Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Ailesbury Private Nursing Home
Centre ID:	0002
Centre Address:	58 Park Avenue Sandymount Dublin 4
Telephone number:	01-2692289
Fax number:	01-2604116
Email address:	Ailesbury@anh.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Robert Fagan
Person in charge:	Alison Woods
Date of inspection:	29 and 30 March 2011
Time inspection took place:	**Day-1 Start:** 08:40 hrs **Completion:** 17:30 hrs **Day-2 Start:** 09:00 hrs **Completion:** 15:30 hrs
Lead inspector:	Angela Ring
Support inspector:	Finbarr Colfer
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **Announced** ☐ **Unannounced**

About inspection

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

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

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

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

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

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

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

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

Registration inspections are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

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

About the centre

Description of services and premises

Ailesbury Private Nursing Home is a three-storey building with accommodation for 46 residents. There were 45 in residence on the day of inspection. All residents were over 65 years with general care needs and several residents had dementia related conditions.

Accommodation for residents is provided on three floors, with stair and lift access to the upper floors. The main entrance is through a conservatory which opens into a hallway. The hallway leads to the main sitting room, nurses' station, provider's office, two smaller sitting rooms, a split-level dining room, and kitchen.

Bedroom accommodation on the ground floor consists of three single bedrooms, two twin rooms, and two four-bedded rooms. Two single rooms have en suite toilet and wash-hand basins. On the first floor, bedroom accommodation consists of four single bedrooms and three twin bedrooms. Two of these bedrooms have en suite toilet facilities. On the second floor there are nine single bedrooms, one twin bedroom, two three-bedded rooms, and one bedroom with accommodation for four. Four of the single rooms have en-suite toilets and wash-hand basins. All bedrooms have wash-hand basins.

The first floor has a wheelchair-accessible toilet and no bathroom or shower and residents use the ground floor facilities. In total, there are nine additional assisted toilets and four assisted bathrooms over the three floors.

The conservatory on the ground floor looks out onto an attractive front garden which has a water feature and garden furniture.

Location

Ailesbury Private Nursing Home is located on Park Avenue which is close to Sandymount village on the south side of Dublin city. There are bus stops and Dart station nearby.

Date centre was first established:	9 October 1989
Number of residents on the date of inspection	45
Number of vacancies on the date of inspection	1

Dependency level of current residents	Max	High	Medium	Low
Number of residents	18	11	7	9

Management structure

Ailesbury Nursing Home is a family run centre. Robert Fagan is the named provider on behalf of the family and together with his brother, James Fagan, the Senior Administrator and Alison Woods, they manage the centre. The owners are Robert Fagan Senior and Ursula Fagan. They also own Ashbury Nursing Home, which is located in Blackrock Co. Dublin. Alison Woods is the Person in Charge for both centres. Nursing and care staff report to the Person in Charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	4	10	3	3	0	3*

* There was an activities coordinator, bus driver and maintenance personnel also on duty on the day of inspection. There were three administration staff working of-site on the day of inspection.

Summary of findings from this inspection

This was an announced registration inspection and the second to be carried out by the Health Information and Quality Authority (the Authority). As part of the registration process, the provider and person in charge have to satisfy the Chief Inspector that they are fit persons and that will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Inspectors carried out fit person interviews with the person in charge and the provider and the fit person self assessment document was completed in advance of this visit. All of this information was reviewed by inspectors, in addition to the information provided in the registration application form and supporting documents. Inspectors met with residents and relatives and reviewed documentation as part of the inspection process.

Inspectors followed up on the areas for improvements that were identified in the previous inspection report and found that they were adequately addressed in most cases.

Inspectors found that the provider, administrator and person in charge were fully committed to providing high quality care to residents. They were aware of their legal responsibilities and were keen to comply with the Standards and Regulations. Inspectors found them to be transparent, approachable and very proactive and responsive to areas identified for improvement.

Inspectors found that improvements had been made since completing the fit person entry programme self assessment. The person in charge and her team had initiated an increased training programme for staff and care plans were being further developed.

In summary, inspectors found that this centre was safe and well run, residents' healthcare needs were met and there were interesting things for residents to do during the day.

Comments by residents and relatives

Inspectors received nine questionnaires prior to inspection and spoke to residents and relatives during the inspection. All of the comments were positive and complimentary about the care provided at the centre. All of the residents and their relatives spoke highly of the governance of the centre and of quality of the service.

Residents and relatives agreed that there were adequate staff on duty at all times and that staff were courteous and respectful.

All agreed that the food was of a very high standard and that personal preferences were well catered for. Residents agreed that there was enough to do during the day and they enjoyed the many trips in the minibus.

Relatives said they were kept well informed of their family member's condition, and were always made feel welcome. They all agreed that the centre was safe, clean and well maintained.

Two relatives told inspectors that they were made to feel part of the family in Ailesbury Nursing Home and they enjoyed their visits.

Overall findings

1. Governance: how well the centre is organised

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

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

Evidence of good practice

The provider and person in charge work full-time and they demonstrated good leadership skills and were good role models for staff. They had a good understanding of their responsibilities as outlined in the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2009 (as amended) and *National Quality Standards for Residential Care Settings for Older People in Ireland*. The provider and person in charge completed the fit person entry programme to a high standard and identified goals for further improvements in areas such as communication and staff appraisals.

The person in charge is responsible for the two centres owned by the family. These centres are approximately 7 km apart and the person in charge spends time in both centres. Inspectors found that there were good governance structures in place to ensure that this centre was well managed at all times. There were two assistant directors of nursing (ADONs) who deputised in the absence of person in charge. There was a senior person on call in the evenings and at weekends. Inspectors met with both ADONs and found that they were good managers and had very good knowledge of residents needs.

Inspectors found that the person in charge was committed to continuous quality improvement. Inspectors reviewed monthly audits completed on falls, incidents, use of catheters, infections, prevalence of pressure sores and use of restraint. The person in charge explained to inspectors that she used this information to determine trends and to highlight areas for improvement which were implemented.

Inspectors reviewed the policy for managing residents' finances and spoke to the provider. There were small sums of residents' money stored in a safe, with comprehensive records maintained to provide a clear audit trail of each resident's finances. There were two signatures for each transaction and there was a policy in place for managing residents' finances and possessions.

The provider assured inspectors that there was a contingency budget in place for unforeseen circumstances that required significant expenditure.

Inspectors found that the statement of purpose and Residents' Guide were available to the residents. They clearly outlined the ethos of care, detailed the services provided and complied with the requirements in the Regulations. Inspectors found that the service provided reflected the Statement of Purpose.

Inspectors noted that the contract of care complied with the Regulations and detailed the additional fees to be paid by residents. There was an up-to-date insurance certificate. Inspectors reviewed the register of residents and found that it was updated to meet the requirements of the Regulations.

There was a comprehensive, centre-specific emergency plan in place with details of evacuation procedures. Staff spoken to were aware of the emergency plan which was displayed in a prominent position.

Inspectors reviewed the recent incidents and accidents which were recorded on a pre-determined template. There was adequate detail of the incident, the outcome of each incident for the resident, follow up by the doctor where necessary and notification of the residents next of kin.

Inspectors found that the procedures in place for preventing, detecting and responding to fire were satisfactory. The staff were aware of the procedures to follow in the event of fire and said they attended regular fire drills. There were records to indicate that all of the staff had attended recent training on fire prevention and procedures. There were records to indicate that there were recent checks of fire alarms, fire equipment and lighting. Inspectors reviewed written confirmation from a suitably competent person that all requirements of the statutory fire authority were complied with.

Inspectors viewed the complaints log and found that it contained a small number of minor complaints, all of which were addressed in a timely and satisfactory manner by the person in charge. The complaints policy complied with the requirements in the Regulations and it was displayed in a prominent place. The provider and person in charge told inspectors that they welcomed complaints and comments from residents and saw them as opportunities for learning and service development. There was an independent appeals process in place and the only improvement to be made was the inclusion of the contact details of the independent appeals process in the displayed complaints procedure and Statement of Purpose. This was completed a short time after the inspection.

Inspectors found that staff had good knowledge of the procedures to follow in the case of suspected elder abuse. There were records to indicate they had all attended training and there was a centre-specific policy in place. The person in charge was aware of the procedure to follow in the case of investigating suspected elder abuse.

Some improvements required

Improvements were required in falls management. There were evidence of measures being taken to prevent falls such as bed and chair sensor alarms and medication reviews. However, there were a small number of residents who fell frequently and there was no formal system in place for a multidisciplinary review of these residents to identify the root cause and implement measures to prevent falls from reoccurring.

The safety statement, which included the risk management policy, addressed most of the regulatory requirements but did not contain the procedures to follow in the event of risks associated with assault, aggression and violence and self-harm. Inspectors found that the safety statement identified most of the environmental and clinical risks in the centre. However, inspectors identified additional potential risks which were not included in the safety statement, such as the steps between the two dining areas and a kettle which was accessible to residents. This was brought to the attention of the provider and administrator and inspectors found that measures had been taken to reduce the risks associated with these issues and the safety statement had been amended.

2. Quality of the service

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

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

Evidence of good practice

Inspectors found that there was an unhurried pace and relaxed atmosphere during the day. Residents told inspectors that there was flexibility in the daily routine and they could decide when to get up and go to bed. They also told inspectors that staff were aware of their need for privacy and knocked on their bedroom doors and waited for a response prior to opening the door. Inspectors observed this to be the case. They found that the staff demonstrated a good knowledge and understanding of each resident's preferences. All of the staff spoken to said they enjoyed their work and believed that there was a high quality of care provided to the residents.

Residents' civil rights were up held and spiritual needs met. Residents told inspectors that mass took place every week and there was also a Church of Ireland service each week. The person in charge explained that voting was facilitated for residents at the centre for each election and transport was provided for residents who wished to vote in their own constituency.

There was a schedule of activities on offer each day and inspectors met with an activity coordinator who was deputising in the absence of the activity manager. Inspectors observed her providing one-to-one activities to the more dependent residents and to those who do not wish to engage in group sessions. There were numerous group activities for residents such as music, exercises, flower arranging, movies, pet therapy, complementary therapy, hand massage, newspaper readings and SONAS (a therapeutic activity focussed on communication). Residents told inspectors there was plenty to do during the day and they were not bored.

There were some examples of residents continuing to maintain contacts with their community. Inspectors noted that the centre had a wheelchair accessible minibus which was used to transport residents on outings, several residents told inspectors that they frequently went out to the seaside, to concerts and to the theatre. Residents were seen going into the local town for errands and out with family members.

Inspectors visited the kitchen and spoke with the chefs who demonstrated a good awareness of each resident's dietary needs and preferences. Inspectors found that they took great pride in providing a high quality dining experience to residents and operated a very well run kitchen with varied menus. Inspectors reviewed records that showed the catering staff had received training in food hygiene to ensure that best practice was adhered to when serving food to residents.

While residents were given some opportunities to be consulted with and participate in the running of the centre, inspectors found that there further development of the consultation process would enhance the culture of care at the centre. The provider and person in charge agreed that arrangements would be put in place to address this.

Some improvements required

Inspectors had lunch with residents in the main dining room. Staff provided discreet, respectful assistance to residents who required it and there was a good choice of food available. Inspectors found that residents requiring a soft diet had their meal served attractively. The food was freshly cooked, hot and nutritious and special diets were available as required. The tables were nicely set in all dining rooms and there was a friendly atmosphere during mealtimes. However, inspectors found that the layout of the dining area was too small for all residents to sit comfortably. Some residents had to reposition their chairs to allow another resident to pass by. Inspectors identified an area of risk where residents had to negotiate a small number of steps to gain access to the lower level of the dining area. Inspectors saw a small number of residents with poor mobility using these steps and this constituted a potential falls hazard. When this issue was highlighted to the provider, inspectors were satisfied that this risk had already been identified as they had consulted an architect and work was due to commence the following week.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

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

Evidence of good practice

Overall, inspectors found that residents' health needs were met. All residents were over 65 years and some had dementia related conditions.

Inspectors found that there was good links maintained with the general practitioner (GP) practices in the local area. A review of the residents' medical files showed that residents were reviewed every three months by their GP and more often when necessary. The residents told inspectors that the staff contacted the doctor when necessary and they were satisfied that their healthcare needs were met.

Inspectors noted that residents' health was well monitored as their weight, blood pressure and pulse rate were recorded monthly. The person in charge told inspectors that there were no residents with pressure ulcers, wounds or feeding tubes on the day of inspection. Inspectors found that residents had access to physiotherapy as a group session once a week and privately if required. There was written evidence of referral to chiropody, dietician and dentist where necessary.

Inspectors found that there were no residents receiving end-of-life care on the days of inspection. However, they reviewed the procedures and facilities in place for end-of-life care for residents. There was a centre-specific policy on end-of-life care and the person in charge explained that she completed a short course on end-of-life care and they had access to the local palliative care team when necessary.

The medication policy was reviewed by inspectors who found that it contained the procedures for prescribing, administering, recording and storing of medication. The prescription and administration records were clear and updated to record the most recent administration of medication. Inspectors observed a nurse during the medication round and observed her practice in administration. They found that it complied with best practice as she identified and assessed the resident, checked the prescription, explained what each tablet was to the resident and gained their consent, waited while the resident swallowed the medication, and then signed the medication as administered. Inspectors looked at the controlled drugs register and found that that the stocks were checked at the end of each shift.

Some improvements required

There was an electronic system of care planning in place. Inspectors reviewed a sample of care plans and found that there was a comprehensive pre-admission assessment completed on all residents requiring long-term care to assess their needs and determine if the centre could meet their needs. There was then a comprehensive assessment carried out on each resident on admission and a three-monthly assessment was done following admission. Risk assessments were completed on the risk of developing pressures ulcers, prevention of falls, risk of developing pressure ulcers and malnutrition. The daily narrative notes for each resident were detailed and descriptive and related to the problems identified in the care plans. However, improvements were still required in the following areas:

- there was little evidence of the residents taking an active part in the care planning process
- care plans did not contain an adequate amount of information on the resident's preferred daily routine and interests
- some care plans had generic information and were not person-centred to the individual resident.

Inspectors found that there were a number of residents using bed rails and lap belts. There was a comprehensive restraint policy to guide staff. Inspectors reviewed records which indicated that residents were assessed by the nursing staff prior to the use of restraint. There was evidence of alternatives to restraint being explored such as using chair and bed sensors to alert staff of a resident's movement. However, there was little evidence of the resident giving informed consent for the use of restraint. There was also evidence of lap belts being used unnecessarily such as with residents who also had a chair alarm in place and residents who were being assisted to eat by a staff member.

There was a comprehensive policy in place on behaviours that challenge and staff had received training on responding to residents' needs in this regard. However, inspectors found that improvements were required in the documentation of triggers, behaviours and the alleviating factors in order to identify patterns and triggers and to put a plan in place to address them. Interventions described in documentation and by staff tended to be on medical treatment, psychiatric referral and medication as oppose to non-pharmacological interventions such as diversion. The person in charge informed inspectors that she had identified this as an area for improvement and further training was booked for staff in April 2011.

4. Premises and equipment: appropriateness and adequacy

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

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

Evidence of good practice

The centre was clean and well maintained throughout. Inspectors found that the centre was homely and domestic in nature. There were three sitting rooms on the ground floor, all of which were used by residents.

Inspectors found there was an adequate amount of equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. Inspectors reviewed records of servicing to electric beds, hoists and lifts. There was a maintenance book at reception to record any items which required repair and evidence that issues were promptly addressed by the three maintenance staff employed. There were an adequate number of assisted bathrooms and toilets to meet residents' needs.

Inspectors found that the disposal of waste was well-managed and clinical waste and soiled laundry was placed in separate bins for safety and hygiene purposes. There were hand gels, gloves and aprons available to staff to use for infection control purposes. Inspectors met with a cleaner who explained the procedures he followed to ensure that a high standard of cleanliness was maintained. Inspectors observed that all cleaning chemicals were locked in a press at all times.

There was a small staff locker room. Inspectors found that although the laundry was small, it was clean, well ventilated, well organised and had industrial sized machines. There was adequate room for storage and segregation of soiled clothing. Inspectors spoke with a staff member who works full-time in the laundry, she explained the procedures she follows to ensure that clothing is laundered appropriately and returned to residents. Residents told inspectors that their clothes were well cared for.

Some improvements required

Inspectors found that the signage for people with dementia was inadequate. However, the provider told inspectors that he was currently researching best practice in relation to this issue to help orientate people with dementia and there were plans in place to address the issue.

Although the multi-occupancy rooms complied with the minimum space requirements in the Standards, inspectors visited some bedrooms with residents' permission and found that some of the multi-occupancy rooms had limited space to allow residents to personalise their bed sleeping area. One resident expressed dissatisfaction with the amount of space she had and at having to share with other residents and a staff member stated that the limited space made it difficult to use equipment. This was brought to the attention of the provider who had met with architects and had provisional plans to reconfigure the home and build an extension over the coming years to reduce the number of residents in multi-occupancy rooms.

While improvements had been made in creating additional storage space, it was still inadequate as commodes, hoists and specialised wheelchairs were seen stored in residents' bedrooms, corridors and communal areas.

Inspectors were informed by the person in charge that a resident had a confirmed case of an infectious disease which required isolation. Inspectors spoke with staff who demonstrated a good awareness of the procedures to follow in infection control and there were adequate amounts of hand gels, gloves and aprons available to staff to use for infection control purposes. There was evidence of staff attending infection control training. Inspectors reviewed the infection control policy which stated that residents with infectious disease should be isolated. However, the centre was unable to adhere to its own policy as there was no contingency plan in place so that a resident could be isolated when necessary and the when the resident was being cared for in a multi-occupancy room. The person in charge was aware of this issue and assured inspectors that measures would be taken to isolate residents in future outbreaks in so far as possible within the constraints of the environment.

There was no secure accessible outdoor space for residents. This issue was identified at the previous inspection and measures had been taken to address the issue such as fencing in the garden. However, inspectors found that it had not been satisfactorily addressed and residents could not independently access a secure outdoor space for fresh air and exercise.

5. Communication: information provided to residents, relatives and staff

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

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

Evidence of good practice

Inspectors found that there were was an effective communication system in place. Staff said they were kept informed of all aspects of the running of the centre and of any changes that occurred. Inspectors observed the staff communicating effectively with residents with dementia and residents with communication problems.

There was an independent advocacy service available to residents and a group of residents and relatives met each month to discuss issues around living in the home and to identify potential improvements in the quality of life for residents. Inspectors reviewed the minutes of these meetings and found that residents spoke openly and freely. Inspectors found that suggestions and comments were followed up by the assistant director of nursing and necessary changes occurred if required from these meetings.

There were suggestion boxes available at reception and specially designed comment cards so that residents, staff and relatives could make comments in private if they wished. The person in charge carried out food satisfaction surveys with residents and relatives to identify areas for improvement. There were several notice boards with information on the activity schedule, fire and complaints procedures and infection control procedures.

Inspectors found that records were stored in a secure cupboard in the office to ensure confidentiality. There was a sign in book at reception which kept a record of all visitors.

Inspectors found that the policies and procedures were centre specific, updated and comprehensive. There were records to indicate that staff had read and understood each policy. Staff were aware of the policies and told inspectors that they referred to them for guidance when necessary.

Residents told inspectors that they had access to telephones and newspapers, and inspectors saw newspapers and other reading material were readily available to residents. There was a mobile telephone to allow residents to make a call in private if

they wished. There were orientation boards in the communal areas for residents with details of the day, date and a brief weather update.

Inspectors reviewed records of monthly staff meetings which were displayed in a booklet format and was readily available to staff. There was evidence of discussion of privacy and dignity and infection control. There were additional meetings related to staffing issues and staff were represented by two members of staff. The provider told inspectors that these meetings helped to ensure that effective communication systems were in place.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs.

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

Evidence of good practice

Inspectors found that there were adequate numbers of staff on duty to care for residents. Call bells were answered promptly and residents said they were never left waiting for long periods when they required assistance. There was a good skill-mix of staff with at least three nurses on duty each day. The staff explained that they attended a morning report and this informed their plan of work for the day. All staff agreed that there were adequate staff on duty at all times. Staff spoken to said they enjoyed their work and had been given several opportunities for further training and development.

The person in charge and provider explained to inspectors that staffing levels were determined by assessing the dependency levels of residents and additional staff were rostered each shift to allow for potential absenteeism. There was a very low rate of staff turnover.

Inspectors reviewed the recruitment policy which addressed all of the procedures to be followed in recruitment and induction of staff. The person in charge explained to inspectors that there was an induction programme for nursing and care staff where each member of staff received an induction folder and was allocated a mentor who was responsible for ensuring that the new employee had received all relevant information. The induction programme consisted of staff having to complete a verbal test of the centres policies and procedures. Others issues covered on induction were residents' privacy and dignity, infection control, personal care, assisting residents to eat, and competency based skills such as bed bathing, assisting with toileting, hand washing and oral care.

Staff were observed using good manual handling techniques with residents and there were records to indicate that they received training in safe moving and handling.

Inspectors saw evidence that the person in charge was implementing a formal staff appraisal system where staff members' goals and training needs could be identified.

Inspectors found that there was a strong culture of staff training and further education in the centre. Inspectors found that several care staff had completed

Further Education Training Awards Council (FETAC) Level 5 training which gave them skills and knowledge to provide high quality, evidenced based care to residents and some other care staff were commencing the course in September 2011. The provider, administrator, person in charge and assistant directors of nursing completed a FETAC Level 6 course in management and the person in charge was commencing a post graduate course in gerontological nursing in September 2011.

There were records to indicate that staff received training in manual handling, prevention, detection and response to elder abuse and fire prevention and detection. Inspectors found that staff had also received training on issues such as best practice in infection control, behaviours that challenge and medication management.

The person in charge told inspectors that dementia care was one of the main areas of interest and focus for staff development in the year ahead. As a result she had arranged for some staff to commence a training course in dementia care to allow them to complete more specialised assessment of residents and to meet their needs in a more person centred manner.

There were records of nurses' registration with their professional body.

Some improvements required

Inspectors reviewed a sample of staff files and found that newly recruited staff members had all of the required documentation. Garda Síochána clearance had been applied for each staff member, some were still outstanding. The inspector reviewed some files of staff that had been working in the centre for over ten years. The provider told inspectors that verbal references were sought on recruitment a number of years ago but no written references. There were no references for a number of staff who had been working in the centre for a number of years. However, the provider explained the difficulties associated with retrospectively gaining references for staff who were working in the centre for a number of years and there was some evidence of attempts being made to get this information retrospectively. There were self declarations of medical fitness in staff files. However, there was no evidence that it was impractical for the provider to obtain this information from a suitably qualified person.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, administrator and person in charge to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Angela Ring

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

1 April 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
4 August 2010	☐ Registration ☒ Scheduled ☐ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report*

Centre:	Ailesbury Private Nursing Home
Centre ID:	0002
Date of inspection:	29 and 30 March 2011
Date of response:	5 May 2011

Requirements

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

1. The provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not meet with the requirements in the Regulations. All actual and potential identified risks were not addressed in the risk management policy. There were inadequate arrangements in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events such as falls.
Action required: Develop a comprehensive risk management policy that complies with the requirements in the Regulations.

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

Action required: Put arrangements in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events such as falls.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We immediately contacted our risk management company and had the additional risks added to our safety statement. A falls awareness programme has commenced, with a named nominated staff member responsible for coordinating a programme of falls awareness among staff, residents and family members, with all staff signed up on a programme of education relating to specifically to falls.	 Completed Ongoing

2. The person in charge is failing to comply with a regulatory requirement in the following respect: All residents' individual needs were not recorded in an individual care plan developed and agreed with the resident.	
Action required: Set out residents' needs in an individual care plan developed and agreed with the resident.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The care plans will be reviewed accordingly with a renewed focus on the psychosocial aspects of care along with the nursing/medical perspective.	 Three months

3. The provider is failing to comply with a regulatory requirement in the following respect: Staff files did not have all of the documents as required in Schedule 4 of the Regulations.	
Action required: Put a plan in place to obtain all records as listed under Schedule 4 of the Regulations.	
Reference: Health Act, 2007 Regulation 18: Recruitment Regulation 22: Maintenance of Records Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As per page 20 of our report, all staff where possible have the required documentation. It is only the staff who have been with us for a number of years that are missing references in some cases. We carried out a very lengthy exercise to obtain documentation for all staff and we have tried to contact previous employers but this has proved to be next to impossible due to the number of years that have passed. We will endeavour to try again to obtain theses references. In relation to the medical declarations we feel we have met the requirements outlined in Schedule 2.10 of the Health Act, 2007. This states the "Evidence that the person is physically and mentally fit for the purposes of the work that they are to perform at the designated centre or, where it is impracticable for the person to obtain such evidence, a declaration signed by the person that they are so fit." We feel that we have fully complied with this as we have obtained declarations from all staff members that they are fit for work. We feel it would be a very timely and costly exercise to complete a full medical for every staff member. We have however requested all staff to obtain a declaration from their own GP on their next visit.	Ongoing

4. The provider is failing to comply with a regulatory requirement in the following respect: There was no plan in place for isolating residents with infectious disease. Residents could not independently access a secure outdoor space for fresh air and exercise. There was inadequate storage for assistive equipment such as hoists.
Action required: Ensure that the physical design and layout of the premises meets the needs of each resident.
Action required: Put a plan in place to provide appropriately maintained external grounds, suitable for and safe for use by residents.
Action required: Provide adequate storage for assistive equipment such as hoists.
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have amended our contract of care to allow us to isolate a resident with an infectious disease in a single room in extreme circumstances. As per our inspection in August 2010, the inspector asked us to install a secure fence around our garden, which we did. As explained to the inspectors during our inspection, we installed the fence and we feel that we exceed the requirements below. Residents have access to the garden at anytime (with assistance if required) and it is utilized by residents and families regularly.	 Completed Ongoing

We feel there would be a safety risk created if all residents had the freedom to leave the nursing home unattended. For example, if a mobile resident with dementia opened a door to enter the garden unassisted they could easily fall, slip on ice, go out in the rain etc. We are responsible for or residents care and welfare at all times. **Regulation 19** *"external grounds which are suitable for, and safe for use by, residents are provided and appropriately maintained"* **Standard 25** *"Set out below are the minimum facilities to be provided in existing residential care settings[3].* *(3) These criteria apply to existing designated centres including existing designated centres seeking re-registration after change of ownership. The six-year timeframe, applicable to existing designated centres, commences on the implementation of the Standards.* *The existing residential care setting provides, where possible, a safe outdoor space with seating, accessible to all residents, including residents with mobility impairments and those using wheelchairs. The grounds are kept safe, tidy and attractive. In residential care settings that accommodate people with dementia, there is a secure perimeter. Where outdoor space is not available, the resident has access to a programme of outdoor activities."*	
We plan to convert the existing office into an equipment store and convert a bedroom on the ground floor into an office. As discussed with the inspector additional facilities will be provided in our refurbishment.	Ongoing

Recommendations

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

Standard	Best practice recommendations
Standard 25: Physical Environment	Review the layout of the multi-occupancy room to ensure the space is maximised to meet residents' needs.
Standard 2: Consultation and Participation	Continue to provide opportunities for residents to be consulted with and participate in the running of the home.
Standard 25: Physical Environment	Implement a plan to ensure the signage is dementia friendly.
Standard 21: Responding to Behaviour that is Challenging	Put a plan in place to demonstrate that residents are giving informed consent for the use of restraint. Ensure that all restraints are used appropriately.

Any comments the provider may wish to make:

Provider's response:

The Registered Provider, the Person in Charge, Management, the Fagan family and the staff of Ailesbury Nursing Home would like to thank the inspection team for ensuring that our inspection was a pleasant and enjoyable experience.

As per the recommendations mentioned above, we are currently working on renovation plans and we are aware of our requirements within the six-year time frame. We are undertaking to acquire more dementia friendly signage and will be providing more opportunities for residents to be consulted with and participate in the running of the home.

We feel the process of preparing for the inspection and the volume of paperwork involved is onerous and excessive and distracts from the day to day running of the nursing home.

Furthermore, we respectfully request that Department of Health and Children review the requirements in relation to references from previous employers. It proved impossible for the Proprietors, who has been self-employed for forty years to obtain references from previous employers. This was also the case for a number of staff whom have been with us in excess of ten years. Perhaps a cut off point should be considered.

Finally, we welcome the arrival of the Authority and the Standards. However, whilst the Authority are committed to improving and maintaining high standards of care throughout the nursing home sector as are we, we feel that it is an immoral situation that the National Treatment Purchase Fund (NTPF) on behalf of the HSE, as purchaser, are driving the standards and quality of care down. They are of the view that the cheapest price tag is what should dictate care provision in residential care settings. Pricing, lack of awareness and a lack of interest in patient care and a lack of interest in services being offered by nursing homes are the driving factors in agreeing the lowest rate achievable. In the interest of preventing another cause for investigation into care of the elderly in residential settings, we feel there should be a more pro-active approach between all parties involved in providing, maintaining and purchasing care for the vulnerable of our society.

We would once again like to thank the inspectors for the professionalism and courtesy shown to all the staff, residents and families in Ailesbury Nursing Home on the days of the inspection and we look forward to working with the Authority again in the future.

Provider's name: Robert Fagan
Date: 13 May 2011