NATIONAL STANDARDS FOR RESIDENTIAL CARE SETTINGS FOR OLDER PEOPLE

Services for Older People and Palliative Care,
Department of Health and Children
A working group was formed by the Minister for Health, in November 2005 with the aim of developing standards for all residential care settings where older people are cared for.

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Introduction

Background to the development of National Standards for Residential Care Settings for Older People

According to a recent report by the Organisation for Economic Co-operation and Development (OECD, 2005), home continues to be the predominant and preferred location for the majority of older people with care needs. However, where it is not possible for an older person to be cared for at home there is a need to provide high quality long stay residential care. Internationally, there is evidence that the quality of long term care services for older people varies and often does not meet the expectations of the public, service users and their families (OECD, 2005). In developing these standards the Department of Health and Children is seeking to put in place a robust system to protect vulnerable older people, and through the implementation of these standards to ensure the provision of high quality care to older people living in residential care settings. In Ireland, long-stay residential care for older people is provided in a range of settings. There are currently 19,416 long stay beds in Ireland. Of these, 12,174 are in private nursing homes (Department of Health and Children, 2005), with the voluntary sector currently providing 2429 beds and the rest provided in public facilities.

Under current legislation, private nursing homes are required to register with, and be inspected by, the Health Service Executive (HSE) and cannot operate as nursing homes unless they are registered. However, inspection and registration has not applied to public and voluntary providers of long-stay residential care. The Human Rights Commission (2002) points out that the HSE as a provider has not been subject to any external assessment, while it is the inspectorate of the private sector providers. Teams from the HSE inspect private nursing homes using the standards set out in The Nursing Homes (Care and Welfare) Regulations 1993 which were made under the Health (Nursing Home) Act 1990. A voluntary Code of Practice for Nursing Homes is also available from the Department of Health and Children. This code sets out best standards of care to which nursing homes should operate and covers a range of issues in relation to the provision of nursing home care. However the code is not legally binding and its implementation is not monitored in a systematic way (The Human Rights Commission, 2002).

The Health Strategy, Quality and Fairness - A Health System for you (Department of Health and Children, 2001) developed four guiding principles: Equity; People-centredness; Quality and Accountability. These principles underpin these national standards for residential care settings for older people. The Health Strategy also recommended that the remit of the Social Services Inspectorate be extended to include all residential care for older people and that national standards for long term residential care of older people should be prepared.

Office of the Chief Inspector of Social Services and Inspection of Residential Care Settings

The Social Services Inspectorate (SSI) has been operating on an administrative basis since 1999. The SSI has focused on child welfare and protection services and its remit is being extended to include the inspection of all public, private and voluntary residential care settings for older people which is in line with the recommendations of the Human Rights Commission (2002). It is intended that the Health Bill, 2006 will establish the Office of the Chief Inspector of Social Services on a statutory basis within the Health Information and Quality Authority (HIQA) and contains provisions to underpin a more robust inspectorial system.

In assessing whether a residential care setting meets the requirements to be registered, the Office of the Chief Inspector of Social Services, will inspect the residential care setting using the standards set...
out in this document. It is envisaged that these standards will be published by HIQA. They will apply from (date TBC), unless otherwise stated in any standard. Additionally, the Inspectorate may make recommendations on best practice standards to support an environment that improves the quality of older peoples’ lives. It is envisaged that residential care settings will be inspected every six months and will be required to re-register every three years.

Accreditation standards for residential care settings for older people
The standards set out in this document must be met in order for a care setting to operate. The Irish Health Services Accreditation Board (ISHAB) which was established under Statutory Instrument in 2002 (S.I. 160) has also developed standards as part of an accreditation scheme entitled ‘Residential and Non-Acute Care Accreditation Scheme’.

The accreditation process utilises a quality and safety framework which incorporates five headings-Leadership and Partnerships, Care/Services, Environmental and Facilities Management, Human Resource Management and Information Management.

These National Standards for Residential Care Settings for Older People and the Residential and Non-Acute Care Accreditation Scheme (ISHAB, 2005) have been developed to ensure that they are consistent and complement each other. When an organisation undergoes an accreditation survey, the findings from the inspection report will be utilised as evidence of compliance with the accreditation standards. However, **compliance with accreditation standards will not in itself confer the right to registration.**

Aim of standards for residential care settings for older people
This document sets out national standards for all residential care settings for older people. These standards are core standards that apply to all residential settings where older people are cared for and for which registration is required. The standards are based on legislation, research findings and best practice. While broad in scope, the standards acknowledge the unique and complex needs of the individual person at the centre of care, and the additional specific knowledge, skills and facilities needed in order for service providers to deliver a person-centred and comprehensive service that promotes health, well-being and quality of life. The standards allow for circumstances in which pre-existing buildings are not expected to meet standards as provided in some individual standards, although they will be expected to do so by (date TBC). It is intended that registration/de-registration will be in accordance with the Health Bill, 2006 and no residential setting for older people will be allowed to operate without being registered.

These standards will be applicable in public, private and voluntary services that provide some or all of the following for older people: long term care, respite, rehabilitation and convalescence. This will include elderly homes/hospitals; welfare homes; district/community hospitals; community nursing units; voluntary elderly care homes/hospitals; and private nursing homes. These standards will also apply to designated care of the older person wards in acute hospitals but designated wards will be excluded from some standards, for example space restrictions may prevent acute hospitals from meeting all of the physical environmental standards.
The standards
The development of these standards took into account key national and international documents, reports and legislation including, in particular:

- The Health (Nursing Homes) Act, 1990;
- Nursing Homes (Care and Welfare) Regulations 1993;
- Quality of Life for Older People in Long Stay Residential Care in Ireland (National Council for Ageing and Older People, 2006);
- National Minimum Standards for Care Homes (Department of Health, England);
- Nursing homes, Registration and Inspection Standards (Department of Health, Social Services and Public Safety, Northern Ireland).

The standards, and the regulatory framework within which they operate, should be viewed in the context of the Government’s overall policy objectives for older people. Health policy for older people in Ireland is set out in The Years Ahead… A Policy for the Elderly (Department of Health, 1988) which aims to provide high quality hospital and residential care for older people when they can no longer be maintained in dignity and independence at home.

These standards aim to be realistic, fair and transparent. The regulatory standards state the level below which no provider may operate and are designed to ensure the protection of residents, to safeguard and promote their health, welfare and quality of life and to ensure that there is a focus on the well-being, dignity and autonomy of older people (National Council for Ageing and Older People, 2000). The standards set service providers the goal of providing a setting in which older people can experience a good quality of life.

A recent report by the National Economic and Social Forum (NESF, 2006) points out that quality of care is a key determinant of quality of life. It is recognised that there will be differences in the quality of care in different settings. According to a report by the National Council for Ageing and Older People, (Murphy et al 2006) high quality care may be found even in poor environmental settings where the key ingredient is often high quality staff. Therefore, these national standards for residential care settings for older people focus on achievable outcomes for residents.

Quality of care is about more than objective standards and should include the context of care or how people experience the service. A meaningful measurement of quality of care, therefore, has to involve on-going consultation with service users (National Economic and Social Forum, 2005). Setting standards of quality in terms of infrastructure and process needs to change and move more towards measuring improvements in outcomes and the dissemination of this information to service users, existing and prospective. There is also the case for making information on the quality of care and the prevalence of adverse outcomes more transparent and accessible to the public on a regular basis (OECD, 2006). In Ireland, at local and regional level, there are a number of quality initiatives being utilised to improve the quality of care to older people in residential care settings, for example: Essence of Care; and the Ten Steps to Healthy Ageing.

These national standards provide the framework upon which the very best quality of care can be achieved and should be the basis on which policies and procedures are developed within the care setting. Locally developed initiatives will assist service providers in ensuring that they meet these national standards.
The standards are set out in two parts. The first part focuses on the standards concerning the resident as an individual and includes: personal identity; social connectedness; rights; and health care. The second part focuses on the organisational aspects of the residential care setting and includes management; staffing; care environment and health and safety. The facing page lists relevant current legislation, supporting documentation and provides the reference link of each national standard to ISHAB’s Residential and Non-Acute Care Accreditation Scheme.

Each of the sections in this document is prefaced with background information relating to the standards that follow. Each standard is preceded by an outcome statement for the resident which is to be achieved by the residential care setting. While the standards are qualitative, they provide a mechanism for judging the quality of life of residents; they are also measurable. Inspectors will seek evidence that the standards are being met and a good quality of life enjoyed by residents through:

- Interviews with residents and their families and friends,
- Interviews with staff and managers and others;
- Observation of daily life in the residential care setting and how it is managed;
- Assessment of written policies, procedures and records;
- Observation of other inspection reports (e.g. fire, environment etc.)
- Physical examination of residents where appropriate.

Throughout the National Standards, we refer to the Health Bill 2006. When we mention the Bill we do so in the context of what is the intention of the Bill at this time rather than what may or may not be enacted.
PART 1 – STANDARDS IN RELATION TO THE INDIVIDUAL

1. Personal identity

2. Social connectedness

3. Rights

4. Health care
1. PERSONAL IDENTITY

STANDARDS 1 TO 8

This section deals with issues relating to the personal identity of residents in long stay residential care. It is generally felt that greater attention needs to be given to protecting dignity and independence of older people (NESF, 2005; OECD 2005). Therefore, the principles of care set out and adhered to by the residential care setting must ensure that the residents are treated with respect, that their dignity is preserved at all times, and that their right to privacy is always respected. Fundamentally, the test of whether these principles are put into practice or not will be determined by how the individual resident feels about how they are treated and spoken to by staff, whether they are consulted regarding their own care and whether their wishes are respected or views taken into account.

Each residential care setting must produce a statement of purpose and other information materials (residents’ guide) setting out its aims and objectives, the range of facilities and services it offers to residents and the terms and conditions on which it does so. This information should be clearly stated in its contract with residents. In this way prospective residents can make a fully informed choice about whether or not the service provided is suitable and able to meet the individual’s particular needs. Copies of the most recent inspection reports should also be made available.

The statement of purpose will enable inspectors to assess the extent to which the residential care setting claims to be able to meet residents’ requirements and that expectations are being fulfilled. It is not possible to expect every residential care setting to offer the same range of facilities and lifestyle but it is essential that older people have a choice. There needs to be diversity in types of residential care provided for older people. If a residential care setting says it provides for the needs of people with dementia, it will have to make clear how this is done, for example, small group living with structured activities, different rooms for different functions; safe accessible outdoor space; and use of colour and lighting helpful to people with dementia (Dementia Services Information and Development Centre, 2006).

Assessment

Often the initial assessment, which determines whether or not an individual goes into residential care for older people, will be made by people outside of this setting e.g. a General Practitioner (GP) or hospital consultant. A resident should only go into residential care where a full assessment has been made, except in the case of an emergency. The person-in-charge and relevant professional staff within the residential care setting should be involved in that full assessment and only accept a new resident if they feel the residential care setting can adequately meet the needs of the prospective resident as determined through that assessment. It is impossible to lay down standards for every aspect of care required for all residents as the care which a resident receives must be based on their own individual assessed needs. This makes the assessment process and the care planning all the more important in standard setting.

Care plan

The information from the assessment forms the foundation of the resident’s care plan. Care must then be delivered in accordance with the care plan. The care plan then becomes the measure for determining whether appropriate care is delivered to the resident. It is a dynamic document, which changes to reflect the changing needs of each individual resident, and should include assessment, planning for care, implementation and evaluation of care.
**Contract**
Residents will receive a contract or in some cases, a statement of terms and conditions setting out what they should be able to expect regarding, for example, accommodation, care and services, and their terms and conditions of occupancy.

**Food and nutrition**
Mealtimes was identified by residents of long stay care as an issue affecting their quality of life (Murphy et al 2006). The availability, quality and style of presentation of food, along with the way in which staff assist residents at mealtimes, are crucial in ensuring residents receive an appealing and nutritious diet. While it is recognised that many residents will no longer be able to play an active part in preparing food, many still want to retain some capacity to do so. Restrictions on access to main kitchens because of health and safety considerations may mean that residential care settings will have to look at alternative ways of maintaining residents’ involvement, for example, by providing kitchenettes, organising cooking as part of a range of daily activities and enabling residents to be involved in laying and clearing the dining rooms if they wish to. Food preferences, culture and religion, are part of the individual identity of the resident and must always be observed and recorded in each individual care plan. These should be ascertained when an individual is considering moving into the residential care setting and the service provider has an opportunity at this time to make it clear whether or not those preferences can be observed.

**Independence**
Maintaining, promoting and maximising the residents independence is essential, as is providing a physical and social environment that enables residents to achieve this. It is important for the residential care setting to work with the relevant people/agencies to make available the necessary assistive technology to residents. This could range from a simple walking stick to the use of a power wheelchair, and can add significantly to quality of life and enable the resident to engage freely and actively in the community of the residential care setting.
Legislation, supporting documents, and links with accreditation standards

Legislation

*The Nursing Homes (Care and Welfare) Regulations (1993), Article 17*

‘the registered person and the person-in-charge of the nursing home shall have a brochure available with information about the nursing home, including the name and address of the home, the name of the registered person, the admission policy, accommodation provided on special facilities and services’.

Nursing Homes (Fees) Regulations, 1993 (S.I. 223) Dublin: Stationery Office

Nursing Homes (Subvention) (Amendment) Regulations, 1993 (S.I. 378) Dublin: Stationery Office

Nursing Homes (Subvention) Regulations, 1993 (S.I. 227) Dublin: Stationery Office

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS  5.5; 5.6; 6.1 – 6.7; 7.1 & 7.2; 8.1-8.7

LP  3.1-3.3
STANDARD 1
Information

OUTCOME
Prospective residents have the information they need to make an informed choice about where to live.

1.1 The registered person has an up to date statement of purpose that accurately describes what the residential care setting sets out to provide for its residents and the manner in which this is achieved. The statement describes the physical facilities of the premises. The statement is available, accessible and understood by all staff and prospective residents.

1.2 The registered person produces and makes available to prospective residents an up to date statement of purpose that sets out:
   - The aims, objectives, ethos of care, services and facilities
   - Terms and conditions of the residential care setting
   - A resident’s guide to the services provided

1.3 There is a resident’s guide clearly written and made available in a language and/or format suitable for intended residents and includes:
   - A brief description of the services provided;
   - A description of the individual accommodation and communal space provided;
   - The relevant qualifications and experience of the person-in-charge/manager;
   - The number and qualifications of staff on duty throughout a 24 hour period
   - The number of places provided and any special needs or interests catered for;
   - A copy of the most recent inspection report;
   - A copy of the complaints procedure;
   - Residents’ views of the residential care setting;
   - Fees/cost of care

1.4 The registered person ensures that prospective residents are invited to visit the residential care setting and invited to move in on a trial basis, before they and/or their representatives make a decision to stay. Unplanned admissions are avoided where possible. The opportunity to meet with other residents during a visit is facilitated.

1.5 Prospective residents are given the opportunity for staff to meet them in their own homes or current accommodation if this is what the prospective resident wishes.

1.6 Residents and their representatives are given information in writing in a suitable format about how to contact the Office of the Chief Inspector of Social Services and the Health Service Executive.

1.7 Residents and their representatives receive a written policy outlining referral, admission and discharge procedures.

1.8 When an emergency admission is made, the registered person undertakes to inform the resident within 48 hours about key aspects of the service, and to meet all other admission criteria within one week.
Legislation, supporting documents and accreditation links

Legislation

*The Nursing Homes (Care and Welfare) Regulations (1993) Article 5 and 30*

5. The registered proprietor and the person in charge shall ensure that there is provided for dependent persons maintained in a nursing home:

(a) suitable and sufficient care to maintain the person’s welfare and well-being, having regard to the nature and extent of the person’s dependency

30(c) a person’s right to refuse treatment shall be respected and documented and the matter brought to the attention of the person’s medical practitioner and the person acting on his or her behalf

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS 5.7; 6.1-6.7; 7.1
STANDARD 2
Assessment

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>All new residents should have their needs assessed prior to moving into a residential care setting.</th>
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2.1 Residents are given the choice as to whether their family or representatives are involved in their care.

2.2 Prospective residents are admitted only on the basis of a full assessment undertaken by appropriate professionals trained to do so, and with the involvement of the prospective resident.

2.3 All necessary information relating to the resident is obtained from the referrer prior to admission. For unplanned admissions, this information is obtained as soon as possible after admission.

2.4 The care setting has a policy that outlines the process for seeking consent from residents prior to any treatment or intervention in accordance with best practice. The policy addresses when a resident does not wish to consent and when a resident lacks capacity to consent.

2.5 The admitting nurse carries out an initial risk assessment with each resident using a validated assessment tool prior to admission. General risk and fall prevention assessments, using validated tools, are carried out and recorded as part of the nursing care assessment within 24 hours of admission to the residential care setting and are repeated at least monthly thereafter.

2.6 An initial assessment using a validated assessment tool is carried out with residents within 7 days of admission. This assessment must be reviewed after one month and at least at six monthly intervals thereafter or as the need arises.

2.7 The personal and health care needs of the resident are assessed and reflect the resident’s preferences regarding daily routine, level of independence, family situation, and views on sharing a room or participating in communal activities, preferences regarding intimate care, hobbies and interests. The assessment identifies the residents health care needs including medication, nutritional requirements etc.

STANDARD 3
Contract

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>Each resident has a written contract/statement of terms and conditions with the residential care setting.</th>
</tr>
</thead>
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Legislation, supporting documents and accreditation links

Legislation

*The Nursing Homes (Care and Welfare) Regulations 1993, Article 7*

7.1 Within two months of registration of a nursing home, the registered person or person in charge shall execute a contract with each dependent person and or a person acting on his or her behalf.

7.2 In the year following the commencement of the Act, the registered person or person in charge shall execute a contract with a dependent person and /or a person acting on his or her behalf within two months of the admission of that dependent person to the nursing home.

7.3 Such contract shall deal with the care and welfare of that person in the nursing home and shall include details of the services to be provided for that person and the fees to be charged

Health Amendment Act (2005) Dublin: Stationery Office

Nursing Homes (Fees) Regulations, 1993 (S.I. 223) Dublin: Stationery Office

Nursing Homes (Subvention) Regulations, 1993 (S.I. 227) Dublin: Stationery Office

Nursing Homes (Subvention) (Amendment) Regulations, 1993 (S.I. 378) Dublin: Stationery Office

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS 5.7; 6.1; 7.1
3.1 Each resident is provided with a contract specifying terms and conditions at the point of moving into residential care. If admission is unplanned the resident has a contract within one week. The resident and/or representative is involved in discussing the contract and it is signed by both resident or representative and the service provider.

3.2 The contract includes (where applicable):

- Room to be occupied; once a room is allocated (single or multiple-occupancy). Residents are not moved (unless for medical reasons) without their consent. This applies to residents who are absent from the residential care setting for acute hospital admission;

- Overall care and services (including food) covered by fee;

- Fees payable and by whom (resident, Health Service Executive, or other);

- Additional services (including food and equipment) to be paid for over and above those included in the fees;

- Rights, obligations and liability of the resident and the registered provider;

- Terms and conditions relating to the period of occupancy including period of notice to leave;

- The circumstances under which a resident could be discharged;

- The policy on absences by the resident from the care setting is clearly outlined.

STANDARD 4
Resident care plan

<table>
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<th>OUTCOME</th>
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<tr>
<td>The resident’s health, personal and social care needs are set out in an individual care plan</td>
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4.1 A resident’s care plan is generated within 48 hours of admission from a comprehensive assessment drawn up with each resident and provides the basis for the care to be delivered.

4.2 The care plan sets out in detail the action which needs to be taken by care staff to ensure that all aspects of the health, personal and social care needs of the resident are met.

4.3 The care plan meets relevant clinical guidelines produced by the relevant professional bodies concerned with the care of older people, and includes a risk assessment.

4.4 The care plan is drawn up with the involvement of the resident or representative and where possible agreed and signed by the resident. If the resident is unable to participate this is documented. The plan is reviewed by the person-in-charge in consultation with the resident/representative and staff at least once a month, updated to reflect changing needs and current objectives for health and personal care, and actioned.
Legislation, supporting documents and accreditation links

Legislation

<table>
<thead>
<tr>
<th>Nursing Homes (Care and Welfare) Regulations (1993) Article 5</th>
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<tr>
<td>a) Suitable and sufficient care to maintain the persons welfare and well-being, having regard to the nature and extent of the person’s dependency</td>
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<tr>
<td>b) A high standard of nursing care</td>
</tr>
<tr>
<td>c) Appropriate care by a medical practitioner of the person’s choice or acceptable to the person</td>
</tr>
<tr>
<td>g) Privacy to the extent that the person is able to undertake personal activities in private</td>
</tr>
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Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS  6.4; 9.1-9.4; 11.1; 11.2; 11.4;
IM  5.1-5.5
STANDARD 5
Privacy and Dignity

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<td>Residents feel they are treated with respect and dignity and their right to privacy is upheld.</td>
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5.1 The arrangements for personal and health care ensure that residents’ privacy and dignity are respected at all times, and with particular regard to:
- maintaining social contacts with relatives and friends;
- consultation with, and examination by, health and social care professionals;
- personal care-giving, including nursing, bathing, washing, using the toilet or commode;
- entering bedrooms, toilets and bathrooms;
- following death.

5.2 Residents have access to a telephone for use in private. As residents aged over 65 years are entitled to a telephone line free of charge the service provider assists the resident in availing of this, should the resident wish to do so.

5.3 Residents receive their mail promptly and unopened.

5.4 All information held pertaining to a resident is confidential and should be made available to the resident should he/she so wish. (See standard 26.4)

5.5 Residents wear their own clothes at all times.

5.6 Residents are addressed by staff using their preferred term of address.

5.7 Residents are treated with respect at all times and all staff are instructed during induction on how to treat residents with respect.

5.8 Residents undergo medical examination and treatment in their own room (where possible).

5.9 Where residents have chosen to share a room, full fixed screening is provided to ensure that their privacy is not compromised when personal care is being given or at any other time.
Legislation, supporting documents and accreditation links

Legislation

The Nursing Homes (Care and Welfare) Regulations (1993) Article 5
5 (f) freedom to exercise choice to the extent that such freedom does not infringe on the rights of other persons

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS  2.2; 2.3; 6.4; 8.6; 10.6; 11.1; 11.2; 14.1-3
LP  2.2; 6.6
HR  2.1; 4.1-4.4
EF  1.5
STANDARD 6
Meeting Needs

OUTCOME
Residents and their representatives know that the residential care setting they enter will meet their needs.

6.1 The registered person is able to demonstrate the residential care setting’s capacity to meet the assessed personal and care needs (including specialist needs) of individuals admitted to the residential care setting.

6.2 All specialised services offered (e.g. services for people with dementia or other cognitive impairments, sensory impairment, physical disabilities, learning disabilities, intermediate or respite care) are based on current best practice, and reflect relevant specialist and clinical guidance.

6.3 The needs and preferences of specific minority ethnic communities, social/cultural or religious groups catered for are understood by staff, and are met.

6.4 Staff individually and collectively have the skills and experience to deliver the services and care which the residential care setting offers to provide.

6.5 The person-in-charge ensures that, based on assessed personal needs, residents have opportunities to have their preferences met.

6.6 The person-in-charge ensures that based on assessed needs, residents have access to the health care professionals needed to assist with maintaining optimum health and independence.

STANDARD 7
Choice

OUTCOME
Residents are helped to exercise choice and control over their lives.

7.1 The person-in-charge runs the residential care setting so as to maximise residents’ capacity to exercise personal autonomy and choice. Where a resident’s choice is limited due to legal restrictions, the reason for restricting this choice is explained and documented and appropriate support provided (e.g. Ward of Court etc.).

7.2 Residents handle their own financial affairs for as long as they wish to and have the capacity to do so.

7.3 Residents and their relatives and friends are informed of how to contact external agents (e.g. advocates).
Legislation, supporting documents and accreditation links

Legislation

**The Nursing Homes (Care and Welfare) Regulations 1993, Article 13 and 16**

13 In every nursing home there shall be:
   (a) a separate kitchen with suitable and sufficient cooking facilities, kitchen equipment and tableware;
   (b) provision for the storage of food in hygienic conditions.

16 (1) The registered person and person-in-charge of the nursing home shall ensure that suitable, sufficient nutritious and varied food, prepared, cooked and served is provided
(2) Any dietary restriction on medical or religious grounds shall be respected
(3) Fresh drinking water shall be provided on each floor of the nursing home.

Food Safety Authority of Ireland Act, 1998

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

| CS | 10.2 |
| EF | 4.3 |
7.4 Residents are entitled to bring personal possessions with them, the extent of which will be agreed prior to admission.

STANDARD 8
Meals and Mealtimes

**OUTCOME**
Residents receive a wholesome appealing balanced diet in pleasant surroundings at times convenient to them.

8.1 The person-in-charge ensures that residents receive a varied, appealing, wholesome and nutritious diet, which is suited to their individual assessed and recorded requirements and preferences, and that meals are taken in a congenial setting and at times suited to the residents. The breakfast routine does not dictate the time of patients rising.

8.2 Each resident is offered three full meals each day (at least one of which must be a hot meal) at intervals of not more than five hours during the day.

8.3 In addition to the three meals (standard 8.2), a snack meal is offered in the evening prior to the resident retiring for the night and the interval between this and breakfast the following morning is no more than 10 hours. Hot and cold drinks and snacks are available at all times and offered regularly.

8.4 All food and fluid intake is monitored routinely and any changes noted.

8.5 Food, including liquified meals, is presented in a manner which is attractive and appealing in terms of texture, flavour, and presentation, in order to maintain appetite and nutrition.

8.6 Special therapeutic diets / feeds are provided when advised by health care and dietetic staff.

8.7 Residents with swallowing difficulties, who require altered consistency food or fluids, or parenteral/enteral nutrition should be assessed and reviewed by a dietician to ensure that their nutritional requirements are being met.

8.8 Residents with reduced upper limb function are assessed where appropriate and adaptive equipment is provided to enable them to feed themselves independently.

8.9 Independent eating is encouraged for as long as possible. However, staff are ready to offer assistance in eating where necessary, discreetly, sensitively and individually.

8.9 Religious or cultural dietary needs are catered for as agreed at admission and recorded in the individual care plan.

8.10 Food for special occasions is made available.
Legislation, supporting documents and accreditation links

Legislation
Food Safety Authority of Ireland Act, 1998

Supporting documentation
8.11 The person-in-charge ensures that mealtimes are unhurried with residents being given sufficient time to eat.

8.12 The person-in-charge ensures that there is a menu (changed at least fortnightly in consultation with residents), offering a choice of meals in written or other formats to suit the capacities of all residents, which is given, read or explained to residents.

8.13 All staff receive training and are compliant with safe food handling and hygiene e.g. HACCP (Food Safety Authority, 2006)

8.14 The person-in-charge ensures that potable water is available to all residents.

**STANDARD 9**

**Independence**

Residents are encouraged to maintain and maximise their independence

9.1 The person-in-charge ensures that independence is promoted, maintained and maximised

9.2 The person-in-charge ensures that based on assessed need, residents have access to the healthcare professionals needed to assist with maintenance of independence (e.g. Physiotherapist; Occupational Therapist etc.).

9.3 Where these professionals deem assistive technology will maximise independence and minimise risk, appropriate systems are in place to facilitate the prescription and provision of same.
Legislation, supporting documents and accreditation links

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS 5.4; 7.1; 9.1-4; 11.3
2. SOCIAL CONNECTEDNESS

STANDARDS 10 to 11
This section deals with social and community contact for residents and also activities provided by the residential care setting. What is clear from the ‘Improving Quality of Life study for older people in long-stay care settings in Ireland’ (Murphy et al. 2006) is the importance that residents in long term care attach to the relationships within the residential care setting, both between residents but also with staff and how vital it is for residents to maintain and foster their family and community connections.

Older people moving into residential care will have differing expectations and preferences as to lifestyle within the residential setting. For example, in a study undertaken by Age and Opportunity (2003) ‘Home from Home’ religion and religious observance was found to be of significant interest to many of the residents interviewed prior to their admission for long term care. Attending religious services was part of the older persons interaction with the community as they tended to meet with friends and neighbours after services at weekends. Other interests were TV and radio and most read a newspaper on a daily basis and attended local sporting occasions. According to this study factors that assist an older person to make a positive transition to long-term care include; being involved in the decision, visiting the home before making the decision, visits to family and friends and receiving visitors.

An important aspect of quality of life is also the need for activities and therapies which older people in residential care settings find therapeutic and purposeful and which include some outdoor activities (Murphy et al 2006). The degree to which, and the way in which, social life is organised within the residential care setting, along with the range of activities available, must be set out in the information materials (statement of purpose and residents’ guide) so that prospective residents get a clear picture of what is on offer. Some people will want an active, well-organised social life; in contrast, others will want a level of privacy and independence from other residents, although looking to the service provider for resources such as a library, quiet room or a space for religious observance. The capacity for social activity will vary according to the individual and many residents will need special support and assistance in engaging in the activities of daily life. For them, a structured daily life may well be a therapeutic requirement. These standards take this wide variation in preferences and capacity into account.

STANDARD 10
Social Contact and Activities

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents find the lifestyle experienced in the residential care setting matches their expectations and preferences, and satisfies their social, cultural, religious and recreational interests and needs (based on the information given about the service prior to admission).</td>
</tr>
</tbody>
</table>
Legislation, supporting documents and accreditation links

Legislation

**The Nursing Homes (Care and Welfare) Regulations (1993) Article 5**

5. (d) facilities for the occupation and recreation of persons
   (e) opportunities to participate in activities appropriate to his or her interests and capacities
   (f) freedom to exercise choice to the extent that such freedom does not infringe on the rights of other persons
   (g) privacy to the extent that the person is able to undertake personal activities in private
   (h) information concerning current affairs, local matters, voluntary groups, community resources and events;
   (i) adequate arrangements to facilitate a person in the practice of his or her religion

6. (a) encourage dependent person to maintain contact with persons of their choice
   (b) allow reasonable times during which the person in the nursing home may receive visits

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

| CS | 7.1; 10.3; 11.3; 11.4 |
| EF | 1.4 |
10.1 The routines of daily living and activities made available are flexible and varied to suit residents’ expectations, preferences and capacities. These are reviewed six monthly in consultation with residents and as part of care plan reviews.

10.2 Each resident has a care plan for daily living, and longer term outcomes, based on the residential care setting’s own needs assessment that are drawn up in consultation with the resident and/or their representative and they receive a copy of this care plan (see Standard 4).

10.3 Residents have the opportunity to exercise their choice to participate or not in:
- leisure, community and social activities and cultural interests;
- meals and mealtimes;
- routines of daily living;
- personal and social relationships;
- religious observance.

10.4 Residents interests are recorded and they are given opportunities for participation in meaningful and purposeful activity, occupation or leisure inside and outside the residential care setting which suit their needs, preferences and capacities; particular consideration is given to people with dementia and other cognitive impairments, those with visual, hearing or dual sensory impairments, and those with physical disabilities or learning disabilities.

10.5 If residents do not wish to participate in any activities, this is respected at all times.

10.6 Up-to-date information about activities is circulated to all residents in formats suited to their capacities.

10.7 Residents are offered the opportunity to contribute in the day to day activities of running the residential care setting e.g. gardening etc.

10.8 The person-in-charge facilitates the establishment of an in-house residents representative group for feedback and consultation on issues of concern to the residents

**STANDARD 11**

**Community Contact**

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents maintain contact with family/friends/representatives and the local community as they wish.</td>
</tr>
</tbody>
</table>

11.1 Links with family and friends are encouraged and facilitated.

11.2 Links with, and involvement of, local community groups in the residential care setting and/or volunteers are developed and maintained in accordance with residents’ preferences.

11.3 Management ensure the safety of residents during visits.
11.4 Residents are able to receive visitors in private and to choose whom they see and do not see and their wishes are observed and recorded.

11.5 The person-in-charge ensures that there is no restriction on visits except when requested to do so by the resident or when a visitor is deemed to pose a security risk.

11.6 Relatives, friends and representatives of residents are given written information about the service provider’s policy on maintaining relatives and friends’ involvement with them at the time of moving into residential care.

11.7 Residents have access to television programmes, information via computer (for email and internet access), a notice board displaying information regarding local events and newspapers.
Legislation, supporting documents and accreditation links

Legislation

Equal Status Act, 2000

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS 8.6; 11.1
EF 1.4
3. RIGHTS

STANDARDS 12 to 16

This section sets out a number of key standards in relation to the residential care setting providing privacy, dignity and choice for the resident with an emphasis on valuing of self expression by the resident. The very important issue of the resident’s rights as both a citizen and an individual are also included in this section.

The manner in which residents and/or their relatives and representatives can make complaints in relation to the residential care setting, in terms of the treatment and care given by staff or the facilities which are provided, is included in these standards. They deal with complaints procedures within the residential care setting relating to matters about or between the resident, other residents, staff, and the person-in-charge. Complainants may, of course, also make their complaints directly to the Health Service Executive and the Office of the Chief Inspector and residents are advised of this.

The opportunity to make constructive suggestions (rather than complaints) is essential, as is having a robust and effective complaints procedure which residents feel able to use. Making suggestions about how things might be improved may create co-operative relationships within the residential care setting and prevent situations where reason for complaints arises. However, it is important to remember that many older people may not like to complain perhaps because it is difficult for them or because they are afraid of being victimised. If a residential care setting is truly committed to the principles outlined in other sections of this document, an open culture within the residential care setting will develop which enables residents and staff to feel confident to make suggestions and/or complaints without any fear of victimisation.

The safety of residents is paramount and developing practices that ensure their safety is essential. Care settings must put in place mechanisms to ensure that issues such as challenging behaviour, restraint and abuse are dealt with in a timely, appropriate, sensitive and effective manner.

STANDARD 12

Rights

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>Residents’ legal rights are protected</th>
</tr>
</thead>
</table>

12.1 Residents are informed of their rights and entitlements.

12.2 Residents have their legal rights protected and are facilitated to exercise their legal rights including their participation in civic and political processes e.g. voting in elections.

12.3 Where a resident lacks capacity, the registered person facilitates access to advocacy services in accordance with the wishes of the resident.

12.4 The policies and practices regarding residents’ money and financial affairs ensure residents’ access to their personal financial records on request. The safe storage of money and valuables, consultation on finances in private, and advice on personal insurance is also made available on request.

12.5 Residents who wish to make a Will are facilitated.
Legislation, supporting documents and accreditation links

**Legislation**

*The Nursing Homes (Care and Welfare) Regulations (1993) Article 5, 19 and 26*

5(a) suitable and sufficient care to maintain the person’s welfare and well-being, having regard to the nature and extent of the person’s dependency

19.1 In every nursing home the following particulars shall be kept in a safe place in respect of each dependent person:

i) a record of any substantial complaint made by the dependent person or a person acting on his or her behalf and of the outcome of the investigation

26.1 A dependent person being maintained in a nursing home or person acting on his or her behalf, may make a complaint to the chief executive officer or a designated officer of the health board.

26.2 A complaint shall be made in writing, save as provided in article 26.3

26.3 A chief executive officer may cause a verbal complaint to be considered and investigated where he or she is satisfied that it is not possible to make a written complainant is acting in good faith

26.4 A complaint may be made in relation to any matter concerning the nursing home or the maintenance, care, welfare and well being of a dependent person while being so maintained

**Supporting documentation**


**Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme**

| CS  | 11.6; 11.7 |
| HR  | 2.1; 8.4   |
| LP  | 4.1; 6.8; 9.3 |
STANDARD 13
Complaints

**OUTCOME**
Residents and their relatives and friends are confident that their complaints will be listened to, taken seriously and acted upon.

13.1 The residential care setting provides an environment that is conducive to residents, staff, family and visitors being able to raise issues and make suggestions and complaints.

13.2 The person-in-charge ensures that there is a simple, clear and accessible complaints procedure which includes; the stages and timescales for the process; that complaints are dealt with promptly and effectively; and that written information is provided to all residents for referring a complaint to the Health Service Executive at any stage, should the complainant wish to do so.

13.3 A record is kept of all complaints made and includes details of investigation and any action taken and this is made available for inspection.

13.4 The person-in-charge ensures that complaints and comments are raised at team meetings for feedback and improvement respecting the confidentiality of the complainant where requested.

STANDARD 14
Protection

**OUTCOME**
Residents are protected from abuse.

14.1 The person-in-charge ensures that residents are safe from physical, financial or material, psychological or sexual abuse, neglect, discriminatory abuse or self-harm, inhuman or degrading treatment, through deliberate intent, negligence or ignorance. Any allegations of any such incidents are fully and promptly investigated in accordance with written policies.

14.2 All staff receive training in dealing with concerns of abuse incidents or suspicion of abuse and there is a written policy and guidelines on elder abuse.

14.3 Procedures for protecting vulnerable adults are included in the induction programme for all staff.

14.4 Robust procedures for responding to suspicion or evidence of abuse or neglect ensure the safety and protection of residents, including passing on concerns to the Health Service Executive and the Office of the Chief Inspector of Social Services in accordance with Health Service Executive guidelines.
Legislation, supporting documents and accreditation links

Legislation

*Nursing Homes (Care and Welfare) Regulations (1993) Article 19*
19.1 In every nursing home the following particulars shall be kept in a safe place in respect of each dependent person:
(h) A record of any occasion on which physical or chemical restraint is used, the nature of the restraint and its duration.

Health Bill 2006

Supporting documents


Federation Nursing Home Reform Act from the Omnibus Budget Reconciliation Act 1987 [OBRA ‘87 regulations] USA


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS 10.7; 10.8; 10.9; 10.10
14.5 Staff members are under a clear obligation to report any concerns about neglect or abuse to the person-in-charge, or in the event that the concern relates to the person-in-charge, directly to the Health Service Executive. Any action taken is recorded. Where a criminal offence may have been committed it must be reported to the Gardaí. Where an act of neglect or abuse has been identified, the appropriate professional should also be reported for fitness to practice to their respective regulatory body.

14.6 Where neglect or abuse is identified the appropriate professional should also be reported to fitness to practice of their respective regulatory bodies.

14.7 The person-in-charge must ensure that all staff working in the area are suitable and competent to work with vulnerable adults.

14.8 There is a written policy and written procedures on ‘Whistle blowing’ and staff are aware of whom they report concerns to and can do so without fear of adverse consequences to themselves.

STANDARD 15
Managing challenging behaviour and the use of restraint

**Outcome**
Residents’ safety needs are met in an environment that has the least restrictions and promotes well-being.

15.1 There are easily accessible, evidence based, up-to-date guidelines in meeting safety needs of residents that are used by staff on a daily basis.

15.2 The policies and practices of the residential care setting ensure that physical and/or verbal aggression by residents are understood and dealt with appropriately. Physical intervention is used only as a last resort.

15.3 All staff have up to date knowledge and skills in the management of challenging behaviour and there are arrangements to obtain advice and support from key health professionals who have the required expertise in the management of challenging behaviour.

15.4 There is a management plan for challenging behaviour that outlines the use of interventions such as observation, psychosocial interventions or restraint based on a interdisciplinary assessment of risk.

15.5 There is a policy on the management of restraining practices that is evidence-based and reflects the principle of ‘putting the resident first’.

15.6 Restraint (both physical and chemical) is not used in lieu of adequate staffing levels or routinely in the management of residents. It is only used as a last resort, agreed and recorded in accordance with good practice guidelines and procedures, is time-limited and regularly reviewed. The decision involves the consent of the resident or their family and the interdisciplinary team. Physical restraint must never take the form of tying, strapping or the positioning or use of furniture.
Legislation, supporting documents and accreditation links

Supporting documentation

Federation Nursing Home Reform Act from the Omnibus Budget Reconciliation Act 1987 [OBRA ‘87 regulations] USA


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

| HR  | 2.1; 4.1; 4.5; 4.6; 6.1; 6.2; 6.8; 8.2-4; |
| LP  | 2.2; 9.1-3; 3.1; 4.1; 4.4; 13.1-4       |
| CS  | 10.3; 11.1-4; 14.2; 16.1-4             |
| EF  | 1.3                                     |
15.7 The decision to use chemical restraint should not be taken unless efforts have been made to determine and treat the basic cause of the challenging behaviour rather than to mask dementia symptoms with sedating medications (OBRA ‘87 regulations). This may include a full medical assessment by a geriatrician or a psychiatrist.

15.8 Decisions made to use and manage restraint are documented and full particulars are recorded by the staff involved as soon as possible but within 12 hours.

15.9 Team reviews of adverse incidents that compromise residents’ safety are held and inform learning and practice development.

STANDARD 16
Safeguarding

**OUTCOME**
The resident is kept safe through conscious steps designed to ensure a regime and ethos that promote a culture of openness and accountability.

16.1 The residential care setting has a written policy on safeguarding residents. The policy complements good care practices, effective management, residents’ rights and the role of advocates and external monitoring of standards and includes:

- Recruitment procedures;
- Induction, ongoing training, supervision and appraisal of staff;
- Monitoring standards of care;
- Advocacy;
- Residents’ rights and participation in decision making;
- Contact with people external to the residence;
- Anti-bullying.

16.2 Staff understand and comply with the policy on safeguarding residents.

16.3 The care settings’ recording systems are monitored by the person-in-charge and easily accessed by inspectors.

16.4 Residents’ views are sought when developing induction and training schedules for staff and these inform policies, practices, induction and training schedules for staff.
Legislation, supporting documents and accreditation links

Supporting documentation


4. HEALTH CARE

STANDARDS 17 to 20
Whilst ensuring that the residential care setting focuses on providing a homely environment, the majority of residents will have some of the complex health issues related to ageing. This section clearly identifies the process for assisting residents in meeting their health needs from health promotion, assessment, planning and delivery of care and medication management, to palliative and end of life care. As with all other decisions made regarding residents’ care, health issues should, where possible be discussed with the resident or their chosen representative(s) and decisions regarding treatment should be made with their approval. Where possible health and independence should be promoted and fostered and this may be demonstrated through the care setting’s participation in projects such as the Health Promoting Residential Care Initiative (developed jointly by the National Council for Ageing and Older People and the Irish Health Promoting Hospitals Network).

The health care needs of residents should be addressed in a systematic, efficient and comprehensive fashion. There is an obligation on the care setting to ensure that the specific health care needs of all residents including nutrition, wound management, continence and oral health are assessed comprehensively and managed effectively.

Inevitably, the majority of residents will be taking some medication. Some will be self-medicating upon admission to long stay care and where possible this independence should be fostered and arrangements made for residents to continue self-medicating should be in place. Where this is no longer possible or where the resident expresses a wish to no longer care for their own medicines then the residential care setting must have stringent policies and procedures in place to ensure that medication is administered safely, adhering to regulations and in line with professional guidelines.

If the residential care setting is truly to be the residents’ home, then it is likely to be their last home. The quality of the care residents receive in their last days and hours is as important as the quality of life which they experience prior to this. Their physical and emotional needs should be met, their comfort and well-being attended to and their wishes respected. Pain and symptoms should be controlled and privacy and dignity preserved at all times. The professional skills of a specialist palliative care team should be requested, if necessary, to ensure the comfort of residents who are dying and to provide support and information to the resident’s family and the staff of the care setting if needed.

Residents should be encouraged to express their wishes about what they want to happen when death approaches and to provide instructions about the formalities to be observed after they have died. Cultural and religious preferences must be observed. The impact of the death of a resident on the community of residents may be significant and it is important that the staff ensure that opportunities are available for the other residents to come to terms with their loss in ways that individual residents find comforting and acceptable. Staff should be open and willing to talk about death, dying, and about those residents who have recently died. Staff themselves may also need support at such times. The needs of family and friends should also be attended to. It is essential for residential care settings to have clear policies and procedures to ensure that residents’ last days are spent in comfort and dignity and that their wishes are observed throughout.
Legislation, supporting documents and accreditation links

Legislation

**Nursing Homes (Care and Welfare) Regulations (1993) Articles 15, 30 and 31**

15. The registered proprietor and the person in charge of the nursing home shall ensure that:
   (e) where items such as disposable sheets and incontinence pads are necessary, they are available in sufficient quantities

30. The registered person and the person-in-charge of the nursing home shall ensure that:-
   (a) Where medical treatment is recommended and agreed to by a dependent person or the person acting on his or her behalf that it is carried out
   (b) When a person requires physiotherapy, chiropody, occupational therapy or other health service, such service is made available by the registered person or by arrangement with the health board
   (c) A person’s right to refuse treatment shall be respected and documented and the matter brought to the attention of the person’s medical practitioner and the person acting on his or her behalf

31. A health board may provide services (being services of a kind provided by or on behalf of health boards for the purposes of their functions) to a nursing home at the request of the registered person or person-in-charge upon such terms, charges and conditions and to such extent as the health board may determine, following discussion with the registered person of the home.

Supporting documents

National Council of Ageing and Older People and Department of Health and Children (1998) *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People in Ireland*. Dublin: NCAOP


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS 3.1-4;
STANDARD 17
Health promotion

OUTCOME
Residents and staff benefit from practices and policies which promote health and well-being.

17.1 The person-in-charge promotes and maintains residents’ health.

17.2 The residential care setting has a written health promotion policy.

17.3 The residential care setting provides opportunities for residents to pursue healthy lifestyle choices (e.g. healthy food options; meaningful activity or occupation; smoke free areas etc).

17.4 Opportunities are provided for appropriate indoor and outdoor exercise and physical activity.

17.5 Appropriate precautions/interventions are carried out for residents identified as at risk of falling; this may include referral to a relevant health care professional.

STANDARD 18
Health Care

OUTCOME
Residents’ health care needs are fully met.

18.1 The person-in-charge ensures access to health care services to meet assessed needs.

18.2 All of the resident’s health needs are monitored regularly and preventative and restorative care provided.

18.3 The person-in-charge ensures that protocols based on current best practice are developed, implemented and reviewed annually, particularly in relation to nutrition, skin care (pressure sores), wound management, infection control and continence.

18.4 Nutritional screening is undertaken on admission and subsequently on a six monthly basis or as required, a record maintained of nutrition, including weight gain or loss, and appropriate action taken (See standard 8 on meals and meal times).

18.5 Residents are assessed by a relevant professional to identify those who have developed or are at risk of developing pressure sores and appropriate preventative measures and interventions are taken and recorded in the care plan. An identified assessment tool should be used as part of the assessment on admission and as required.

18.6 The incidence of pressure sores, their treatment and outcome, are recorded in the resident’s individual care plan and reviewed on a continuing basis.

18.7 Aids and appliances in line with current best practice that are necessary for the promotion of tissue viability and the prevention or treatment of pressure sores are provided.
Legislation, supporting documents and accreditation links

Legislation

<table>
<thead>
<tr>
<th><strong>Nursing Homes (Care and Welfare) Regulations (1993), Article 29</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>29. The registered person and the person-in-charge of the nursing home shall:</td>
</tr>
<tr>
<td>a) Make adequate arrangements for the recording, safe-keeping, administration and disposal of drugs and medication.</td>
</tr>
<tr>
<td>b) Ensure that the treatment and medication prescribed by the medical practitioner of a dependent person is correctly administered and recorded.</td>
</tr>
</tbody>
</table>

Health Amendment Act 2005


Health (Miscellaneous Provisions) Act, 2001

Supporting documents


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

| CS  | 1.5 |
| LP  | 6.6 |
| EF  | 1.5 |
18.8 Staff maintain the personal and oral hygiene of each resident and, wherever possible, support the resident’s own capacity for self-care.

18.9 There is a continence management policy that is evidence-based. Continence management by staff skilled and educated in the management of continence is available and on their advice, residents are provided with ‘needs specific’ products for urinary and faecal incontinence.

18.10 Where medical care is not provided by the residential care setting team, the person-in-charge enables residents to register with a GP of their choice (where it is practical and the GP is agreeable).

18.11 The person-in-charge enables residents to have access to specialist medical, nursing, dental, pharmaceutical, chiropody and therapeutic services (including physiotherapy, occupational therapy, dietetics and speech therapy), hearing and sight tests and appropriate aids and care from hospitals and community health services according to need (Health (Miscellaneous Provisions) Act, 2001).

18.12 The person-in-charge ensures that residents’ entitlements to health services are upheld by providing information about entitlements and ensuring access to advice.

18.13 The person-in-charge, for the purposes of monitoring, managing and inspection, keeps a general record of all instances of wound management, falls, restraint, infectious diseases, medication errors and other serious illnesses and records the name of residents involved and the date of the instances.

STANDARD 19
Medication

OUTCOME
Residents are protected by the residential care setting’s policies and procedures for medication management and where appropriate, are responsible for their own medication.

19.1 The person-in-charge ensures that there is a medication management policy and that staff adhere to procedures, for the prescription, supply, receipt, self administration recording, storage, handling, administration, and disposal of medicines. Unacceptable practices such as: crushing medication; covert administration; withholding medication; verbal orders and transcription of prescriptions should be detailed in the policies of the residential care setting. There must also be a policy relating to the recording and management of errors and the use of unlicensed (off label) medicines.

19.2 Residents are able to take responsibility for their own medication if they wish, within a risk management framework.

19.3 The resident, following assessment as able to self-administer medication, has a lockable space in which to store medication, to which suitably trained, designated staff may have access with the resident’s permission.
Legislation, supporting documents and accreditation links

Legislation
Irish Medicines Board (Miscellaneous Provisions) Act, 2006
Misuse of Drugs Act, 1977 and 1984
Nurses Act, 1985

Supporting documentation

Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme
CS 9.4; 13.1; 13.2; 13.3; 13.4
19.4 Records are kept of all medicines received, administered to patients and given to patients leaving the care setting, or returned to the pharmacy, to ensure that there is no mishandling. A drug administration chart is maintained for each resident (including those self-administering).

19.5 Medicines in the custody of the service provider are handled according to the requirements of the Medicinal Products (Prescription and Control of Supply) Regulations 2003, (S.I. 540 of 2003) and the Misuse of Drugs Acts, 1977 and 1984 which authorise the nurse to possess and supply medicinal products. Nursing staff abide by The Code of Professional Conduct for each Nurse and Midwife, (An Bord Altranais, 2000) and are familiar with the Guidance to Nurses and Midwives on Medication Management (An Bord Altranais, 2003).

19.6 All medicines, including controlled drugs, (except those for self-administration) are administered by a registered nurse. The administration of controlled drugs is witnessed by another designated, appropriately trained member of staff (this does not have to be a nurse).

19.7 Scheduled controlled drugs must be locked in a separate container/cupboard from other medicinal products to ensure further security as set out by the Misuse of Drugs Regulations, 1988 and 1993.

19.8 The receipt, administration and disposal of controlled drugs are recorded in a Controlled Drugs Register.

19.9 The person-in-charge seeks information and advice from a pharmacist regarding medicines policies within the residential care setting and medicines dispensed for individuals in the residential care setting.

19.10 The condition of the resident on medication is monitored regularly and concerns reported to the resident’s doctor if there are any concerns about any change in condition that may be as a result of medication. Regular review of medication is based on the changing needs of the resident.

19.11 All residents on long term medication are reviewed by their medical doctor on a regular basis and not less frequently than every three months.

19.12 In the event of a resident’s death being referred to the Coroner, medication is retained until the results of the post-mortem are known.

19.13 Residents of nursing homes have access to non-prescription medicinal products.

STANDARD 20
Palliative and end of life care

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents can expect to receive care at the end of life which addresses their physical, psychological, emotional, social and spiritual needs and which respects their dignity.</td>
</tr>
</tbody>
</table>
Legislation, supporting documents and accreditation links

Legislation

Nursing Homes (Care and Welfare) Regulations (1993) Article 6 and 22

6 (c) provide adequate arrangements of the care of the dying
   (d) ensure respect for the remains of deceased persons and make arrangements for
    the removal of remains

22 When a dependent person dies in a nursing home, the registered proprietor or the person
    in charge shall send notice in writing of the date and time of death to the Medical Officer
    of Health for the area in which the nursing home is situated, not later than forty eight
    hours after it occurs and the certified cause of death as soon as possible thereafter.

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS 2.1; 2.2; 8.6; 8.7; 9.4; 11.5; 15.1; 15.5; 15.6; 15.7
LP 6.6; 7.2; 7.3
20.1 Residents’ are given the choice as to whether and to what extent their family or representative(s) are involved in their care at the end of life.

20.2 The residents’ total palliative care needs are fully assessed and reviewed in conjunction with appropriate professionals, the resident and their representative(s), where available and appropriate friends or relatives are referred to bereavement care services.

20.3 The person-in-charge ensures that, where appropriate, external specialist services are brought into the residential care setting in order to further assess and meet residents’ needs, particularly in relation to specialist palliative care needs including pain and symptom relief and psychological, spiritual and emotional needs.

20.4 The person-in-charge ensures that residents’ needs and wishes at the end of life are clearly identified and recorded.

20.5 Where appropriate, decisions relating to advanced care planning [e.g. resuscitation etc.] and withholding and withdrawing of life prolonging treatments will reflect the residents wishes and be made with the resident, and where appropriate their representative(s), and where possible within the context of an interdisciplinary team. Such will be reviewed regularly by the team in the context of the changes in the resident’s clinical situation or his/her wishes.

20.6 Staff will follow best practice guidance for residents unable to make decisions for themselves. All such decisions will be recorded in the residents’ records and reviewed as the residents’ assessed needs change.

20.7 Staff are provided with appropriate training and guidance.

20.8 Every effort is made to ensure that residents’ choice as to the place of death and who is to be present at the time of their death is identified and respected. All relevant staff are aware of residents’ wishes in this respect.

20.9 Residents’ wishes regarding religious and cultural practices concerning death and dying are recorded and implemented.

20.10 Upon death, time and privacy is allowed for family, friends and carers to pay their respects.

20.11 After death, appropriate support is provided to other residents, staff, family and friends. This may include holding memorial services within the residential care setting. Where residents would like to hold such a service it is facilitated.

20.12 The residents’ personal possessions are treated with respect and returned to family and friends in an appropriate and timely manner.

20.13 In line with HSE guidelines, the person-in-charge ensures that notice of the date and time and certified cause of death is sent in writing to both the Senior Medical Officer in the Local Health Office and the local Coroner’s Office, no later than 48 hours after the death has occurred.
PART 2: ORGANISATIONAL STANDARDS

5. Management  
6. Staffing  
7. Care environment  
8. Health and safety
Legislation, supporting documents and accreditation links

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

LP  2.1-2.2; 3.1-3.4; 4.1; 4.3; 4.4;
CS  16.1
HR  8.3; 8.7
5. MANAGEMENT

STANDARDS 21 to 26
This section sets out the standards relating to the qualifications, qualities and experience required of the person in day to day control of the delivery of care, and how they should exercise their responsibilities. The standards highlight the importance of consulting residents about their health and personal care, interests and preferences. A competent, skilled manager is adept at fostering an atmosphere of openness and respect, in which residents, family, friends and staff all feel valued and that their opinions matter. Quality of care is achieved when there is an overall commitment to continuous improvement, with the manager of the care setting being properly supported and resources available to take full control of day to day operations. One of the most significant factors identified as having an impact on the quality of life of residents in long term residential care settings in Ireland is the care philosophy of the unit in which they live (Murphy et al., 2006) The management must promote an ethos which clearly fosters the principles of respect, equality, openness and transparency.

All residential care settings where older people are cared for will be required to register with the Office of the Chief Inspector of Social Services. The Registered Person will be the person named on the Certificate of Registration. The Person-in-charge is the person who either runs the residential care setting and is registered with the Office of the Chief Inspector/HSE to do so (the registered person); or manages the residential care setting for older people and is registered with the Office of the Chief Inspector/HSE to do so (the person-in-charge). In some cases the registered provider may also manage the residential care setting. In private nursing homes one person could be the owner, the registered person and the person-in-charge.

It is essential that the residential care setting demonstrates clear, sound accounting and financial procedures. This includes the management of residents’ finances and the record keeping associated with these practices.

STANDARD 21
Ethos

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents benefit from the ethos, leadership and management approach of the residential care setting which reflects the principle of equality.</td>
</tr>
</tbody>
</table>

21.1 The person-in-charge ensures that the management approach of the residential care setting for older people creates an open, positive and inclusive atmosphere.

21.2 The person-in-charge communicates a clear sense of direction and leadership consistent with the aims and purpose of the residential care setting.

21.3 The person-in-charge has systems and processes for enabling staff, residents and other stakeholders to positively influence the way in which the service is delivered.

21.4 The processes for managing and running the residential care setting are open and transparent.
Legislation, supporting documents and accreditation links

Legislation

**Nursing Homes (Care and Welfare) Regulations (1993) Article 14**

10.1 There shall be a person-in-charge of a nursing home

10.2 Subject to article 10.3 the post of person-in-charge shall be full time and the person in charge shall be a nurse with a minimum of three years appropriate post registration experience within the previous six years

10.3 Where the registered person is a registered medical practitioner, solely employed in the carrying on of a nursing home and has a minimum of three years experience carrying on a nursing home under the Health (Homes for Incapacitated Persons) regulations, 1985 or as a registered person of a nursing home, the registered person may be the person in charge, provided that at all times there is a nurse on duty in the home.

10.4 The registered person shall notify the health board in writing if the person-in-charge of registration ceases to be the person-in-charge during the period of registration and shall notify the health board in writing of the name of the new person-in-charge within one month of the appointment.

Supporting documentation

**Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme**

- LP 6.3; 5.1; 5.2; 6.11
- HR 4.2; 4.3; 5.1;
- CS 11.1
21.5 There is a process for dealing with ethical issues in care/service delivery (e.g. Do Not Resuscitate orders etc.)

**STANDARD 22**
Operational management

**OUTCOME**
Residents live in a residential care setting which is run and managed by a person who is fit and competent to be in charge, of good character and able to discharge his or her responsibilities fully.

22.1 The person-in-charge is qualified, competent and experienced to run the residential care setting for older people and meet its stated purpose, aims and objectives.

22.2 The person-in-charge has at least 3 years experience in a senior management capacity in the managing of a relevant residential care setting within the past six years;

22.3 The person-in-charge is responsible for no more than one registered establishment. In circumstances where the registered establishment is located in separate buildings or on more than one site the person-in-charge must ensure that a suitably qualified and competent person is available on each site.

22.4 The person-in-charge can demonstrate that he/she has undertaken periodic training to update his/her knowledge, skills and competence, whilst managing the residential care setting for older people.

22.5 The person-in-charge and other staff are familiar with the conditions/diseases associated with old age as appropriate to their role.

22.6 The job description of the person-in-charge enables him/her to take responsibility for fulfilling his/her duties.

22.7 There are clear lines of accountability within the residential care setting between the registered person and the person-in-charge and with any external management.

22.8 Where the registered person is in day-to-day control of the residential care setting, he/she meets all standards applying to the person-in-charge.

22.9 The Office of the Chief Inspector of Social Services is notified if there is change in the person-in-charge of the residential care setting within one month of appointment.

**STANDARD 23**
Quality Assurance

**OUTCOME**
The residential care setting is run in the best interests of residents.
Legislation, supporting documents and accreditation links

Legislation

*Nursing Homes (Care and Welfare) Regulations (1993) Article 34*
The registered proprietor shall ensure that dependent persons are adequately insured against injury while being maintained in the home.

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

LP  2.2; 4.4; 4.5; 6.6; 6.9; 13.1-13.4; 16.1
CS  2.2; 16.1-16.4
23.1 Effective quality assurance and quality monitoring systems, based on seeking the views of residents, are in place to measure success in meeting the aims, objectives and statement of purpose of the residential care setting.

23.2 There is continuous self-monitoring, using a verifiable method (preferably a professionally recognised quality assurance system) and involving residents; and an internal audit takes place at least annually.

23.3 Feedback is actively sought from residents about services provided through e.g. anonymous user satisfaction questionnaires and individual and group discussion, as well as evidence from records; and this informs all reviews and future planning.

23.4 The results of resident surveys are published and made available to current and prospective users, their representatives and other interested parties including the inspectors.

23.5 Residents have the option to decline the opportunity to give feedback/participate in surveys.

23.6 The views of family and friends and of stakeholders in the community (e.g. GPs, chiropodists, staff of voluntary organisations) are sought on how the residential care setting for older people is achieving goals for residents.

23.7 Any recorded views of residents on file are made available to inspectors for inclusion in their inspection reports, as required.

23.8 Policies, procedures and practices are regularly reviewed in light of changing legislation and of good practice advice from the Department of Health and Children, HSE, HIQA, specialist / professional organisations, and residents’ views.

**STANDARD 24**
Financial Procedures

<table>
<thead>
<tr>
<th>OUTCOME</th>
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</thead>
<tbody>
<tr>
<td>Residents are safeguarded by the accounting and financial procedures of the residential care setting for older people.</td>
</tr>
</tbody>
</table>

24.1 Suitable accounting and financial procedures are adopted to demonstrate current financial viability and to ensure there is effective and efficient management in line with current legislation.

24.2 Insurance cover is put in place against loss or damage to the assets of the business. The level of cover reflects the full replacement value of buildings, fixture, fittings and equipment and includes public liability and contents. The person-in-charge also ensures that residents are adequately insured against injury.
Legislation, supporting documents and accreditation links

Legislation

*Nursing Homes (Care and Welfare) Regulations (1993) Article 19*

19.2 Records kept under article 19.1 shall be retained for a period of not less than five years after the dependent person whom they relate ceases to be resident in the home.

Nursing Homes (Fees) Regulations, 1993 (S.I. 223) Dublin: Stationery Office

Nursing Homes (Subvention) (Amendment) Regulations, 1993 (S.I. 378) Dublin: Stationery Office

Supporting documentation

Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

LP 4.5; 8.1; 8.2; 8.5;
CS 11.1
EF 1.4
24.3 There is an annual service and financial plan for the residential care setting, which is available for inspection and is reviewed annually.

24.4 There are agreed protocols for HSE Service Level Agreements which are implemented.

24.5 All payments to the residential care setting (e.g. subvention/pension contributions) are in accordance with current legislation.

STANDARD 25
Residents’ finances

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents’ financial interests are safeguarded.</td>
</tr>
</tbody>
</table>

25.1 The residential care setting has clear guidelines on the management of residents’ accounts and can show compliance with these guidelines.

25.2 The person-in-charge ensures that residents control their own money except where they state that they do not wish to or they lack capacity. Safeguards are in place to protect the interests of the resident.

25.3 Written records of all financial transactions are maintained and retained for 7 years.

25.4 Where the money of individual residents is handled, the manager ensures, in particular, that the personal allowances of these residents are not pooled and appropriate records and receipts are kept.

25.5 The person-in-charge may be appointed by the resident as agent for a resident only where no other person is available. In this case, the manager ensures that:
   - the Office of the Chief Inspector is notified on inspection;
   - records are kept of all incoming and outgoing payments; and
   - the Department of Social and Family Affairs is given appropriate notice when the person-in-charge is the resident’s appointee.

25.6 Secure facilities are provided for the safe-keeping of money and valuables on behalf of the resident.

25.7 Records and receipts are kept of possessions handed over for safe keeping both at admission and subsequently. Two people sign to verify receipt of these possessions.
Legislation, supporting documents and accreditation links

Legislation

Nursing Homes (Care and Welfare) Regulations (1993) Article 18, 19 and 20

18.1 In every nursing home there shall be kept in a safe place a bound register of all dependent persons resident in the home which shall include the following particulars in respect of each person:

(a) the first name, surname, address, date of birth, marital status and religious denomination of the person;
(b) the name, address and telephone number of the person's relative or other person nominated to act on the person's behalf as a person to be notified in the event of a change in the person's health or circumstances;
(c) the name, address and telephone number of the person's medical practitioner;
(d) the date to which the person was last admitted to the nursing home;
(e) where the person left the nursing home the date on which he or she left and a forwarding address;
(f) where the person is admitted to hospital the date of and reasons for the admission and the name of the hospital;
(g) where the person dies in the nursing home the date, time and certified cause of death.

19.1 In every nursing home the following particulars shall be kept in a safe place in respect of each dependent person:

(a) where the person is in receipt of a health board subvention, a summary of the assessment of the person's level of dependency on admission and on review;
(b) a copy of the contract which the registered proprietor or person-in-charge executed with the dependent person or a person acting on his or her behalf in accordance with 7.1 or 7.2;
(c) a record of the medical and nursing condition of the person at the time of admission;
(d) an adequate nursing record of the person's health and condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty;
(e) a medical record with details of investigations made, diagnosis and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner.
(f) a record of drugs and medicines administered giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines.
(g) a record of any accident or fall involving a dependent person;
(h) a record of any occasion on which physical or chemical restraint is used, the nature of the restraint and its duration;
(i) a record of any substantial complaint made by the dependent person or a person acting on his or her behalf and of the outcome of the investigation.

20. The registered proprietor and the person in charge shall ensure that all records pertaining to a dependent person are treated with confidentiality, subject to the requirements of article 23.2.

Data Protection Act 1998

Supporting documentation

Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme
IM 2.1; 3.1; 3.2; 3.3; 5.1; 5.2; 5.3; 5.4;
STANDARD 26  
Record Keeping

OUTCOME
Residents’ rights and best interests are safeguarded by the residential care setting’s record keeping policies and procedures.

26.1 Medical, nursing and organisational records are secure, up to date and in good order and are constructed, maintained and used in accordance with the Data Protection Act 1998 and the Freedom of Information Act (1997/2003) and are accessible and available for monitoring purposes. There is an appropriate system for recording the interventions of visiting health care professionals.

26.2 Records for the protection of residents and for the effective and efficient running of the care setting are maintained, up to date and accurate at all times. A bound register must include the following information in respect of each resident:
- the first name(s), surname, address, date of birth, marital status and religious denomination of the resident;
- the name, address and telephone number of the resident’s relative or representative nominated to act on the resident’s behalf as a person to be notified in the event of a change in the resident’s health or circumstances;
- the name, address and telephone number of the resident’s medical practitioner;
- the date to which the resident was last admitted to the residential care setting;
- where the resident left the residential care setting, the date on which he or she left and a forwarding address;
- where the resident is admitted to hospital the date of and reasons for the admission and the name of the hospital;
- where the resident dies in the residential care setting the date, time and certified cause of death.
Records must also include:
- where the resident is in receipt of a health board subvention, a summary of the assessment of the persons level of dependency on admission and on review;
- a copy of the contract between the residential care setting and the resident;
- a record of the medical and nursing condition of the resident at the time of admission;
- an adequate nursing record of the residents health and condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty;
- a medical record with details of investigations made, diagnosis and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner;
- a record of drugs and medicines administered giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines;
- a record of any accident or fall involving a resident;
- a record of any occasion on which physical or chemical restraint is used, the nature of the restraint and its duration;
- a record of any substantial complaint made by a resident or his/her representative and the outcome of the investigation.
### Legislation, supporting documents and accreditation links

#### Legislation

**Nursing Homes (Care and Welfare) Regulations (1993) Article 18, 19 and 20**

<table>
<thead>
<tr>
<th>Article</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.2</td>
<td>In every nursing home there shall be kept in a safe place a bound register of all dependent persons resident in the home which shall include the following particulars in respect of each person:</td>
</tr>
<tr>
<td>(h)</td>
<td>the first name, surname, address, date of birth, marital status and religious denomination of the person;</td>
</tr>
<tr>
<td>(i)</td>
<td>the name, address and telephone number of the persons relative or other person nominated to act on the persons behalf as a person to be notified in the event of a change in the persons health or circumstances</td>
</tr>
<tr>
<td>(j)</td>
<td>the name, address and telephone number of the persons medical practitioner</td>
</tr>
<tr>
<td>(k)</td>
<td>the date to which the person was last admitted to the nursing home</td>
</tr>
<tr>
<td>(l)</td>
<td>where the person left the nursing home the date on which he or she left and a forwarding address</td>
</tr>
<tr>
<td>(m)</td>
<td>where the person is admitted to hospital the date of and reasons for the admission and the name of the hospital</td>
</tr>
<tr>
<td>(n)</td>
<td>where the person dies in the nursing home the date time and certified cause of death</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Article</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.1</td>
<td>In every nursing home the following particulars shall be kept in a safe place in respect of each dependent person:</td>
</tr>
<tr>
<td>(a)</td>
<td>where the person is in receipt of a health board subvention, a summary of the assessment of the persons level of dependency on admission and on review</td>
</tr>
<tr>
<td>(b)</td>
<td>a copy of the contract which the registered proprietor or person-in-charge executed with the dependent person or a person acting on his or her behalf in accordance with 7.1 or 7.2;</td>
</tr>
<tr>
<td>(c)</td>
<td>a record of the medical and nursing condition of the person at the time of admission</td>
</tr>
<tr>
<td>(d)</td>
<td>an adequate nursing record of the persons health and condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty;</td>
</tr>
<tr>
<td>(e)</td>
<td>a medical record with details of investigations made, diagnosis and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner.</td>
</tr>
<tr>
<td>(f)</td>
<td>a record of drugs and medicines administered giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines.</td>
</tr>
<tr>
<td>(g)</td>
<td>a record of any accident or fall involving a dependent person;</td>
</tr>
<tr>
<td>(h)</td>
<td>a record of any occasion on which physical or chemical restraint is used, the nature of the restraint and its duration;</td>
</tr>
<tr>
<td>(i)</td>
<td>a record of any substantial complaint made by the dependent person or a person acting on his or her behalf and of the outcome of the investigation.</td>
</tr>
</tbody>
</table>

**20.** The registered proprietor and the person-in-charge shall ensure that all records pertaining to a dependent person are treated with confidentiality, subject to the requirements of article 23.2

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**Data Protection Act 1998**


**Supporting documentation**

**Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme**

IM 2.1; 3.1; 3.2; 3.3; 5.1; 5.2; 5.3; 5.4;
26.3 There is also a policy for the retention and destruction of records in compliance with the Data Protection Act, 1998.

26.4 Residents have access to their records and information about them held by the service provider, as well as opportunities to help maintain their personal records, in accordance with the Data Protection Act 1998 and Freedom of Information Act (1997) (see Standard 5.4)
Legislation, supporting documents and accreditation links

Legislation

Nursing Homes (Care and Welfare) (Amendment) Regulations, 1994 (S.I. 147),
Nursing Homes (Care and Welfare) Regulations (1993), Dublin: Stationery Office
Terms of Employment (Information) Act, 1994
Protection of employees (Part Time Work) Act, 2001
Protection of Employees (Fixed-Term Work) Act, 2003

Supporting documentation

Buchan J (2005) A certain ratio? The policy implications of minimum staffing ratios in nursing? *Journal of Health Services Research and Policy* 10(4); 239-244


Department of Health and Children (2005) *Report of the working group to: examine the development of appropriate systems to determine nursing and midwifery staffing levels.* Dublin: Stationery Office


6. STAFFING
STANDARDS 27 to 31
This section sets out some baseline staffing standards which apply to all residential care settings for older people. In Ireland, as in most countries, there is no established ratio of nurse to patient in any care setting (e.g. public, private, acute, long stay etc.) and there is a significant variation in nurse staffing levels in residential care settings for older people. Appropriate staffing levels and skill mix are based on a complex and dynamic set of variables. In some countries legislation is in place stating minimum staffing levels; however, static minimum staffing levels do not take account of patients individual daily needs, and minimum staffing levels can become the average or the maximum (Buchan, 2005). There is no consensus on what constitutes a suitable or even acceptable level of staffing for units providing long stay care for older people. Each residential care setting must determine the appropriate staffing levels and skills required to meet the assessed and recorded needs of its own particular residents at all times (this should include nursing, healthcare assistant and therapy staff). The person-in-charge must satisfy the inspectors regarding the adequacy of staffing levels at all times.

The Commission on Nursing (DOHC, 1998) recommended the examination and development of appropriate systems to determine nurse staffing levels. The report of a working group set up to look at this issue (DOHC, 2005) recommended that further work on the method for determining staffing levels was needed. The report of the working group to examine the development of appropriate systems to determine nursing and midwifery staffing levels (DOHC, 2005) also suggested that pilot sites be identified where systems of measuring patient dependency, examining the principles of skill mix and measuring workload could be tested and evaluated in the Irish health care system. The results of this work are awaited.

Staff shortages and staff qualifications are the number one concern of long-term policy makers in the OECD countries (OECD, 2005). The number of staff and the qualifications/competencies of the staff on duty must meet the assessed needs of the residents. The person-in-charge must have sound recruitment practices and employ appropriate staff with the competencies required for the post. In order to retain staff the person-in-charge must ensure that the residential care setting provides a healthy working environment. Staff should receive induction/orientation and ongoing training and support in their role including appropriate supervision.

STANDARD 27
Recruitment

<table>
<thead>
<tr>
<th>OUTCOME</th>
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<tbody>
<tr>
<td>Residents are supported and protected by the residential care settings recruitment policy and practices.</td>
</tr>
</tbody>
</table>

27.1 The person-in-charge operates a thorough recruitment procedure based on current legislation and best practice.

27.2 All qualifications are checked (for nurses this must include verification of registration on the active register of An Bord Altranais), references sought (including last place of employment), gaps in employment explored and where applicable, registration status confirmed. New staff are confirmed in post only following completion of a satisfactory Garda clearance.
### Legislation, supporting documents and accreditation links

#### Legislation

<table>
<thead>
<tr>
<th>The Nursing Homes (Care and Welfare) Regulations (1993), Article 10, 19 and 21</th>
</tr>
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<tbody>
<tr>
<td>10.1</td>
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<td>10.2</td>
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<td>10.3</td>
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<td>10.5</td>
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<td>a)</td>
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<tr>
<td>b)</td>
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<tr>
<td>c)</td>
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<tr>
<td>d)</td>
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</table>

<table>
<thead>
<tr>
<th>21. In every nursing home there shall be kept in a safe place a record of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
</tr>
<tr>
<td>(b)</td>
</tr>
<tr>
<td>(c)</td>
</tr>
</tbody>
</table>

#### Supporting documentation


- O’Reilly M (2005) Review of nursing and support staff team requirements. Health Service Executive Western Area

#### Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

| HR | 2.1; 2.2; 2.4; 4.5; 4.6; 5.1; 5.2; 5.3; 7.1; 7.2; |
| LP | 10.1; 10.2; 11.1; 11.4 |
27.3 All staff have written job descriptions and a written copy of their terms and conditions of employment within two months.

27.4 Staff are employed in accordance with current legislation.

27.5 Staff records are developed for all new staff and include all documentation relating to recruitment.

27.6 Recruitment procedures ensure that all staff are competent to certification level in basic skills including: manual handling, health and safety, CPR and handling violence and aggressive behaviour.

27.7 The person-in-charge ensures that agencies providing staff to the care setting have a vetting system in place which includes qualification checks, references and Garda checks.

**STANDARD 28**

**Staffing**

<table>
<thead>
<tr>
<th>OUTCOME</th>
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<tbody>
<tr>
<td>The number of staff and the qualifications of staff on duty at all times meet the assessed needs of residents.</td>
</tr>
</tbody>
</table>

28.1 An up-to-date and accurate record is kept of the full name, date of birth, qualifications and experience of staff, trainees, students and volunteers working in the residential care setting. A photocopy of annual registration renewal, where appropriate, is kept on file e.g. An Bord Altranais registration.

28.2 Staffing numbers and skill mix of qualified/unqualified staff are appropriate to the assessed needs of the residents, the size, layout and purpose of the residential care setting, and the assessed nursing care, social and recreational needs of the residents at all times.

28.3 A recorded staff rota showing staff on duty at any time during the day and night and in what capacity is maintained.

28.4 The ratios of care staff to residents must be determined according to the assessed needs of residents, and a system operated for calculating staff numbers required, in accordance with any guidance provided by the HSE.

28.5 A minimum ratio of 50% trained members of care staff (FETAC level 5 or equivalent) is achieved by (date TBC) excluding the person-in-charge.

28.6 Any agency staff working in the residential care setting are included in the 50% ratio.

28.7 Registered nurses working in the residential care setting are where possible, facilitated to undertake a recognised post-registration/post-graduate qualification in Care of the Older Person Nursing (e.g. Masters/Higher Diploma/Post Graduate Diploma in Gerontology Nursing).
Legislation, supporting documents and accreditation links

Legislation


Nursing Homes (Care and Welfare) (Amendment) Regulations, 1994 (S.I. 147),

Nursing Homes (Care and Welfare) Regulations (1993), Dublin: Stationery Office

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

LP  9.1-9.4;
HR  4.5; 4.6
28.8 Additional appropriate staff are on duty at peak times of activity during the day.

28.9 There are night staff including registered nurses on duty in numbers that reflect the numbers and needs of residents and the layout of the residential care setting.

28.10 Staff left in charge have sufficient experience and capacity to manage all contingencies.

28.11 Staff providing personal care to residents have sufficient experience and capacity to manage all contingencies.

28.12 Ancillary staff are employed to ensure that standards relating to food and meals, transport, laundry, cleaning and maintenance of the premises are fully met.

28.13 Administrative staff are employed to ensure that standards relating to administration are fully met.

28.14 There are arrangements for the person-in-charge to carry out and document a competency and capability assessment with any nurse who is given the responsibility for being in charge of the residential care setting.

28.15 Staff undertaking supervised practice working in the residential care setting are properly supervised.

28.16 Staff undertaking supervised practice working in the residential care setting are supernumery and therefore are not to be taken into account in any staffing calculations.

28.17 The recruitment and selection process for any volunteers involved in the organisation is thorough and references are sought.

28.18 Volunteers’ and trainees’ roles and responsibilities are set out in a written agreement between the residential care setting and the individual.

STANDARD 29
Staff Supervision

OUTCOME
Staff are appropriately supervised.

29.1 The person-in-charge ensures that the employment policies and procedures adopted by the residential care setting for older people including its induction, training and supervision arrangements are implemented.
Legislation, supporting documents and accreditation links

Legislation

**Nursing Homes (Care and Welfare) Regulations (1993) Article 32**
A health board may provide training facilities for staff of nursing homes by agreement with the registered proprietor or person-in-charge upon such terms, charges and conditions and to such an extent as the health board may determine following discussion with the registered proprietor

Employment Equality Act 1998-2004


The Equal Status Act, 2000

Organisation of Working Time Act, 1997

Food Safety Authority of Ireland Act, 1998

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

HR 4.1; 4.2; 4.3; 4.4; 4.5; 4.6; 7.2;
29.2 Supervision covers:
- all aspects of practice;
- ethos of care in the residential care setting;
- career development needs and training.

29.3 All staff are supervised as part of the normal management process on a continuous basis and regular staff meetings are convened.

29.4 Volunteers receive training, supervision and support appropriate to their role and do not replace paid staff.

STANDARD 30
Staff Training

OUTCOME
Staff are trained and competent to do their jobs.

30.1 The person-in-charge ensures that there is a staff training and development programme which ensures staff fulfil the aims of the residential care setting and meet the changing needs of residents.

30.2 The person-in-charge ensures that minimum mandatory training requirements for all staff are met e.g. Manual handling, Hazard Analysis and Critical Control Points (HACCP), Fire safety Cardio-pulmonary Resuscitation; etc. prior to commencement.

30.3 All members of staff receive induction within 4 weeks of appointment to their posts, including training on the principles of care, safe working practices, the organisation and worker role, the experiences and particular needs of the resident group, and the influences and particular requirements of the service setting.

30.4 All staff receive training within the first six months of appointment, which equips them to meet the assessed needs of the residents, as defined in their individual care plan.

30.5 A record of all staff training and development is maintained

30.6 All staff receive training outside of rostered working hours (including in-house training).

30.7 The continuing professional development of staff is facilitated, evaluated and documented.

30.8 A performance review is undertaken with all members of staff and an individual training and development assessment and profile is developed. Systems are put in place to resolve identified issues.
Legislation, supporting documents and accreditation links

Legislation

Supporting documentation

Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

HR  8.1; 8.2; 8.3; 8.4
LP  6.8
STANDARD 31
Healthy work environment for staff

**OUTCOME**
The residential care setting’s work environment is safe, healthy and positive for all staff, contractors and volunteers.

31.1 The residential care setting provides an occupational health service to staff and addresses the issues of staff health and well-being.

31.2 A healthy positive work environment is created by management.

31.3 There is a documented complaints and grievances procedure in place for staff regarding matters related to their employment.

31.4 The management actively and effectively consults with staff, contractors and volunteers on workplace issues.
Legislation, supporting documents and accreditation links

**Legislation**

**Nursing Homes (Care and Welfare) Regulations (1993) Articles 8, 11 12 and 27**

8  

h) suitable and sufficient lighting and ventilation in rooms which are regularly occupied by dependent persons  
i) over bed lamps at each bed accessible to the person and permanent night lighting with dimming facilities  
j) emergency call facilities are provided at each bed  
k) suitable and sufficient heating of 65 degrees F (18 degrees C) in bedroom areas and 70 degrees F (21 degrees C) in day areas.

11.1 In every nursing home there shall be provided suitable and sufficient accommodation which meets the minimum standards as follows:  
a) adequate accommodation and space in single and shared sleeping rooms and portable screens or screening curtains to ensure privacy for individual persons;  
b) adequate day space for each person in an area separate from the circulation and sleeping areas and adequate dining and sitting space for mobile persons;  
c) doorways and corridors which allow for easy use of wheelchairs and walking aids and access ramps where appropriate  
d) a visitors reception area and adequate facilities for persons to receive visitors in private  
e) an office or station for staff and general use  
f) suitable and sufficient equipment and facilities having regards to the nature and extent of the dependency of the persons maintained in the nursing home  
g) bed and bedding appropriate to the dependency of each person and suitable and sufficient furniture and other necessary fittings and equipment

12 The registered proprietor and the person in charge of the nursing home shall;  
e) take precautions against risk of accidents to any dependent person in the nursing home and in the grounds of the nursing home;  
f) ensure that handrails are provided in circulation areas and that grab-rails are provided in bath, shower and toilet areas  
g) ensure that handrails are on both sides of stair cases except where a stairlife is provided;  
h) ensure that, where dependent persons are maintained on more than two floors and the health board so requires, a life is provided  
i) ensure that safe floor covering is provided

27.1 The registered person and the person-in-charge of the nursing home shall:  
a) take adequate precautions against the risk of fire, including the provision of adequate means of escape in the event of fire make adequate arrangements for detecting, containing and extinguishing fires, for giving of warnings and for the evacuation of all persons in the nursing home in the event of fire, and for the maintenance of fire fighting equipment.

**Supporting documentation**

- BS 8300:2001 “Design of buildings and their approaches to meet the needs of disabled people – Code of Practice”

- Dementia Services Information and Development Centre (2006) *Design*. Dublin: Dementia Services Information and Development Centre

- National Disability Authority (2002)*Buildings for everyone – Inclusion Access and Use*


- European Health Property Network ‘Accommodation for Care of the Elderly: Single Room Provision Across Europe’.

**Accreditation standards links** - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

EF 1.1; 1.2; 1.3; 1.4; 1.5; 2.5; 2.6; and LP 8.2;
7) CARE ENVIRONMENT

STANDARDS 32 to 36
This section sets out the broad principles for providing a care environment conducive to caring for older people requiring long stay residential care. The physical environment should match the needs of the residents. Such needs can vary considerably. Although the physical character of the residential care setting for older people will vary according to the needs of residents, there are certain standards of provision common to all residential care settings for older people which must be met such as a safe, clean and pleasant environment. There is an obligation on the part of the person-in-charge to meet and comply fully with all relevant statutory provisions (e.g. Planning Acts and Regulations, Building Regulations and HACCP Regulations etc.). The physical environment should be designed to be accessible to older people with disabilities. Issues to consider in this regard include: level access; provision of lifts and ramps; widths of doors; adequate space; grab rails and handrails; quality of lighting; call systems; signage; colour schemes; detailed design of furniture; fitting and finishes and facilities for those with hearing impairment.

The residents of long term care show a clear preference that regardless of the type of residential care setting, the environment should be ‘homely’ (Murphy et al., 2006). Fundamental characteristics which may be considered in order to provide a homely environment include, for example, lighting; ventilation; choice of materials; colours; textures; furnishing; access to gardens, space for the residents own furniture etc. The links between the style of residential care setting for older people, its philosophy of care and its size, design and layout are interwoven. Where special needs are catered for, the design and layout of the physical environment are crucial. People with dementia have particular needs for the layout of communal space and associated signage which aid their capacity (Dementia Services Information and Development Centre, 2006). Other older people, however, could find some of these features patronising. The onus will be on the person-in-charge to make clear which clientele their residential care settings are aimed at and to make sure the physical environment matches their requirements.

There have been huge advances in assistive living technology and the impact that this can have on caring for older people. Assistive technology is a generic term used to include assistive, adaptive and rehabilitative devices used to increase, maintain or improve an individual’s independence in activities of daily living. Assistive technologies include; mechanical, electronic, and microprocessor based equipment: This includes microcomputers, electronic communication devices and other sophisticated devices, non-mechanical and non-electronic aids. Examples include; a ramp to replace steps, walking sticks, walking aids, power wheelchairs, communication aids, adapted furniture and utensils used in the activities of daily living. It is likely that this technology will increasingly play a part in the care of older people and this should be considered in the development of services.

Some residential care settings for older people do not currently meet the standards set out below regarding space requirements and the provision of baths, showers and toilet facilities. It is a requirement of registration that by (date TBD) all residential care settings meet these standards.

STANDARD 32
Premises

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents live in a safe, pleasant, well-maintained environment with access to safe and comfortable indoor and outdoor communal facilities.</td>
</tr>
</tbody>
</table>
Legislation, supporting documents and accreditation links

Legislation


Supporting documentation
Dementia Services Information and Development Centre (2006) Design. Dublin: Dementia Services Information and Development Centre


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

EF 1.5;
32.1 Appropriate technology is used when it is in the interest of maintaining residents’ independence.

32.2 The location and layout of the residential care setting is suitable for its stated purpose; it is accessible, safe, hygienic, spacious and well-maintained; meets residents’ individual and collective needs in a comfortable and homely way and has been designed with reference to relevant guidance e.g. Dementia Services Information and Development Centre Guidelines etc.

32.3 A programme of routine maintenance and renewal of the fabric and decoration of the premises is produced and implemented and records maintained.

32.4 The building and contents are adequately insured and the person-in-charge is able to produce a valid insurance certificate.

32.5 There is outdoor space for all residents with seating, accessible to those in wheelchairs or who have other mobility problems. Grounds are kept safe, tidy, attractive and accessible to residents and designed to meet their needs including those with physical, sensory and cognitive impairments.

32.6 The building complies with the requirements of the local fire authority and the current building regulations and includes appropriately placed and clearly marked fire exits.

32.7 CCTV cameras can be installed in entrance and exit areas for security purposes but do not intrude on the daily lives of residents.

32.8 Where a timescale has been set for compliance with any standard relating to the physical environment of the residential care setting, a plan and programme for achieving compliance is produced and followed and records maintained.

32.9 Communal space is available which includes:
- rooms in which a variety of social, cultural and religious activities can take place; and residents can meet visitors in private;
- dining room(s) to cater for all residents;
- a sitting room;
- some residential care settings are exempt from the Public Health (Tobacco) Acts 2002, 2004 and may provide a small designated smoking area in line with Department of Health and Children guidance.

32.10 Lighting in communal rooms is domestic in character, sufficiently bright and positioned to facilitate reading and other activities.

32.11 Furnishings of communal rooms are domestic in character and of good quality, and suitable for the range of interests and activities preferred by residents.

32.12 The residential care setting provides; sitting, recreational and dining space (referred to collectively as communal space) apart from resident’s private accommodation and excluding corridors and entrance hall amounting to at least 4.1 sq metres for each resident.
**Legislation**

**Nursing homes (Care and Welfare) Regulations (1993) Article 15**

15. The registered person and the person-in-charge of the nursing home shall ensure that:

   a) there is sufficient supply of piped hot and cold water and that wash hand basins are provided in each bedroom.

   b) there is a sufficient number of toilets having regard to the number of dependent persons in the home and that a sufficient number of toilets are designed to provide access for dependent persons in wheelchairs, having regards to the number of persons using wheelchairs in the nursing home.

   c) a sufficient number of commodes is provided.

   d) there is a sufficient number of baths and showers having regards to the number of persons in the nursing home and that a sufficient number of assisted baths and showers are provided, having regards to the dependency of persons in the nursing home.

**Building Control Act (1990) Dublin: Stationery Office**


**Supporting documentation**

BS 8300:2001 ‘Design of buildings and their approaches to meet the needs of disabled people – Code of Practice’

Dementia Services Information and Development Centre (2006) Design. Dublin: Dementia Services Information and Development Centre


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

EF 1.5;
32.13 The heating, lighting, water supply and ventilation of residents’ accommodation meet the relevant environmental health and safety requirements and the needs of individual residents’ and rooms are individually and naturally ventilated with windows conforming to recognised standards.

32.14 In newly built residential care settings, extensions and all first time registrations, the height of the window enables the resident to see out when seated or in bed.

32.15 Rooms are centrally heated with pipe work and radiators guarded or guaranteed to have low temperature surfaces. Heating can be controlled in the resident’s own room.

32.16 Lighting in residents’ own accommodation is domestic in character, and includes table-level lamp lighting.

32.18 Emergency lighting is provided throughout the residential care setting.

32.19 Water is stored at a temperature of at least 60oC and distributed at 50oC minimum, to prevent risks from Legionella. To prevent risks from scalding, pre-set valves of a type unaffected by changes in water pressure and which have fail safe devices are fitted locally to provide water close to 43oC.

32.20 There are adequate storage facilities for equipment including hoists and power wheelchairs.

**STANDARD 33**

**Toilets and Washing Facilities**

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents have sufficient and suitable toilets and washing facilities.</td>
</tr>
</tbody>
</table>

33.1 Toilet, washing and bathing facilities are provided to meet the needs of residents. Each resident has a toilet within close proximity of his/her private accommodation and toilets are accessible, clearly marked and close to lounge and dining areas.

33.2 There is at least one toilet to every five residents (including en-suites) and one hand basin for each resident.

33.3 Pre-existing residential care settings provide at least 1 assisted bath (or assisted showers provided this meets residents needs) to 7 residents.

33.4 In all newly-built, new extensions and first time registrations there is a ratio of 1 assisted bath (or assisted shower provided this meets residents needs) to 7 residents. Where suitably adapted en-suite bathing/shower facilities are provided in residents’ rooms, these rooms can be excluded from this calculation. Communal bathrooms and shower rooms have a minimum area of 10 m² and toilets are a minimum of 4 m² and at least 2 m long (5.5m² for assisted use).

33.5 En-suite facilities (at minimum a toilet and hand-basin) are provided to all residents in all new building, extensions and all first time registrations from 2008.
Legislation, supporting documents and accreditation links

Legislation


Supporting documentation
Dementia Services Information and Development Centre (2006) Design. Dublin: Dementia Services Information and Development Centre


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

EF 1.4; 1.5;
CS 11.4
33.5 The installation of en-suite facilities is in addition to the minimum usable floor space standards in any resident’s room.

33.6 En-suite facilities in rooms accommodating residents using wheelchairs, power wheelchairs, hoists or other aid’s, are accessible to them.

33.7 Sluices are located separately from residents’ toilet and bathing facilities.

**STANDARD 34**  
**Individual Accommodation: Space Requirements**

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents own rooms suit their needs.</td>
<td></td>
</tr>
</tbody>
</table>

34.1 The residential care setting provides accommodation for each resident which meets minimum space as set out in standards 34.2 and 34.3

34.2 In all newly built residential care settings, extensions and first time registrations, all single rooms have a minimum of 13sq metres usable floor-space (excluding en-suite facilities).

34.3 Single rooms accommodating wheelchair users have at least 13sq metres usable floor space (excluding en-suite facilities).

34.4 Room dimensions and layout options ensure that there is space on either side of the bed, to enable access for carers and any equipment needed.

34.5 Where rooms are shared, they are occupied by no more than two residents who have made a positive choice to share with each other.

34.6 When a shared place becomes vacant, the remaining resident has the opportunity to choose not to share, by moving into a different room if necessary.

34.7 Rooms which are currently shared have at least 16sq metres of usable floor space (excluding en-suite facilities).

34.8 No more than 20% of the accommodation is provided in double bedrooms. Where existing care settings have rooms that are shared, no more than two residents occupy them and fixed screening is provided. Residents sharing double bedrooms are given the opportunity to move into a single room when one becomes available.
### Legislation, supporting documents and accreditation links

#### Legislation

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing Homes (Care and Welfare) Regulations (1993) Article 8</strong></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The registered person and person-in-charge of the nursing home shall ensure that:</td>
</tr>
<tr>
<td></td>
<td>a) provision is made for the safe keeping of the personal belongings of a dependent person and a record kept of valuables signed by the person or a person acting on his or her behalf</td>
</tr>
<tr>
<td></td>
<td>b) adequate space is provided for a reasonable number of personal possessions</td>
</tr>
</tbody>
</table>


#### Supporting documentation

- Dementia Services Information and Development Centre (2006) *Design*. Dublin: Dementia Services Information and Development Centre

#### Accreditation standards links
- Irish Health Service Accreditation Board (2005) *Residential and Non Acute Care Accreditation Scheme*
  - CS 5.2; 5.3; 6.4;
  - EF 1.1; 1.2; 1.3; 1.5; 2.1 -2.5;
STANDARD 35
Individual Accommodation: Furniture and Fittings

OUTCOME
Residents’ bedrooms are safe and comfortable with their own possessions around them.

35.1 The residential care setting for older people provides private accommodation for each resident which is furnished and equipped to assure comfort and privacy, and meets the assessed needs of the resident.

35.2 In the absence of residents’ own provision, furnishings for individual rooms are provided to the minimum as follows:
- a clean comfortable adjustable height bed, minimum 900mm wide, at a suitable, safe height for the resident, and bed linen;
- curtains or blinds;
- mirror;
- overhead, over-bed and bedside lighting;
- comfortable seating for two people;
- drawers and enclosed space for hanging clothes;
- at least 2 accessible double electric sockets;
- a table to sit at and a bed-side table;
- wash hand basin

35.3 Adjustable beds are provided for residents receiving nursing care.

35.4 The main floor coverings of the resident’s rooms should be easy to clean and meet the requirements of infection control policy.

35.5 Doors to residents’ private accommodation are fitted with locks suited to their capabilities and are accessible to staff in emergencies.

35.6 Residents are provided with keys unless their risk assessment suggests otherwise.

35.7 Each resident has lockable storage space for medication, money and valuables and is provided with the key which he or she can retain (unless the reason for not doing so is explained in the care plan).

35.8 Full fixed screening is provided in rooms with more than one occupant to ensure privacy for personal care.

STANDARD 36
Adaptations and Equipment

OUTCOME
Residents have the specialist staff and equipment they require to maximise their independence.
Legislation, supporting documents and accreditation links

Legislation

**Nursing Homes (Care and Welfare) Regulations (1993) Article 12**

12. The registered proprietor and the person in charge of the nursing home shall:

   b) ensure that handrails are provided in circulation areas and that grab-rails are provided in bath, shower and toilet areas

   c) ensure that handrails are on both sides of stair cases except where a stairlife is provided;

   d) ensure that, where dependent persons are maintained on more than two floors and the health board so requires, a life is provided


Supporting documentation

Dementia Services Information and Development Centre (2006) *Design*. Dublin: Dementia Services Information and Development Centre


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

CS 5.2; 5.3; 6.4;
EF 1.1; 1.2; 1.3; 1.5; 2.1 -2.5;
36.1 Where services such as physiotherapy and occupational therapy are provided within the residential care setting, appropriate accommodation is provided to house both the services and their equipment.

36.2 The person-in-charge demonstrates that an assessment of the premises and facilities has been made by suitably qualified persons, including a qualified occupational therapist, with specialist knowledge of the client groups catered for, and provides evidence that the recommended disability equipment has been secured or provided and environmental adaptations made to meet the needs of residents.

36.3 There are written guidelines for staff to ensure that specialist medical devices and equipment are provided to meet the needs of individual residents.

36.4 There is a written policy on the management of medical devices and equipment.

36.5 There is an identified person who has responsibility for medical devices and equipment management that includes staff training and safety assurance.

36.6 Medical devices and equipment that are designated for single use are not reused under any circumstances.

36.7 All medical devices and equipment are maintained in good condition and repair and are cleaned after each use.

36.8 Residents have access to all parts of residents’ communal and private space, through the provision of ramps and passenger lifts, where required to achieve this, or stair/chair lifts where they meet the assessed needs of residents and the requirements of health and safety legislation.

36.9 The residential care setting provides grab rails and other aids in corridors, bathrooms, toilets, communal rooms and where necessary in residents’ own accommodation.

36.10 Aids, hoists, wheelchairs and assisted toilets and baths are installed which are capable of meeting the assessed needs of residents and there is at least one hoist per floor or wing.

36.11 Doorways into communal areas, residents’ rooms, bathing and toilet facilities and other spaces to which wheelchair users, power wheelchair chair users and those requiring the use of hoists have access, are of sufficient width to allow wheelchair users adequate access. In all newly built residential care settings for older people, new extensions to existing care settings and first time registrations, doorways into areas to which wheelchair users have access have a clear opening of 850mm. There should be a minimum clear dimension of 300mm between the leading edge of the door and the nearest return wall or other obstruction.
Legislation, supporting documents and accreditation links

Legislation


Nursing Homes (Care and Welfare) (Amendment) Regulations, 1994 (S.I. 147),

Nursing Homes (Care and Welfare) Regulations (1993), Dublin: Stationery Office

Supporting documentation

BS 8300:2001 ‘Design of buildings and their approaches to meet the needs of disabled people – Code of Practice’


Dementia Services Information and Development Centre (2006) Design. Dublin: Dementia Services Information and Development Centre

36.12 Facilities, including communication aids (e.g. a loop system), and signs are provided to assist the needs of all residents, taking account of the needs, for example, of those with hearing impairment, visual impairment, dual sensory impairments, learning disabilities or dementia or other cognitive impairment, where necessary.

36.13 Storage areas are provided for aids and equipment, including wheelchairs, power wheelchairs and hoists.

36.14 Call systems with an accessible alarm facility are provided in every room and for every bed.

36.15 The person in charge is up to date with and facilitates the use of assistive living technology to maximise the independence of residents.
Legislation, supporting documents and accreditation links

Legislation

<table>
<thead>
<tr>
<th>Nursing Homes (Care and Welfare) Regulations (1993) Article 19, 27 and 28</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.1 In every nursing home the following particulars shall be kept in a safe place in respect of each dependent person:</td>
</tr>
<tr>
<td>g) a record of any accident or fall involving a dependent person</td>
</tr>
<tr>
<td>i) a record of any substantial complaint made by the dependent person or a person acting on his or her behalf and the outcome of the investigation.</td>
</tr>
<tr>
<td>27.1 The registered proprietor and the person-in-charge of the nursing home shall:</td>
</tr>
<tr>
<td>a) take adequate precautions against the risk of fire, including the provision of adequate means of escape in the event of a fire and make adequate arrangements for detecting, containing and extinguishing fires, for all giving of warnings and for the evacuation of all persons in the nursing home in the event of fire, and for the maintenance of fire fighting equipment;</td>
</tr>
<tr>
<td>b) make adequate arrangements to secure by means of fire drills and practices that the staff and so far as practicable, dependent persons in the nursing home, know the procedure to be followed in the case of fire;</td>
</tr>
<tr>
<td>c) take all reasonable measures to ensure that materials contained in bedding and the internal furnishings of the nursing home have adequate fire retardancy properties and have low levels of toxicity when on fire;</td>
</tr>
<tr>
<td>d) ensure that emergency lighting is provided in the home;</td>
</tr>
<tr>
<td>27.2 The registered proprietor shall:</td>
</tr>
<tr>
<td>i) supply to the health board with the application for registration of the nursing home, written confirmation from a competent person that the requirements of article 27.1(a),(b),(c) and (d) and articles 28.1 and 28.2 have been compiled with or</td>
</tr>
<tr>
<td>ii) where in the opinion of a competent person the home does not comply with the requirements of article 27.1(a),(b),(c) and (d) and articles 28.1 and 28.2, supply to the health board a written schedule prepared by a competent person of measures which would enable the home to comply with the provisions of the above articles by a date to be agreed by the health board.</td>
</tr>
<tr>
<td>27.3 A written confirmation provided in accordance with article 27.2(i) shall suffice on any subsequent registration of the nursing home, save where structural alterations to the home have been carried out, in which case, a new written confirmation in accordance with article 27.2(i) shall be produced to the health board.</td>
</tr>
<tr>
<td>28.1 In every nursing home there shall be kept in a safe place a record of:</td>
</tr>
<tr>
<td>a) all fire practices which take place at the home;</td>
</tr>
<tr>
<td>b) all fire alarm test carried out at the home together with the result of any such test and the action taken to remedy defects;</td>
</tr>
<tr>
<td>c) the number and type and maintenance record of fire fighting equipment</td>
</tr>
<tr>
<td>28.2 In every nursing home the procedure to be followed in the event of a fire shall be displayed in a prominent place in the nursing home.</td>
</tr>
</tbody>
</table>

Disabilities Act 2005


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

EF 3.1; 3.2; 3.3; 3.4; 3.5; 5.4; 5.5; 5.6; 6.2;
CS 10.7
LP 9.1 – 9.3;
8. HEALTH AND SAFETY

STANDARDS 37 to 38

This section deals with the health and safety of the residents, staff and visitors to the residential care setting for older people and how their health and safety can be maintained. In order to ensure the health and safety of residents, staff and visitors, the care setting must have comprehensive health and safety policies in place. These policies must cover all aspects of health and safety including; the environment; work practices; and equipment. Policies must be translated into the everyday practice in the care setting.

The person-in-charge must provide leadership to ensure quality care, resident safety and a safety culture. The person-in-charge must also ensure that all staff are trained, competent and confident in the management of safe working practices and in following procedures in the event of an emergency e.g. fire or accident. The promotion of healthy and safe working practices on fire safety, manual handling, first aid, and food hygiene are essential. The person-in-charge also has a responsibility to ensure that staff have access to the equipment and machinery needed to provide care safely at all times.

Hygiene and control of infection need to be addressed in both a written policy and the practices within the care setting.

STANDARD 37
Health and safety

<table>
<thead>
<tr>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health and safety of residents, staff and visitors to the residential care setting is promoted and protected.</td>
</tr>
</tbody>
</table>

37.1 There is a written policy and written procedures that comply with health and safety legislation for providing and maintaining:—

- A safe and healthy place of work with safe access to and egress from it;
- Working practices that are safe and without risk to health or welfare;
- A safe and healthy working environment; and
- Equipment.

37.2 The registered person promotes healthy and safe working practices through the provision of information, training by individuals or agencies with expertise in specific areas, supervision and monitoring of staff under the following broad headings:

- A safe and healthy working environment with safe systems of work;
- A safe place of work with safe access to it and egress from it;
- Fire safety;
- Infection control;
- Moving and handling;
- Falls management;
Legislation, supporting documents and accreditation links

Legislation
Disabilities Act, 2005

Food Safety Authority of Ireland Act, 1998


Supporting documentation

BS 5839-6:2004 Fire detection and fire alarm systems for buildings. Code of practice for the design, installation and maintenance of fire detection and fire alarm systems in dwellings

Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

EF 3.1; 3.2; 3.3; 3.4; 3.5; 5.4; 5.5; 5.6; 6.2;
CS 10.7
LP 9.1 – 9.3;
- First aid;
- Food hygiene;
- Maintenance of all equipment and machinery;
- Personal safety at work;
- Challenging behaviour.

37.3 There are arrangements in place to ensure the person-in-charge of the residential care setting, at any given time, receives relevant information to fulfil health and safety responsibilities.

37.4 Publicly displayed health and safety procedures are in formats that are easily understood and take account of the special communication needs of people using the building.

37.5 The registered person ensures that risk assessments are carried out for every area of work at least annually. The findings of the risk assessments are recorded and action taken to manage identified risks.

37.6 The registered person ensures that all significant events including accidents, injuries, dangerous occurrences, incidents of fire and illness or communicable disease are recorded individually and notified to the inspectors at the time. Where such an event involved a resident, the next of kin must be notified. This information is audited and feedback and education provided.

37.7 Staff are provided with appropriate protective clothing and equipment suitable for the job to prevent risk of harm or injury to themselves or others.

37.8 There is an up to date fire management plan that is revised and actioned when necessary and whenever the fire risk changes.

37.9 The physical fire precautions are maintained and checked in accordance with relevant legislation, manufacturers and installers guidance.

37.10 All staff on commencing employment and at least once every year thereafter undertake training in fire precautions to be taken or observed in the care setting, including the action to be taken in case of fire.

37.11 Owned and leased vehicles have been certified safe, insured for purpose and are only driven by staff with a full driving licence which entitles them to drive the particular vehicle.

**STANDARD 38**

Services: Hygiene and Control of Infection

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>The residential care setting is clean and hygienic.</td>
</tr>
</tbody>
</table>
Legislation, supporting documents and accreditation links

**Nursing Homes (Care and Welfare) Regulations (1993) Article 13, 14 and 15**

13. The registered person and the person-in-charge of nursing home staff shall:
   a) ensure that the nursing home and its cartilage is maintained in a proper state of repair and in a clean and hygienic condition:
   b) make adequate arrangements for the prevention of infection, infestation, toxic conditions, or spread of infection and infestation at the nursing home
   c) ensure that there are adequate arrangements for the laundering at regular intervals and as occasion may require, of linen, clothing and other articles belonging to or used by dependent persons maintained in the nursing home.
   d) Ensure that a separate well ventilated room is provided for sluicing and for the storage of dirty linen
   e) Maintain a high standards of hygiene in relation to the storage and preparation of food and the disposal of domestic refuse.

14. The registered proprietor and the person-in-charge of the nursing home shall:
   a) ensure that the nursing home and its cartilage is maintained in a proper state of repair and in a clean and hygienic condition
   b) make adequate arrangements for the prevention of infection, infestation, toxic conditions, or spread of infection and infestation at the nursing home
   c) ensure that there are adequate arrangements for the laundering at regular intervals, and as occasion may require, of linen, clothing and other articles belonging to or used by dependent persons maintained in the nursing home
   d) ensure that a separate well ventilated room is provided for sluicing and for the storage of dirty linen
   e) maintain a high standard of hygiene in relation to the storage and preparation of food and the disposal of domestic refuse

15. f) bed linen, disposable sheets and incontinence pads are changed as frequently as may be required for the comfort and well-being of the person;
   g) adequate arrangements are made for the proper disposal of swabs, soiled dressings, instruments, disposable syringes and sheets, incontinence pads and other similar substances and materials

Food Safety Authority of Ireland Act, 1998

Supporting documentation


Accreditation standards links - Irish Health Service Accreditation Board (2005) Residential and Non Acute Care Accreditation Scheme

EF 1.4; 4.1; 4.2; 4.4; 4.5; 4.6; 4.7; 6.2;
38.1 Responsibility for infection prevention and control is clearly defined and there are clear lines of accountability for infection prevention and control throughout the residential care setting.

38.2 There are written policies, procedures and guidelines on the infection prevention and control systems that are used by staff on a daily basis.

38.3 The premises are kept clean, hygienic and free from offensive odours throughout and systems are in place to prevent and control the spread of infection, in accordance with legislation and published professional guidance.

38.4 Staff receive education and regular updates (at least annually) on the risks of infection and their role in preventing and managing infection.

38.5 Alcohol rub and hand washing facilities must be prominently sited throughout the residential care setting (in each room and in all clinical areas). In particular, these must be available in areas where infected material and/or clinical waste are being handled.

38.6 Policies and procedures for control of infection include the safe handling and disposal of clinical waste, dealing with spillages, provision of protective clothing and hand washing. These also include policies on cleaning of equipment in order to prevent cross infection (e.g. cleaning commodes etc.)

38.7 Systems are in place for detecting and responding to an outbreak of infection.

38.8 The residential care setting has a sluicing facility and a sluicing disinfecter.

38.9 There is a staff changing room with shower facilities provided and lockers available to all staff.

38.10 All staff including those employed in the support services such as domestic workers, kitchen staff, porters etc., receive education and training in infection prevention and control that is commensurate with their work activities and responsibilities.

38.11 The laundry floor finishes are impermeable and these and wall finishes are cleanable. Laundry facilities are sited so that soiled articles, clothing and infected linen are not carried through areas where food is stored, prepared, cooked or eaten. There are separate areas for clean and dirty laundry and washing machines have the specified programming ability to meet disinfection standards. There is a linen storage area on each floor or wing depending on the design of the building.

38.12 The person-in-charge must ensure compliance with HACCP
### Appendix 1 - GLOSSARY

<table>
<thead>
<tr>
<th><strong>Activities of daily Living</strong></th>
<th>Activities of daily living are self-care activities that a person must perform every day, such as bathing, dressing, eating, getting in and out of bed or chair and moving around and using the toilet.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td>Collection and interpretation of data to determine an individual’s need for health, personal and social care and support services, undertaken with the individual, his/her relatives/representatives, and relevant professionals.</td>
</tr>
<tr>
<td><strong>Care Plan</strong></td>
<td>A plan, generated from an assessment where applicable, developed by the residential care setting for older people, with the resident and his or her relatives/representatives. The resident’s care plan should cover all aspects of health and personal care, and show how these will be met in terms of daily living and longer term outcomes.</td>
</tr>
<tr>
<td><strong>Complaint</strong></td>
<td>Expression of dissatisfaction with any aspect of a service.</td>
</tr>
<tr>
<td><strong>Contract</strong></td>
<td>Written agreement between the resident and the organisation providing care, setting out the terms and conditions and rights and responsibilities of both parties, and including the care plan.</td>
</tr>
<tr>
<td><strong>Contracted bed</strong></td>
<td>A person may be allocated a ‘contracted bed’ if it is considered that he/she is entitled to a health board long stay place but none is available. The health board pays more than the maximum level of subvention – usually the full cost as agreed with the nursing home.</td>
</tr>
<tr>
<td><strong>Older People</strong></td>
<td>A person aged 65 years or older.</td>
</tr>
<tr>
<td><strong>Person-in-charge</strong></td>
<td>A person who either: runs the residential care setting and is registered with the Office of the Chief Inspector/HSE to do so (the registered person); or manages the residential care setting for older people and is registered with the Office of the Chief Inspector /HSE to do so (the person-in-charge). In some cases the registered provider may also manage the residential care setting.</td>
</tr>
<tr>
<td><strong>Pre-existing residential care setting</strong></td>
<td>For the purposes of applying the standards a pre-existing residential care setting is one which existed immediately before 2007.</td>
</tr>
<tr>
<td><strong>Registered Person</strong></td>
<td>The person named on the Certificate of Registration.</td>
</tr>
<tr>
<td><strong>Representative</strong></td>
<td>A person acting on behalf of a resident, who may be a relative or friend</td>
</tr>
<tr>
<td><strong>Resident</strong></td>
<td>Person living in and provided with services by a residential care setting for older people.</td>
</tr>
</tbody>
</table>
Residential care setting  
Public, private and voluntary services providing some or all of the following for older people: long term care, respite, rehabilitation and convalescence. This will include elderly homes/hospitals, welfare homes, district/community hospitals; community nursing units; voluntary elderly care homes/hospitals, designated wards in acute hospitals and private nursing homes.

Respite care  
Respite care is a short-term care arrangement with the primary purpose of giving the resident and carer a short term break from their usual routine.

Service level agreement  
A contract between a provider of a service and the funding authority (HSE) that specifies the level of service that is expected during the term of the agreement.

Staff  
Person working for pay within or from the residential care setting for older people home, full time, part-time, casual or on contract.

Standard  
A measure by which quality is judged.

Therapy professions  
Includes; physiotherapists, occupational therapists, speech and language therapists, dieticians and chiropodists.

Usable Floor Space  
Space which is accessible to the resident for furniture, possessions and daily living, with attention to e.g. room shape, positioning of doors, windows or en-suite facilities, and headroom.

Volunteers  
People working without pay, or for expenses only, within or from the residential care setting for older people.
Appendix 2 – BIBLIOGRAPHY AND REFERENCES


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