observations or evidence available to confirm what actions had been taken to develop staff competencies in areas where the need for improvement had been identified.
Significant improvements required

Discussion with the provider, the person in charge and staff confirmed that training had been provided across a range of topics that included for example elder abuse, fire safety, moving and handling and medication management. However, inspectors noted that food safety training was out of date and a number of staff had yet to attend fire safety training. No training needs assessment had been carried out and there were only limited records of staff training available for inspection. The evidence available suggested that the training provided was not commensurate with meeting residents’ needs and addressing the requirements of the relevant legislation.

In the registration application, the provider had applied to be registered in the dementia category of care. However, staff had not been provided with dedicated training in relation to dementia.

A sample of three staff files were reviewed by inspectors and found not to be in compliance the relevant legislation. In a number of instances, references and evidence of physical and mental fitness was absent. While the provider told inspectors that Gardaí Síochána vetting had taken place for all staff, no correspondence had yet been received regarding the outcomes from these checks.
Closing the visit

At the close of the inspection visit, a feedback meeting was held with the provider and the person in charge 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:

Jude O’Neill

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

14 April 2010
**Provider’s response to inspection report**

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<th>Centre:</th>
<th>St Anne's Private Nursing Home</th>
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<tr>
<td>Centre ID as provided by the Authority:</td>
<td>387</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>4 and 5 March 2010</td>
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<td>Date of response:</td>
<td>10 June 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 is failing to comply with a regulatory requirement in the following respect:**

   The emergency exit door opposite the laundry was locked.

**Action required:**

Ensure that all emergency exit doors can be opened immediately to provide an adequate means of escape from the centre in the event of fire.

**Reference:**

- Health Act, 2007
- Regulation 32: Fire Precautions and Records
- Standard 25: Physical Environment

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

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<td>Immediate</td>
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Provider’s response:

Break glass fitted for key to emergency exit at laundry door.
2. The provider is failing to comply with a regulatory requirement in the following respect:

The signage of fire escapes was not always obvious due to the location of internal doors and there were no layout plans on display showing escape routes. Fire action notices did not contain details of assembly points outside the building.

**Action required:**

Ensure the signage of all emergency fire escapes is not obscured by internal doors.

**Action required:**

Display the procedures to be followed in the event of fire in a prominent place together with a layout plan highlighting escape routes.

**Action required:**

Amend fire action notices to also contain details of assembly points outside the building.

**Reference:**

Health Act, 2007  
Regulation 32: Fire Precautions and Records  
Standard 25: Physical Environment

| Please state the actions you have taken or are planning to take with timescales: |
| Timescale: |
| **Provider’s response:** |
| Fire signs will be dropped down so that all escape lights will be seen easily. | Immediate |
| Three layout plans have been displayed in prominent positions showing escape routes. | This is completed in all areas. |
| Three evacuation zones have been indentified and related to each of the fire assembly points i.e. Laundry, Church and at Front of building. | |

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

There was no risk management policy in place.

**Action required:**

Develop a comprehensive risk management policy and procedures which reflects the requirements of the relevant legislation.

**Reference:**

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

**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>
</tr>
</thead>
<tbody>
<tr>
<td>A comprehensive policy on risk management has been developed and is now in operation.</td>
<td>Completed</td>
</tr>
</tbody>
</table>

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

Residents’ care records were found to be disjointed with assessments, care plans and daily nursing notes filed separately and it was difficult for inspectors to follow through the process of assessment, implementation and evaluation of care.

**Action required:**

Revise the storage of care records to ensure ease of access.

**Reference:**

Health Act, 2007  
Regulation 8: Assessment and Care Plan  
Standard 11: The Resident’s Care Plan

**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>
</tr>
</thead>
<tbody>
<tr>
<td>An individual file has been created for each resident and contains all internationally recognised assessments along with care plans and daily nursing notes.</td>
<td>To be completed by 1 July 2010</td>
</tr>
</tbody>
</table>
5. **The provider is failing to comply with a regulatory requirement in the following respect:**

Assessments had not been updated within the preceding three months and there was limited evidence that an assessment of social care needs had been undertaken. There was no emphasis or prescribed interventions within care plans or the need to promote social aspects of care.

**Action required:**

Ensure that assessments and care plans are updated and reviewed at a minimum of three monthly or more frequently as required to reflect the changing needs of residents.

**Action required:**

An assessment of social care needs should be carried out for all residents and there should be an emphasis within care plans on the need to promote social aspects of care.

**Reference:**

- Health Act, 2007
- Regulation 8: Assessment and Care Plan
- Regulation 9: Health Care
- Standard 11: The Resident’s Care Plan
- Standard 13: Healthcare

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

<table>
<thead>
<tr>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed</td>
</tr>
</tbody>
</table>

Provider’s response

All assessments will be updated on a three monthly basis or earlier as required.

All residents’ social care needs have been assessed and identified on care plan with the intention of promoting social aspects of their care.
6. The provider is failing to comply with a regulatory requirement in the following respect:

There were no procedures in place to guide staff on how to respond to an allegation, incident or suspicion of abuse and training on elder abuse had not been provided to all staff.

**Action required:**

Put in place procedures to guide staff on how to respond to an allegation, incident or suspicion of abuse.

**Action required:**

Provide all staff with training on elder abuse.

**Reference:**

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

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

<table>
<thead>
<tr>
<th>Provider’s response</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>An extensive procedure is in place to guide staff on how to respond to an allegation incident or suspicion of abuse.</td>
<td>Completed</td>
</tr>
<tr>
<td>All staff will receive training on elder abuse.</td>
<td>1 month</td>
</tr>
</tbody>
</table>

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

There was no policy and procedure in place in relation to the use of restraint and there was no evidence to confirm that other measures had been considered prior to the use of restraint or that the decision to use restraint had been reached by way of consensus.

**Action required:**

Develop a policy and procedure in relation to the use of restraint.

**Action required:**

Ensure that any use of restraint is only ever considered as a measure of last resort. Where residents lack the capacity to consent to the use of restraint, a consensus view should be reached (between healthcare staff and the residents’ next of kin / significant other) in the best interests of the resident.
### Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 21: Responding to Behaviour that is Challenging

<table>
<thead>
<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>Provider's response:</td>
<td></td>
</tr>
<tr>
<td>Restraint is only considered as a last resort and an extensive clinical behaviour assessment is carried out prior to seeking a consensus between healthcare staff, residents or next of kin.</td>
<td>Completed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. The provider is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was no system in place or evidence of a formal review of the quality and safety of care provided to residents or use of information collated through record keeping to manage high risk areas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put in place a system for reviewing the quality and safety of care provided to and the quality of life of residents.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a review of all falls in the centre having regard to the healthcare needs of residents. Use the data from this analysis to manage clinical risk and improve resident care outcomes.</td>
</tr>
</tbody>
</table>

### 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>
<thead>
<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>Provider's response:</td>
<td></td>
</tr>
<tr>
<td>A formal documentation and review of all falls has now been undertaken.</td>
<td>Completed</td>
</tr>
</tbody>
</table>
### 9. The provider has failed to comply with a regulatory requirement in the following respect:

The physical environment was not in accordance with the Authority’s standards and failed to comply with the relevant legislation.

**Action required:**

Provide the Authority with detailed plans setting out how the physical layout of the centre will be revised to meet the Authority's standards within the six-year timeframe (to be completed by February 2015). In particular, these plans should address the current shortcomings in the dimensions of the bedrooms.

**Action required:**

Put in place dedicated sluicing facilities which meets the Authority's standards and minimises the spread of infection within the centre.

**Action required:**

Put in place a dedicated laundry that meets the Authority’s standards and provides adequate space for the sorting of clean and dirty linen.

**Action required:**

To prevent risks from scalding, preset valves of a type unaffected by changes in water pressure and which have fail safe devices should be fitted locally to provide water to a maximum temperature of 43°C.

**Action required:**

Install a wash hand basin in the kitchen.

**Action required:**

Replace the wooden cupboard doors in the kitchen to address the infection control risk.

**Action required:**

Provide a dedicated cleaning room that complies with legislation and the Authority’s standards.

**Action required:**

Ensure that each resident has their own wardrobe and access to a lockable space to store valuables or other personal items.
<table>
<thead>
<tr>
<th>Action required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make available a separate toilet and changing facilities for catering staff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide adequate bathing facilities to meet the needs of the residents.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Act 2007</td>
</tr>
<tr>
<td>Regulation 19: Premises</td>
</tr>
<tr>
<td>Standard 25: Physical Environment</td>
</tr>
</tbody>
</table>

<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>
<tbody>
<tr>
<td>Provider's response:</td>
<td></td>
</tr>
<tr>
<td>(A) Plans will be developed to revise the layout of the home within the 6 year time frame and will be forwarded to the Authority by September 2010.</td>
<td></td>
</tr>
<tr>
<td>(B) Dedicated sluice facility is now provided.</td>
<td></td>
</tr>
<tr>
<td>(C) A dedicated laundry is now provided.</td>
<td></td>
</tr>
<tr>
<td>(D) Pre-set valves have been fitted which have fail safe devices.</td>
<td></td>
</tr>
<tr>
<td>(E) Wash hand basin fitted.</td>
<td></td>
</tr>
<tr>
<td>(F) Cupboard doors will be addressed within 2 months</td>
<td></td>
</tr>
<tr>
<td>(G) Dedicated cleaning room has been provided.</td>
<td></td>
</tr>
<tr>
<td>(H) All residents have their own wardrobes.</td>
<td></td>
</tr>
<tr>
<td>(I) Lockable space will be provided to residents within 2 months.</td>
<td></td>
</tr>
<tr>
<td>(J) Separate toilet and changing facility for catering staff have been provided.</td>
<td></td>
</tr>
<tr>
<td>(K) Additional shower will be provided within 2 months.</td>
<td></td>
</tr>
</tbody>
</table>

Please see opposite for timescale in some areas.
10. The provider is failing to comply with a regulatory requirement in the following respect:

The dedicated fridge in the clinical room did not have a thermometer to enable staff to monitor and record temperatures.

**Action required:**

Ensure that appropriate and suitable practices and policies are in place relating to the storage and monitoring of refrigerated medications which are in keeping with legislation and best practice.

**Reference:**

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

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thermostat in place.</td>
<td>Completed</td>
</tr>
</tbody>
</table>

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

There was no training needs analysis or other system in place to determine the training requirements of staff. The records of staff training and induction were poorly maintained and it was not possible to determine if all staff had attended mandatory and other training commensurate with meeting the needs of the residents.

**Action required:**

Introduce a system for analysing the training needs of staff.

**Action required:**

Put in place a system of formal supervision and appraisal that enables all staff to develop their competencies and capabilities.

**Action required:**

Introduce a means of monitoring training to ensure it is maintained and kept up-to-date.
**Action required:**

Maintain formal records of all staff induction, supervision and appraisal.

**Reference:**

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

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>An extensive system is in place to analyse the training needs of staff.</td>
<td>Completed</td>
</tr>
<tr>
<td>A system of annual review is now in place.</td>
<td></td>
</tr>
<tr>
<td>A means of monitoring training is now introduced.</td>
<td></td>
</tr>
<tr>
<td>Staff induction check list format records are now available for staff induction and appraisal</td>
<td></td>
</tr>
</tbody>
</table>

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

There was no forum in place to consult residents and as appropriate their relatives on the operation of the centre.

**Action required:**

A forum should be introduced to enable residents and as appropriate their relatives to be consulted and to participate in the operation of the centre.

**Reference:**

Health Act, 2007  
Regulation 10: Residents' Rights, Dignity and Consultation  
Standard 2: Consultation and Participation

**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>
</tr>
</thead>
<tbody>
<tr>
<td>Residents committee will be set up within 1 month.</td>
<td>1 month</td>
</tr>
</tbody>
</table>
13. The provider is failing to comply with a regulatory requirement in the following respect:

Staff personnel files did not contain evidence of physical and mental fitness, three written references and other documents detailed 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 personnel files contain all documents listed in Schedule 2.

**Reference:**

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

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

<table>
<thead>
<tr>
<th>Timescale:</th>
</tr>
</thead>
</table>

| Provider’s response: |
| Staff files will be updated in accordance with Schedule 2. |
| 1 month |

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

Dedicated training on the care of residents with dementia had not been provided to staff.

**Action required:**

Provide staff with dedicated training to develop the understanding and skills required to care for residents with a diagnosis of dementia.

**Reference:**

Health Act, 2007
Regulation 17: Training and Staff Development
Standard 24: Training and Supervision
Supplementary Criteria for Dementia-specific Residential Care Units for Older People

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

<table>
<thead>
<tr>
<th>Timescale:</th>
</tr>
</thead>
</table>
15. The provider is failing to comply with a regulatory requirement in the following respect:

Care plans had not been discussed and agreed with residents and (where appropriate) their representative.

**Action required:**

Develop and agree care plans with each resident and (where appropriate) their representative.

**Reference:**

Health Act, 2007  
Regulation 8: Assessment and Care Plan  
Standard 11: The Resident’s Care Plan

<table>
<thead>
<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>Provider’s response:</td>
<td>Completed</td>
</tr>
<tr>
<td>All care plans have been discussed as appropriate with the residents or relative.</td>
<td></td>
</tr>
</tbody>
</table>

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

There was no system in place to facilitate and encourage communication with residents who could not express themselves verbally.

**Action required:**

Devise an alternative communication system that ensures all residents are facilitated and encouraged to communicate; enabling them to participate in the activities and running of the centre.

**Reference:**

Health Act, 2007  
Regulation 11: Communication  
Standard 17: Quality of Life
Please state the actions you have taken or are planning to take following the inspection with timescales:

<table>
<thead>
<tr>
<th>Timescale:</th>
<th>Provider’s response:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A policy and procedure has been developed in dealing with issues of communication. A resident committee has been established and an advocate appointed.</td>
</tr>
</tbody>
</table>

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

Contracts of care had not been provided to all residents.

**Action required:**

Provide contracts of care within the required time limit of one month of admission and in accordance with Regulation 28.

**Reference:**

- Health Act, 2007
- Regulation 28: Contract for the Provision of Services
- Standard 1: Information

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

<table>
<thead>
<tr>
<th>Timescale:</th>
<th>Provider’s response:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New contracts of care will be provided to all residents / representatives within 6 to 8 weeks.</td>
</tr>
</tbody>
</table>
18. The provider is failing to comply with a regulatory requirement in the following respect:

There was no evidenced based tool used to calculate residents’ dependencies.

**Action required:**

Ensure that residents’ dependency levels are calculated on a daily basis to enable the centre to provide suitable and sufficient care to maintain the resident’s welfare and wellbeing, and address their needs as set out in their care plan.

**Reference:**

Health Act, 2007  
Regulation 6: General Welfare and Protection  
Standard 32: Register and Residents’ Records

<table>
<thead>
<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>Provider’s response:</td>
<td>Immediate</td>
</tr>
<tr>
<td>Residents’ dependencies are calculated on a daily basis using the Barthel tool.</td>
<td></td>
</tr>
</tbody>
</table>

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

The provider and staff were not aware of the provisions of the Health Act 2007 and all regulations and rules made thereunder.

**Action required:**

Ensure that all staff are fully aware of the new legislation and that copies are available within the centre.

**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>
<tbody>
<tr>
<td>Provider’s response:</td>
<td>Completed</td>
</tr>
<tr>
<td>The provider and all staff are now aware of Health Act 2007, all regulations and standards.</td>
<td></td>
</tr>
</tbody>
</table>
20. The provider is failing to comply with a regulatory requirement in the following respect:

The complaints policy did not contain an independent appeals process or identification of a nominated person (independent of the person responsible for investigating the complaint) to ensure that records were appropriately maintained and that all complaints were appropriately responded to in accordance with the relevant legislation.

**Action required:**

Revise the complaints procedure to ensure that the centre has written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in or on behalf of the centre.

**Reference:**

Health Act, 2007  
Regulation 39: Complaints Procedures  
Standard 6: Complaints

<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 complaints procedure has been revised relating to making, handling and investigation of complaints and contains an independent appeals process. | Completed |

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

The range of policies, procedures and guidelines available in the centre had not been updated to reflect the provisions of Schedule 5 of the Health Act (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2009 (as amended).

**Action required:**

Ensure all polices and procedures comply with current legislation, regulations and standards.

**Reference:**

Health Act 2007  
Regulation 22: Maintenance of Records  
Regulation 27: Operating Policies and Procedures  
Standard 29: Management Systems
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>
</tr>
</thead>
<tbody>
<tr>
<td>All procedures required under Schedule 5 have been provided and comply with legislation, regulations and standards.</td>
<td>Completed</td>
</tr>
</tbody>
</table>

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

The statement of purpose was seen to be very brief and did not contain the range of information required by the relevant legislation. In particular, omissions were noted in relation to the arrangements for dealing with complaints, the fire precautions and associated emergency procedures and care plan reviews.

Action required:

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

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The statement of purpose has been modified to comply with Schedule 1 of Health Act 2007.</td>
<td>Completed</td>
</tr>
</tbody>
</table>

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

The Resident’s Guide had not yet been revised to reflect the range of information required by the relevant legislation. There was no summary of the complaints procedure, or summary of the statement of purpose and function or standard form of contract or most recent inspection report. Furthermore, the name and address of the Chief Inspector of the Social Services Inspectorate of the Authority had not been provided.
**Action required:**

Produce a residents guide that includes all matters listed in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and ensure that a copy is made available to all residents and the Chief Inspector of the Social Services Inspectorate of the Authority.

**Reference:**

Health Act, 2007  
Regulation 21: Provision of Information to Residents  
Standard 1: Information

<table>
<thead>
<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>Provider’s response:</td>
<td>Completed</td>
</tr>
<tr>
<td>The Residents Guide has been modified to comply with Health Act 2007, Regulation 21.</td>
<td></td>
</tr>
</tbody>
</table>

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

The record of each resident’s personal property had not been kept up to date.

**Action required:**

Maintain an accurate and up-to-date record of each resident’s property.

**Reference:**

Health Act, 2007  
Regulation 7: Resident’s Personal Property and Possessions  
Standard 9: The Resident’s Finances

<table>
<thead>
<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>Provider’s response:</td>
<td>Completed</td>
</tr>
<tr>
<td>A new procedure has been developed to deal with residents’ property.</td>
<td></td>
</tr>
</tbody>
</table>
25. The provider has failed to comply with a regulatory requirement in the following respect:

Written operational policies were not in place in relation to the ordering, prescribing, storing and administration of medicines to residents.

**Action required:**

Develop and put in place appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the ordering, prescribing, storing and administration of medicines.

**Reference:**

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

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

**Provider’s response:**

An extensive policy and procedure has been developed in accordance with current legislation and best practice for the ordering, prescribing, storing and administration of medication.

**Timescale:**

Completed
## 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>
</table>
| Standard 4: Privacy and Dignity | Ensure that staff use language which promotes the privacy and dignity of residents. Terms such as “nappies” and “cot-sides” should not be used.  
Provider’s response:  
*Staff have been trained in the appropriate use of dignified language towards residents.*  
Staff should always knock and await permission before entering a resident’s bedroom.  
Provider’s response:  
*Staff will always knock and await entry.* |
| Standard 9: The Resident’s Finances | Introduce receipts for all expenditure on behalf of a resident.  
Provider’s response:  
*All receipts issued to residents / relative.* |
| Standard 29: Management Systems | Minuted staff meetings should take place on a regular basis to maximise the opportunities for communication within the centre.  
Provider’s response:  
*Staff meetings will be scheduled on a monthly basis, minutes will be maintained.* |
Any comments the provider may wish to make:

Provider’s response:

I would like to thank the SSI inspectors for a very courteous and helpful registration Inspection. We were very pleased that they indentified the high level of care being provided at St. Anne’s and that their main concern was in relation to paperwork.

We have now addressed all of the issues mentioned in the report and we will now move on with a very positive attitude to HIQA and recognise its value to our residents, management and staff.

Provider's name: Kathleen Smyth.
Date: 10 June 2010