

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:	Ashbury Nursing Home	
Centre ID:	0007	
Centre Address	1A Kill Lane	
	Kill O The Grange	
	Blackrock	
	Co. Dublin	
Telephone number:	01-2841266	
Fax number:	01-2892722	
Email address:	info@anh.ie	
Type of centre:	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public	
Registered provider:	Robert Fagan	
Person in charge:	Alison Woods	
Date of inspection:	7 and 8 September 2010	
Time inspection took place:	7 Sept Start: 10:00 hrs Completion: 18:15 hrs 8 Sept Start: 09:00 hrs Completion: 17:35 hrs	
Lead inspector:	Marian Delaney Hynes	
Support inspector:	Sheila Doyle	
Type of inspection:	<input checked="" type="checkbox"/> Registration <input type="checkbox"/> Scheduled <input checked="" type="checkbox"/> Announced <input type="checkbox"/> 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.the Authority.ie.

About the centre

Description of services and premises

Ashbury Nursing Home is a four-storey residence which has been both a convent and a nursing home in the past. The Fagan family purchased and re-established Ashbury as a nursing home in 2001. The centre has accommodation for 78 residents and there were 75 in residence on the day of inspection, one resident was in hospital. All residents were over 65 years with general care needs with the exception of one resident with a physical disability, many residents had dementia.

The premises are divided into two parts the "main house" and "the Grange wing", there is a link corridor interconnecting the two buildings.

The Grange wing has two storeys with 25 single rooms, 12 on the ground floor and 13 on the first floor. None of the rooms have en suite facilities but the provider has submitted a planning application to provide these facilities in future. There is a passenger lift between floors. There are three assisted toilets and an assisted shower on the ground floor. Additional accommodation in the Grange wing includes a spacious sitting room with a dining room off it and this leads into an attractive enclosed garden. There is a large oratory off the link corridor.

The main house is a four-storey building, with a lift to all floors. The first floor has a reception area, two sitting rooms, a dining area, a nurses' station and treatment room. There is a laundry and sluice room facility on the ground floor and additional sluice room facility in the Grange wing.

Bedroom accommodation is on the remaining three floors. On the lower ground floor there are four single rooms, three of which have en suite shower facilities and three twin rooms one of which has an en suite shower. There are a further two three-bedded rooms one with en suite shower facilities. There are three assisted toilets and an assisted shower and bath on this floor.

The first floor accommodates five single rooms with en suite shower facilities, one twin room and one four-bedded room without en suite. There are an additional four assisted toilets and two assisted showers.

On the second floor there are seven single rooms six have en suite showers, four twin rooms, two with en suite showers, one three-bedded room and two four-bedded rooms one with en suite shower facilities. There are a further two assisted toilets and an assisted shower and bath on this floor.

Location

Ashbury nursing home is located on Kill Lane, Kill O' The Grange close to the villages of Deansgrange and Blackrock, County Dublin.

Date centre was first established:	2001
Number of residents on the date of inspection	75 + 1 in hospital
Number of vacancies on the date of inspection	2

Dependency level of current residents	Max	High	Medium	Low
Number of residents	31	23	10	12

Management structure

Ashbury Nursing Home is one of two centres owned and run by the Fagan family. The Provider is Robert Fagan Jnr. Alison Woods is the Person in Charge and she reports to the Provider. The two Assistant Directors of Nursing, nurses, care managers (who supervise the care assistants) and care assistants report to the Person in Charge while the household and kitchen staff report to the Provider.

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	6	19	5	4 Household 1 Laundry	4	1 Provider 3 Activity Coordinators 3 Maintenance

Summary of findings from this inspection

This was an announced registration inspection, and the first inspection by the Health Information and Quality Authority (the Authority). The provider had applied for registration under the Health Act, 2007 and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 (as amended).

As part of the registration process, the provider and person in charge have to satisfy the Chief Inspector of Social Services that they are fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). This registration inspection took place over two days.

The provider had submitted an application to be registered for people over 55 years of age. Discussions were held with the provider about the category of care applied for, he confirmed that there was a rigorous pre-assessment carried out prior to admission and that residents were only admitted if their needs could be met and this was reflected in the statement of purpose.

The fit person self-assessment had been completed by the provider and the person in charge in advance of the inspection. During the inspection separate fit person interviews were carried out with the provider and the person in charge. Inspectors reviewed all of the information provided in the registration application form and supporting documents. The person in charge and provider had identified a number of areas where improvements had been made. These included providing staff with additional time to complete documentation, the establishment of exit interviews as an HR process and providing all staff with copies of all policies. Areas identified for further development included developing residents' life stories and provision of activities suitable for people with dementia.

Inspectors met with residents, relatives and staff members. They also met with the provider, person in charge, administrator and the accountant who managed residents' finances. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident and complaints logs, policies and staff files.

While areas for improvement were identified, the inspectors found that the provider and person in charge met the majority of the requirements of the Regulations and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. They had established strong management processes to ensure the delivery of services to residents in a consistent and safe manner.

Residents had access to general practitioner (GP) services and to a range of peripatetic services. Care was seen to be provided in a consistent manner through continuous reviews of residents and updating of care plans. There were arrangements in place to meet the specific needs of people with dementia. Some of the staff had received training in caring for people with dementia although further specialist training was required.

Residents' choices were respected and there were a range of activities for them to do.

The premises were homely and comfortable and an adequate amount of communal space was available to residents.

Whilst the provider and person in charge promoted the safety of residents and had a risk management process in place for all areas of the centre, some improvements were required to include the assessment of residents who required bed rails, provision of mandatory training including the prevention of elder abuse, moving and handling and fire safety.

There were six multi-occupancy bedrooms which will need to be modified in order to meet the Standards by 2015. Other areas for improvement included the documentation and investigation of all complaints and the provision of notice to the Chief Inspector of the occurrence of notifiable incidents.

All areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Comments by residents and relatives

Inspectors received ten completed relative questionnaires prior to the inspection. Most of the responses were positive. Relatives described the staff as being friendly, kind, helpful and approachable. Inspectors spoke to many residents and one relative on the days of inspection.

Residents were generally very positive about their experiences of daily life. Some commented on the range of social events and activities available - they described what they liked to do during the day such as reading, gentle exercise, music, massage, flower arranging and attending movies. Residents commented favourably on the hairdressing service and said that they looked forward to having their hair done. They also spoke enthusiastically about the many recent outings that they had enjoyed including trips to the zoo, the theatre and shopping.

Residents were satisfied with meals, choices of food, portion sizes and presentation. They stated that the food was always good and that they could have an alternative dish if they did not like what was on the menu.

Relatives and residents spoke highly of the admission process. They described how the person in charge met with them prior to admission, either in the acute hospital or in their own home and invited them to visit the centre to ensure that they were satisfied. One relative said that she was given a lot of time to make her decision and described the process as being helpful and reassuring.

Residents said that they felt they could complain if necessary. Most identified the person in charge as the person whom they would approach.

A relative commented "The staff are wonderfully kind, patient, and friendly, they respect my mother and her ways, this is a lovely home".

Relatives described the building as being very clean and comfortable, they said that they could visit whenever they wanted and were always made to feel welcome. They stated that there was plenty of staff on duty and that they were always attentive. A small number of residents said that the smoking area could be enhanced. One resident described it as being very cold at times. This issue was followed up during the inspection.

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 the person in charge demonstrated their knowledge of the Regulations and Standards. The person in charge and the staff engaged fully in the inspection process and the person in charge was available at all times during the inspection. The person in charge was suitably qualified, competent and experienced to manage the residential care setting and meet its stated purpose, aims and objectives.

The provider had developed a statement of purpose which met all of the requirements of the Regulations. Information included the organisational structure, fire precautions and associated emergency procedures and the criteria for admission. There was a clear management structure in place and the centre was well organised. There was sufficient staff on duty to meet the needs of residents and both the assistant directors of nursing deputised in the absence of the person in charge.

Inspectors held separate fit person interviews with the provider and the person in charge. The provider was knowledgeable about his legal responsibilities. He stated that there were financial arrangements in place to respond to any unforeseen event such as replacing used or damaged equipment. He told inspectors that he had a "hands on" approach, for example, he attended all staff meetings and read the minutes of residents' meetings to ensure that all items were fully addressed. He was clear about his role, stating he had overall responsibility for the welfare of all residents, staff and relatives alongside provision of all required services for individual residents.

During her interview, the person in charge was able to tell inspectors about her legal obligations. She provided thorough answers to all questions and demonstrated competence, insight and commitment to delivering good quality care to residents and highlighted the importance of open communication with residents and staff. She told the inspectors that she had recently introduced an appraisal system to identify staff members' strengths and weaknesses and used the opportunity for staff development. The person in charge stressed the need to carry out a thorough pre admission assessment to ensure that individual residents' needs could be met.

Inspectors reviewed rotas and found that there was a good balance of nurses and care assistants allocated each day. Residents, relatives and staff confirmed that there were sufficient staff on duty at all times. The person in charge and provider informed inspectors that she had increased the compliment of staff on day and night duty from four to five care assistants to address unforeseen circumstances for example, if a resident became ill and required escort to hospital. All shifts were adequately covered and there were arrangements in place to address staff absences - these were generally covered from within the existing staff compliment which meant that agency staff were not required.

All of the policies and procedures required in the Regulations were in place, staff were familiar with them and they informed practice. Policies were signed and dated by the person in charge, and included dates for review. Copies of the policies and procedures were kept in the nurses' station. Copies of the Standards were available and staff had discussed them at team meetings.

Health and safety and risk management was a priority for the person in charge and provider. There was a safety committee in place which was made up of the provider, person in charge, the safety representative and representative members from all grades of staff. The committee met on a quarterly basis. Inspectors read the minutes of the last meeting which was held on 3 August 2010. Topics discussed included:

- first aid boxes
- location of beds for residents who had Methycillin-Resistant *Staphylococcus Aureus* (MRSA)
- electrical hazards in a bedroom due to over loading of sockets
- re-programming of the fire panel.

The provider had developed risk management policies to promote the safety of residents, staff and visitors. The safety statement had been developed with the assistance of an external agency and had been adapted for the specific needs of the centre. Policies were available to address specific safety measures identified in the Regulations including procedures to be followed should a resident go missing. Health and safety training was ongoing, staff were knowledgeable on safety issues and the inspector noted that the next staff training was scheduled for October 2010.

Residents stated that they always felt safe and could speak to the person in charge or any member of staff should they have concerns. Recruitment practices included Garda Síochána vetting which safeguarded residents. Inspectors saw that closed circuit televisions (CCTV) cameras had been installed at entrances and exits to safeguard against intruders and minimise risks to the residents.

Inspectors reviewed the policy on accidents and incidents and read the reports. The policy provided clear guidelines to staff on what to do in the event of an accident or incident. All events were recorded in detail, and included an account of the action taken and the outcome. Records were signed and dated by the person witnessing the event and by the person in charge when she had reviewed the record.

The provider had fire precautions in place which included regular fire training for staff and a twice weekly fire drill. Inspectors reviewed the records and noted that a

significant number of staff had attended a fire training programme. The most recent training was in August 2010. Inspectors also viewed a log of the twice daily checks of fire exits and call bells and noted that they were checked and signed each day by a designated staff member. The fire alarm was checked twice weekly, as were the automatic door releases. Fire equipment and fire alarms were serviced by an external contractor and the most recent service was June 2010. The fire equipment, emergency lighting, and lift including the chair lift were also serviced in June 2010.

There was an emergency plan and a fire evacuation plan in place. The evacuation plan contained alternative accommodation arrangements for residents should it not be possible to re-enter the building following evacuation.

The person in charge demonstrated a strong commitment to continuous improvement and development of the service. She had carried out audits on medication management in conjunction with the pharmacist in order to improve and safeguard practice. Other audits recently carried out included:

- infection control
- use of restraint
- pressure ulcer care
- elder abuse
- falls
- provision of personal and intimate care

The person in charge told the inspector that it was necessary to carry out such audits in order to inform learning and improve practices.

The inspector saw that residents' finances were well managed by the person in charge. Practices were deemed to be safe and transparent. There were signed records and receipts of possessions including money, which were handed over and withdrawn.

The provider had ensured that the provider had valid insurance cover and that the directory of residents was up-to-date. These documents were viewed by inspectors.

All residents had been provided with a contract of care which specified the terms and conditions of their admission. The inspector observed that contracts had been signed either by the resident or a family member. Copies of these contracts were maintained on file in the provider's office.

Significant improvements required

Inspectors saw the detailed complaints policy, which was prominently displayed and guided practice. Residents, relatives and staff who spoke with inspectors knew the procedure to follow if they wished to make a complaint. The person in charge saw complaints as a mechanism to inform service improvements. The inspector read the complaints log and saw that complaints were comprehensively logged. The log recorded the name of the complainant, the nature of the complaint, the outcome of its investigation and the complainant's level of satisfaction. Although most complaints were logged, inspectors interviewed one resident who had made multiple complaints

which had not been logged. The person in charge, assistant director of nursing and the provider were aware of the complaints.

However, inspectors were concerned that all staff had not completed mandatory training. Records showed that of the 92 staff employed 66 had completed prevention of elder abuse training and 81 had completed moving and handling training and 75 had completed fire training. The inspector noted that three of the staff who had not completed this training were working together on night duty which posed a serious safety risk to residents. Although safe moving and handling practices and hoist transfers were observed in most cases, on one occasion inspectors saw two staff members carrying out a full body lift on a resident in order to reposition him in his chair for his lunch.

A prevention of elder abuse policy had been developed which stated that "the welfare and protection of the resident will be of paramount importance", but a number of staff had not received training in the prevention of elder abuse. Staff who were spoken to were knowledgeable in relation to the detection and protocols for dealing with abuse. Furthermore, the provider failed to notify the Chief Inspector in relation to an allegation of abuse of a resident within the period specified by the Regulations.

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

Staff were attentive to the privacy and dignity of residents. Inspectors saw staff knocking on bedroom doors and waiting for a response before entering. Staff were aware of the importance of speaking to residents in a respectful manner, and were heard calling residents by their preferred name. Staff told inspectors that they asked residents on admission how they wished to be addressed.

Residents' civil, political and religious rights were respected. They told inspectors that the frequency of religious services had been increased at their request and a resident confirmed that he was afforded the opportunity to vote at elections. Residents were well dressed and many had their clothes accessorised with jewellery and scarves. Residents told inspectors that they choose the clothes they want to wear each day and that staff assisted them when asked.

Staff provided residents with choice in many aspects of their lives. Residents told inspectors that they could choose the time to get up and go to bed. Although breakfast was served in the residents' rooms, they confirmed that they were satisfied with this arrangement. They said that they could choose to have breakfast in the dining room if they wished. Residents said that they were able to avail of a shower or bath at a time that suited them. They told inspectors that staff provided them with assistance them if they needed it.

Inspectors saw residents being offered a variety of snacks and drinks throughout the day. Residents told inspectors that they could have tea or coffee and snacks any time they asked for them. Drinking water was available in sitting rooms, and jugs of water were provided in each bedroom. Staff and residents confirmed that nutritious drinks and snacks were available outside of regular mealtimes both day and night.

Residents dined in two separate dining areas and there were two sittings in the main house. The tables were carefully set with fresh tablecloths, tablemats, napkins, glasses, crockery and cutlery. Inspectors observed many residents enjoying the social experience associated with meal times. Residents chatted to each other and the staff during the meal. Sauces and gravy were added at the discretion of the residents.

Staff assisted dependent residents with their meal - they sat beside residents and offered assistance in a discreet and sensitive manner. The inspector observed a staff member in the Grange wing explaining to a resident with cognitive impairment what was for lunch. This staff member assisted the resident in an unhurried manner and chatted to her making the most of the opportunity to spend individual time with the resident.

Some residents had their meat minced and those who required pureed meals were provided with an attractive meal. Moulds were used to shape the pureed chicken, peas and potatoes to resemble normal portions of chicken breast, peas and potatoes.

The menu was clearly displayed, some residents knew what was for lunch and all confirmed that the food was "very good". There was a variety of home cooked food available including cakes, scones and desserts such as cheese cake and a fresh fruit salad was available each day. Inspectors sampled the food and found it to be of high quality.

The chef had gathered information from residents and nurses about residents' meal preferences and dietary needs. Family members of residents with cognitive behaviour informed nursing staff of their dietary likes and dislikes. The chef showed inspectors a new menu cycle that had developed.

Inspectors saw that residents enjoyed a variety of activities during the day. There were four activity coordinators employed, on a full and part-time basis. The activity schedule covered seven days and was posted at the entrance area and in the day rooms, activities included:

- passive exercises
- reminiscence quiz
- flower arranging and crafts
- music and sing along
- baking
- fit for life programme
- movies
- birthday celebrations for residents
- aromatherapy

Interests and hobbies were documented by the activity coordinators and informed activities provision. Residents with cognitive impairment who could not participate in activities which required concentration enjoyed aromatherapy, hand massage and Sonas (a sensory communication programme). They were also provided with small jig saw puzzles and card games.

Complementary therapies were offered on a weekly basis at no additional cost.

Hairdressing services were provided twice a week and residents said that they looked forward to the hairdresser's visit. One resident said "I look forward to getting my hair done each week it makes me feel good".

Emphasis was placed on ensuring that residents kept in touch with events within their community and beyond. Some residents told inspectors of the numerous outings that they had enjoyed and were encouraged to come up with suggestions for new ones. Residents said that they had enjoyed visits to the zoo, musicals, plays, museums and art galleries.

The environment was stimulating and there were plenty of newspapers, books and magazines for residents' use. The television in the communal areas were turned on when residents wanted to view specific programmes. All bedrooms were equipped with satellite television and telephone. There were laptops available for residents use. A resident told inspectors that she could email her daughter whenever she wanted.

Residents had access to an external smoking area. Some residents had complained that this area was cold. The provider responded to this by providing an overhead heating system and on the day of inspection, the provider was also in the process of having a shelter built for residents' comfort and to protect against the elements. Residents told the inspector that they welcomed this development.

Minor issues to be addressed

Independent dining was not encouraged by staff on some occasions. Inspectors noted that residents who were independent were provided with their bread buttered at tea time. The person in charge said that she would address this immediately.

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

There was a robust pre admission process in place. The person in charge visited the resident prior to admission either in their own home or in hospital to carry out a preliminary assessment. In instances where a resident had been admitted from an acute hospital, she received information about their stay which included current medication, multi-disciplinary team reviews and follow-up care. She also met with the family and invited them to visit the nursing home. This was followed by a comprehensive nursing assessment following admission.

All residents had a care plan which was maintained on both electronic and hard copy format. Care planning processes used evidence based, recognised assessment tools to promote health and address health issues. These included assessments for risk of falls, pressure ulcers, continence management, nutrition and mental health. This was not an exhaustive list. Care plans were developed with the resident's involvement or in the case of a resident with cognitive impairment with his/her family or representative. A relative told inspectors that she was fully aware of her relative's care plan - she had been consulted with and kept up-to-date by the staff in relation to changes in the care plan of the resident.

Medical services were appropriate. Many residents had retained their own general practitioner (GP). Where this was not possible, the person in charge arranged for a local GP to be provided. Out-of-hours GP coverage was provided by Dub Doc. The person in charge told the inspector that GPs routinely visited on a weekly basis or more frequently if required. Medical records viewed by the inspector, confirmed this. Residents confirmed that they were satisfied with the medical care provided. The inspector read medical notes and saw that GPs reviewed medications every three months or more frequently as required. Comments were recorded about each medication and any alterations to the prescriptions appropriately.

Peripatetic services were available to residents. Referrals to psychiatry of later life services were made by the GP. Residents had access to domiciliary dental and ophthalmic services which were organised by the nursing home. Inspectors noted that residents had their name printed on the inside of the frames of their glasses to prevent them from being mislaid. Physiotherapy and occupational therapy (OT) services were provided on a referral basis at an additional cost to the resident.

Records showed that the chiropodist visited monthly and provided foot care to residents.

Inspectors observed that continence was promoted by ongoing assessment, care planning and in the following ways:

- staff encouraged the resident to use the toilet on a regular and appropriate basis
- residents who were prone to incontinence wore clothing that was easy to open and remove
- toilet facilities were accessible in all areas of the building
- staff said that there was always appropriate absorbent continence wear provided.

There was a policy on falls management which guided practice. Inspectors reviewed the records of a recent falls audit which identified the rate as being within the average range. All had been recorded and appropriate action taken, for example vital signs were monitored and the GP and family were contacted. Each resident had a falls assessment which was reviewed following a fall to reduce the risk of recurrence. As a result interventions to minimise risk had been implemented such as provision of hip protectors where appropriate. Other residents had sensors fitted in their rooms to alert staff to sudden movement. One resident had a seating assessment carried out by an occupational therapist to ensure her safety.

Residents' weights were checked each month or more regularly if required. Nutrition and hydration assessments were used to develop care plans for residents who had been identified as being at risk.

There was a policy on the management of behaviours that challenge. However, the person in charge and provider said that they do not admit residents whose behaviour is potentially disruptive to other residents and this was identified through the pre-admissions assessment.

There was a comprehensive medication management policy in place which covered all aspects of medication management. The inspector observed a nurse administering medications and observed that safe and correct procedures were followed. Medications which required extra safety procedures were correctly stored in a secure cabinet and checked at the change of each shift. Nurses maintained a register of controlled drugs and a separate stock sheet. Two nurses signed and dated the register and the stock sheets.

There were no incidents of pressure ulcers at the time of inspection. Most nurses had received training in wound management and the nursing staff said that they had access to wound care specialists if required.

There was a policy on end of life care which supported practice. The person in charge told inspectors that hospice care services were available locally and provided the necessary support to the resident, relatives and staff. The assistant director of nursing told the inspector that residents were fully supported to live out their life in the centre and were only transferred to hospital should it be medically determined. The person in charge told inspectors that relatives had been accommodated to stay

with their seriously ill or dying relative. Inspectors read some of the thank you cards from relatives of former residents who expressed their gratitude to the staff for their support and kindness.

Significant improvements required

There was a policy on restraint, however, some residents did not have comprehensive documentation to support the use of lap belts. Two of these residents were in recliner chairs. There was no record to show what alternatives had been used. Staff informed inspectors that a number of residents had bed rails applied at night time. However, there was no documentation in the care plans for their use.

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

There was a good standard of décor throughout the building and an attractive, well utilized enclosed garden to the front. The colour scheme and furnishings were comfortable, coordinated and appropriate. Residents and relatives told the inspectors that they found the premises homely and comfortable. The three sitting rooms in the main building were domestic in size and had period features. The sitting room in the Grange wing was large but had been divided and the chairs positioned to give it a more homely feel. Apart from the sitting rooms there was additional seating on corridors and at the reception area so that residents could sit and chat to fellow residents and visitors.

The building was well maintained both internally and externally. The provider had a plan for the ongoing upgrading and refurbishment of the building. There was also ongoing daily maintenance provided by three maintenance staff. Staff recorded items that required replacing in the maintenance book. The provider and administrator also walked through the building on a daily basis and checked it for maintenance and upgrading requirements. Records and discussions with staff showed that issues were addressed adequately and promptly.

Inspectors found the building to be comfortable, welcoming and attractively decorated with pictures and photographs of residents' outings. There were fresh flowers arrangements throughout the centre, some of which had been done by the residents. The temperature of the building was adequate in bedroom and communal areas.

Corridors were fitted with grab rails throughout. Forty one residents had single rooms - some had en suite toilet and shower facilities but most did not. However the provider was in the process of addressing this and had submitted a proposed plan to the Authority. There were eight twin rooms and six multi-occupancy rooms. The twin rooms had en suite shower and toilet facilities. Some of the multi-occupancy rooms did not. The provider had supplied residents with lockable storage space for valuables.

A high standard of cleanliness was evident throughout the premises. Cleaning schedules and cleaning checklists lists were reviewed by the inspectors. Inspectors interviewed the household staff who understood their role in relation to infection control and ensured that due attention was given to the privacy and dignity of residents while they carried out their duties. They knew how to minimise the risk of infection and how to use and store cleaning chemicals and disinfectants safely when not in use. Adequate staff changing and rest facilities were on the ground floor. Both residents and relatives commented on the cleanliness and decor of the centre.

The laundry service was adequate and a new clothes labelling system had been introduced to reduce the loss of clothing. Residents and relatives said they were satisfied with the laundry service. The laundering of bed linen and towels was outsourced to external contractors. The inspector interviewed the staff member working in the laundry and saw that clean and soiled clothing were segregated.

An inspector met with the chef and viewed the kitchen, which was clean and well maintained. There were ample supplies of meat, fresh fruit, vegetables and dry foods in stock. A variety of snacks such as yoghurts and fresh fruit were available to residents as required.

There was sufficient assistive and other equipment in evidence to meet residents' needs. There were enough hoists available for dependent residents to be transferred safely. Inspectors read the servicing and maintenance records which confirmed that the equipment was well maintained and serviced regularly.

Inspectors observed that staff employed good infection control practices such as hand washing and used protective gloves and aprons as appropriately. Systems for the disposal of domestic and clinical waste management were adequate. Household waste was collected on a weekly basis. Clinical waste was stored in a locked clinical waste bin which was collected and disposed of at the request of the provider.

The centre had its own wheelchair accessible minibus. The provider said that the bus was used by the two centres for transporting residents on day trips and to take residents out to appointments where relatives were unavailable.

Some improvements required

There were six multi-occupancy bedrooms which will need to be modified in order to meet the Standards by 2015.

There was limited storage space for assistive equipment including wheelchairs. Inspectors observed that this equipment was stored in bathroom and toilet areas which limited accessibility for residents.

The corridor on the basement floor was partially obstructed with food trolleys for long periods of time which meant that the residents could not reach the grab rails. The provider said that he would address this matter immediately.

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

There was a newly developed Residents' Guide. It was user friendly and described the facilities and services, as required by legislation. The person in charge said that copies would be made available to residents. Inspectors saw there were leaflets available throughout the building with information about various support services and local events that might be of interest to residents.

The communication policy guided staff in communication with residents especially those who had difficulty communicating, including those with dementia. Staff were able to tell inspectors about these guidelines and inspectors observed staff taking the time to reassure residents with dementia, speaking slowly, using short sentences, and allowing sufficient time to ensure that the resident understood what was being said to them. Communication problems were addressed in the care plans in an individualised manner. For example, one care plan suggested maintaining regular routines so as to minimise confusion and assist communication.

A resident who had speech difficulties had been provided with a light writer which is a communication aid to assist her to communicate with others.

The person in charge had arrangements in place for communication between staff members. There were handover meetings at each change of shift which were attended by nurses and care assistants. These meetings were always held in a confidential manner. Staff members shared information on residents for whom they had responsibility. This information was passed on at each change of shift to ensure continuity of care.

Relatives who completed questionnaires prior to the inspection commented that the staff were always available to respond to their queries. A relative informed inspectors that she always felt welcome and said that she was kept up-to-date with her family member's condition. She said that she could phone day or night and that the staff were always courteous and provided her with the required information. Inspectors observed a good level of communication between staff and relatives during the day and relatives were heard addressing staff by their first name.

Information about activities was posted on notice boards in common areas. Newspapers were available to residents, and each resident had a telephone in their bedroom. There was a hands free phone available to residents when they were away from their rooms. Some residents had personal mobile phones. One resident told inspectors that she felt very independent because she had her own phone. She described the importance of being able to have daily and immediate contact with her son when she felt like a chat.

The person in charge and provider actively sought feedback from residents, relatives and staff. The inspector saw comments, complaints and suggestion forms placed prominently throughout the centre. The person in charge said that although the opportunity was available, people preferred to make a complaint or suggestions verbally. The complaints policy was on also on display.

The person in charge was available to residents, relatives and staff all of whom confirmed that she was very approachable and identified her or one of the nursing staff as the people they could speak to if they had a problem. Residents knew the person in charge and the provider by first name. The person in charge, provider and administrator told inspectors that they felt it was essential to meet with and speak with all residents on a daily basis - this was confirmed by residents, relatives and staff.

There was a residents' forum in place. Meetings were chaired by an advocate who was also the hairdresser. Minutes of these meetings were recorded. The provider read the minutes following each meeting and ensured that all issues raised were discussed and acted upon. The relatives of residents who had cognitive impairment attended the meetings. Meetings were held on a regular basis and minutes were made available to residents who were not in attendance.

The person in charge held staff meetings every six to eight weeks. Inspectors read the minutes and were satisfied that the issues raised were addressed and relevant feedback given. Recent topics included storage of equipment, specialised seating and safety issues. Inspectors spoke with staff who confirmed that these meetings took place. The staff also said that they were satisfied with the outcomes of any issue they had raised. They said that they felt well supported by the senior managers.

All staff wore name badges which displayed their full name and grade. Many residents knew staff by name. Inspectors observed that staff members were pleasant and respectful in their interactions with residents. Staff said that they enjoyed working with the residents and described it as a source of job satisfaction.

Inspectors found that all documentation including care plans, residents' files, staff files, training records and financial files were kept in a secure area. Some of this information was stored either at unit level, in the person in charge's office or in the administration office.

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 were satisfied that there was sufficient staff on duty to meet the needs of the residents. The person in charge used a recognised dependency tool to inform decisions about staffing. Existing staff provided cover for staff absences and agency staff were not required. Inspectors found that the staff were enthusiastic, interested, motivated and committed to delivering a good standard of care and improving the quality of life to all residents. Staffing levels were flexible and were adjusted to meet the changing needs of residents.

There was evidence that comprehensive training was provided on such areas as medication management, infection control, health and safety, venepuncture, food hygiene and use of a nutritional screening tool such as the Malnutrition Universal Screening Tool (MUST). The person in charge also showed inspectors the staff appraisal system recently introduced to identify staff education and training needs on an ongoing basis. Records confirmed that a number of care assistants had been trained to FETAC (Further Education and Training Awards Council) Level 5. The person in charge and training records confirmed that this training was ongoing and was provided on an annual basis.

Some of the staff had worked in the centre for a number of years. They were knowledgeable about residents, had established a good relationship with them and inspectors saw them responding to their needs in an informed way. Staff were clear about their roles and responsibilities and were able to explain these to inspectors.

There was an induction policy in place and staff induction records were maintained in the provider's office. New staff confirmed that they were satisfied with the induction process and confirmed that they were given an opportunity to work alongside more experienced staff for a number of shifts until the person in charge declared them competent.

Some improvements required

Four staff files were reviewed and inspectors found that some did not contain all the required documents such as three written references and curriculum vitae, as set out in Schedule 2 of the Regulations and as required by the centre's policy. The provider said it had been difficult to obtain references for staff that had been recruited from abroad due to communication difficulties.

Closing the visit

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

Marian Delaney Hynes

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

13 September 2010

Provider's response to inspection report

Centre:	Ashbury Nursing Home
Centre ID:	0007
Date of inspection:	7 and 8 September 2010
Date of response:	2 November 2010

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 person in charge has failed to comply with a regulatory requirement in the following respect:

Some staff had received no education on the protection of vulnerable adults.

Some staff had not completed moving and handling training.

Some staff had received no training in fire safety.

Action required:

Make all the necessary arrangements by training staff or by other measures which are aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Action required:

Make the necessary arrangements to ensure that all staff are suitably and sufficiently trained in moving and handling techniques.

Action required:	
Make the necessary arrangements to ensure that all staff are suitably and sufficiently trained fire safety.	
Reference:	
Health Act 2007 Regulation 6: General Welfare and Protection Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>As explained to the inspectors, we were in the process of amalgamating our staff training records between Ailesbury and Ashbury as mandatory training takes place in both centres.</p> <p>Since the inspection and as we have always done, we have been providing the mandatory training for staff.</p> <p>Of the 92 staff employed in Ashbury, 27 of these are non nursing staff. After the inspection we commenced the mandatory training for all staff, for any training they had not undertaken including administration, maintenance staff etc. Also a number of new staff had just commenced employment with us.</p>	Within three months/ongoing

2. The person in charge has failed to comply with a regulatory requirement in the following respect:	
The person in charge failed to notify the Chief Inspector of a notifiable incident.	
Action required:	
Give notice to the Chief Inspector without delay of the occurrence in the centre of notifiable incidences as outlined in the Regulations.	
Reference:	
Health Act, 2007 Regulation 36: Notification of Incidents Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	Timescale:

<p>Provider's response:</p> <p>The Chief Inspector was notified within five days of the incident. The incident has been fully investigated and thorough corrective action has been taken.</p>	Complete
---	----------

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

Some complaints were not recorded and investigated in accordance with the Regulations. The complainant was not informed of the outcome of the complaint or if the complainant was satisfied or not with the outcome.

Action required:

Ensure that all complaints are appropriately documented and investigated and that the complainant is informed of the outcome of the complaint and maintain a record of whether or not he/she was satisfied as set out in the Regulations 2009.

Reference:

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

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

<p>Provider's response:</p> <p>The complainant was encouraged on each occasion to make his complaint "formal" but declined to do so.</p> <p>Management and the complainant have always been in close communication and have worked together to resolve any issues. Since the inspection management have been documenting every issue / comment that arises with this particular resident.</p>	Complete/ ongoing
---	----------------------

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

Staff files did not contain references and the work history of some staff members.

Action required:

Obtain in respect of all staff the information and documents specified in Schedule 2 of the Regulations.

Reference: Health Act, 2007 Regulation 18: Recruitment Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Whilst we do our utmost to obtain all the documentation required under Schedule 2, for new and existing staff members, it is sometimes impossible to obtain this documentation, as in some cases it often is a first job and in other cases previous employers are not contactable. All staff have completed a medical and Garda Síochána clearance waiver as it takes up to seven months to obtain the official clearance from an Garda Síochána.	Ongoing

5. The person in charge has failed to comply with a regulatory requirement in the following respect: Staff did not consistently adhere to the operational policy in the management of restraint. The inspector saw a small number of residents with lap belt restraint. There was no assessment of the safe use of restraint record of the reasons for using the restraint. There was no record to show what alternatives had been used.
Action required: Set out each resident's needs in an individual care plan, including a full assessment and consideration of all ways of managing risks to residents.
Action required: Maintain records of any occasion on which restraint is used, the nature of the restraint and its duration.
Reference: Health Act, 2007 Regulation 25: Medical Records Regulation 8: Assessment and Care Plan Standard 21: Responding to Behaviour that is Challenging

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Immediately after the inspection, we commenced redesigning our current restraint policy including all of its supporting documents. This will include comprehensive restraint care plans and documented alternatives for the use of restraints and restraint release time logging system.</p>	6 months

<p>6. The provider has failed to comply with a regulatory requirement in the following respect:</p> <p>There was a lack of adequate storage space for storing residents' assistive equipment and wheelchairs.</p>
<p>Action required:</p> <p>Provide suitable storage facilities in the centre.</p>
<p>Reference:</p> <p>Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment</p>

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>As discussed with the inspectors, renovation plans have been submitted to the Authority which include additional storage facilities.</p>	By 2015

<p>7. The provider has failed to comply with a regulatory requirement in the following respect:</p> <p>Trolleys and cleaning equipment were stored on the corridor for long periods of time which impinged on the safety of residents.</p>
<p>Action required:</p> <p>Provide suitable storage of equipment within the centre.</p>

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: As soon as the provider was informed of this issue it was resolved with immediate effect. A handrail was also put in place immediately on the other side of the corridor to prevent safety being impinged in the future.	Complete

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 19: Meals and Mealtimes	Provide independent opportunities for residents at meal times.
Standard 25: Physical Environment	Develop a plan to meet the requirements of the Standards within six years of their implementation, to address the issue of multi-occupancy bedrooms.

Any comments the provider may wish to make:

Provider's response:

The registered provider, the person in charge, the Fagan family and the staff of Ashbury Nursing Home would like to thank both inspectors for ensuring that our inspection was a pleasant and relatively enjoyable and informative experience.

As per the recommendations mentioned above, we immediately changed the system of how bread and butter is offered to residents at meal times, when it was first mentioned by the inspectors. As discussed with the inspectors we currently have renovation plans with the Authority and we are aware of our requirements within the six-year period.

We would like to acknowledge that the level of stress experienced by all staff in the build up to the inspection date was felt at a very deep level. We feel the process and volume of paperwork in preparing for the inspection is excessive and onerous and distracts from the day to day running of the nursing home.

We also feel that if a submission for an extension of time for extenuating circumstance is made, then perhaps fairness should prevail. Each application should be considered on a case-by-case basis, as anybody can have unforeseen family situations.

We are also of the opinion that the deadlines imposed for the return of paperwork, with a follow up threat as mentioned below should we fail to meet the deadline is extremely unfair.

Should you fail to provide the listed items/ documentation, your application will not be processed and upon the expiry of the current registration on the Registration Expiry Date, Ashbury Private Nursing Home will not be registered. If you continue to carry on the business of the centre without registration as a designated centre after this date, you will be in contravention of Section 46(1) of the Health Act, 2007¹. A person who contravenes this provision is guilty of an offence and is liable (a) on summary conviction, to a fine of up to €5,000 and/or up to 12 months imprisonment, or (b) on conviction upon indictment, to a fine of up to €70,000 and/or up to 2 years imprisonment².

Furthermore, you should also be aware that residents of a centre that is unregistered and/or providers of such a centre may not qualify for funding under relevant state assistance programmes.

We make this point with specific reference to us having received letters from the Authority by normal post, requesting information to be submitted within five days. Should we have failed to do so we were threatened with the above extract from the Authority's correspondence.

All documentation sent by the Authority is done so by normal post. Some of the requests for information have unreasonable timeframes as the documentation required is of high importance and failure to meet deadlines could result in action being taken by the Authority against the nursing home, we would suggest that the documentation sent by the Authority would be sent by registered post. Information that was sent by us to the Authority by registered post was mislaid resulting in further delays and correspondence.

By contrast, with any submission we have ever made to the Authority, taking into account the legal implications involved, all of our post was and is sent by registered post or by courier. Perhaps the Authority should review the way in which demands and threats are made by including sufficient time to make returns and by using registered post.

Furthermore, we respectfully request that the Authority review the requirements in relation to references from previous employers. It proved impossible for the proprietor, 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 *National Quality Standards for Residential Care Settings for Older People in Ireland*. 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 NTPF on behalf of the HSE, as purchaser, are driving the standards and quality of care down. Pricing, lack of awareness and a lack of interest in patient care or services being offered by nursing homes are the driving factors in agreeing the lowest rate achievable. In the interest of preventing another "Leas Cross", we feel there should be some common ground 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 Ashbury on the days of the inspection and we look forward to working with the Authority in the future.

Provider's name: Robert Fagan

Date: 14 October 2010