

Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act
2007



Centre name:	Newbrook Two Nursing Home
Centre ID:	0680
Centre address:	Ballymahon Road
	Mullingar
	Co Westmeath
Telephone number:	044-9397520
Fax number:	044-9344871
Email address:	adminnb2@newbrooknursing.ie
Type of centre:	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public
Registered provider:	Newbrook Nursing Home Ltd
Person authorised to act on behalf of the provider:	Sarah Ann McGivney
Person in charge:	Mike Weston
Date of inspection:	04 and 05 August 2011
Time inspection took place:	Day 1 Start: 10.10 hrs Completion: 19.15 hrs Day 1 Start: 07:40 hrs Completion: 18:40 hrs
Lead inspector:	Catherine Connolly-Gargan
Support inspector(s):	PJ Wynne Ann Delaney
Type of inspection:	<input checked="" type="checkbox"/> Registration <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced

About the inspection

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority 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 process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Newbrook Two Nursing Home is located on the Ballymahon road outside Mullingar town.

The centre currently cares for older people for long term, residents with dementia care needs, respite and convalescence needs and palliative care needs. Services are also provided to people under the age of 65 with acquired brain injury and disability.

The centre was opened in 2008 and is a two-storey purpose-built facility. A lift is available for travel between the two floors. The lift is spacious and can accommodate a bed with ease.

There are forty two single rooms and five two-bedded rooms with en suite shower, toilet and hand-washing facilities, which include a toilet, shower and wash-hand basin. There is an assisted bath and shower on each floor. There are assisted and disabled access toilets located around the building, which for residents' convenience are close to the dining room and day sitting areas. Other facilities include a private visitors' room, a hair salon and a physiotherapy room.

All entrance and exit doors were ramped ensuring ease of access for residents. There is car parking space available in various areas of the site. The grounds are landscaped to a very good standard. The centre also has access to an enclosed garden which is along a protected canal.

Date centre was first established:			09 July 2008	
Number of residents on the date of inspection:			50	
Number of vacancies on the date of inspection:			2 vacancies	
Dependency level of current residents:	Max	High	Medium	Low
Number of residents	12	16	9	13
Gender of residents			Male	Female
			(✓)	(✓)
			16	34

Management structure

Newbrook Nursing Home Ltd is the Providers of Newbrook Two Nursing Home for which Sarah Ann McGivney is the designated person on behalf of the company. Mike Weston is the Person in Charge and reports directly to the Providers. The person in charge is supported in his role by a deputy person in charge Nora Nolan, staff

nurses, care attendants, kitchen, and laundry, household, clerical and maintenance staff. He is also supported by a quality advisor and a compliance co-ordinator.

Summary of compliance with 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*.

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007.

Inspectors met with residents, relatives, and staff members over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge, both of whom had completed the Fit Person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

This report set out the findings of an announced registration inspection, which took place following an application to the Health Information and Quality Authority (the Authority) for registration under Section 48 of the Health Act 2007.

This was the second inspection of the centre undertaken by the Authority. An unannounced monitoring inspection had previously been carried out by the Authority, Social Services Inspectorate on the 17 September 2010. An action plan detailing five areas which required attention was forwarded to the provider post this inspection. As part of the registration inspection these actions were also reviewed by the inspectors. The last inspection report contained five actions. In all, two of the five actions had been fully completed. The remaining three actions had been partially addressed and referenced elder abuse recognition and prevention training, fire safety training and notification of required incidents and accidents to the Chief Inspector of Social Services. These actions are restated at the end of this report.

Since completing the fit person entry programme they had undertaken a number of initiatives including improvements in training of staff in care of residents with dementia and behaviour that challenge. The activity program had been expanded to offer greater choice and an advocacy service was available to residents. A satisfaction survey had been done but not analysed as yet. A number of policies and procedures were reviewed and many were revised.

Inspectors found that there was non-compliance with the Health Act Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) in a number of areas as outlined in the action plan at the end of this report. The services and facilities as outlined in the Statement of Purpose were reflected in most of the practices to meet the diverse needs of the residents. Inspectors were concerned that residents with acquired brain injury needs did not

have all their health care and fulfilment needs met to enable them to reach their potential. On the 10 August 2011, the provider was requested to complete a comprehensive review and provide a report of same to the Chief Inspector of all care provided for residents with acquired brain injury to ensure all residents' needs were met in the centre.

There were inadequate systems in place to protect residents from abuse but were not fully implemented as all staff did not have elder abuse prevention training and all staff were not appropriately vetted including employment references in place. There were two notifications of alleged elder abuse to residents in the centre. These incidents did not involve the staff working in the centre. However, while one incident of alleged financial abuse was appropriately investigated, an incident referencing alleged physical abuse of a resident was not completed. The provider has been requested to complete this investigation and provide a report including the outcome to the Chief Inspector.

There was some evidence of effective management systems including risk management and review of the quality and safety of care, access to evidenced-based nursing care and allied health services. However, the area of access to evidenced based healthcare required improvement to ensure residents received a good standard of wound management, pressure area care management and restraint management. All incidents and near misses were not recorded and therefore could not inform risk management procedures.

Staffing numbers and skill mix were not adequate at all times of the day and night to take account of the needs of the residents and the size and layout of the premises. Residents could exercise choice in their daily life and were consulted on an ongoing basis. Residents meetings had resumed facilitating residents' opportunity to participate in the running of the centre.

There was a need for mandatory training for staff in fire safety, elder abuse prevention training and in the safe moving and handling of residents. A programme of other training has recently commenced as training of staff requires development. Most policies and procedures have been recently reviewed and now require implementation as they are currently not reflected in all aspects of practice. For example, the medication policy references the wearing of a red apron by the staff nurse while administering medications, which was not the practice in the centre.

Notification of incidents and accidents were not completed on a quarterly basis for April 2011 as required by the legislation. A notification of a serious injury from April 2010 is still outstanding at time of writing report.

The Action Plan at the end of this report identifies mandatory improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009(as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Section 50 (1) (b) of the Health Act 2007

Compliance with 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. Statement of purpose and quality management

Outcome 1

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

A revised statement of purpose and function was forwarded to the Authority on the 11 August 2011. It described the service that is provided in the centre and met all of the requirements of Schedule 1 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

The statement of purpose set out the services and facilities provided in the Newbrook Two Nursing Home. The profile of the residents reflected the statement of purpose and many of the residents were of advanced years and had disabilities associated with old age. The inspector was concerned that the centre's capacity to meet the diverse needs of residents, as outlined in the statement of purpose, was not clearly reflected in practice in relation to residents with acquired brain injury. There was evidence that access to appropriate healthcare and recreational fulfilment was not fully met for residents with needs in this area in the centre. The statement of purpose and function is kept under review by the provider and is available to residents on admission and following review.

Outcome 2

The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:

Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

There was evidence of a quality assurance and continuous improvement system in place. This was in the early stages of implementation and evaluation of findings was not yet completed to identify areas where improvements could be made and areas of good practice to be fostered. The inspector viewed a comprehensive schedule of audits to be carried out on a 2 monthly basis. These included audits of care plans, restraint use, management of residents' finances, residents clothing, communication, medication management, employee records and many others. The provider and person in charge were supported to implement this process by a recently recruited compliance coordinator. Inspectors viewed several audits completed by the compliance coordinator and the quality advisor for the group. Audits of areas such as care planning, call bell response times, audit of medication practice competency done with three staff nurses, and an audit of residents photographs were recently completed and reviewed by inspectors.

Inspectors noted that the care plan audit carried out on the 19 July 2011 identified a number of areas requiring improvement. A plan was put in place to provide additional education in this area for staff. An external trainer facilitated training on 'documentation and care planning at the end of July 2011 and five staff attended. A copy of the presentation was available on file for reference. An audit to ensure that residents' food likes and dislikes was recorded by the cook was completed on the 29 July 2011. This information was not recorded for all residents as eleven residents were not interviewed. Once noted this was immediately rectified. A weekly audit is also completed to ensure that the contents of residents' medication dispensing packs received in the centre from the pharmacy correlate with the residents' prescriptions. Approximately two variances per week were found by staff in the centre. While there was no documentary evidence to support appropriate action to address this area and no evidence of improvement, the person in charge and provider confirmed that these findings had been followed up. While, the current arrangement of double checking dispensing packs at centre level reduced the risk of residents' receiving unprescribed medications or medication omission, in the absence of a comprehensive address of the findings with the pharmacist, this checking procedure continues to consume additional nursing time at centre level which could be utilised for resident care.

The person in charge was not fully aware of the results of the audits recently completed. However, a plan was in place for a review meeting to evaluate the results of these audits with the person in charge, although no date was confirmed.

Outcome 3

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:

Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

The provider and person in charge demonstrated a good attitude to complaints and told inspectors that they welcomed feedback on their service. They said they took all complaints seriously and used the information to improve the service for all residents. The most recent complaint was made at the residents meeting and referenced inadequate equipment to meet the needs of a resident. Inspectors viewed the narrative referencing the investigation and noted it was complete. The outcome was a need to purchase a new sit to stand hoist which was done by the provider. The complainant's satisfaction was clearly documented and standard letters were in place to send to acknowledge the complaint and to ensure satisfaction was achieved. The complaints procedure was displayed in a user friendly format at the entrance and described in the residents' guide and the statement of purpose. A clear algorithm described the complaints process which was given to residents and displayed.

Residents and most relatives told inspectors they felt comfortable raising any concerns with the provider/person in charge or any member of staff should the need arise. Many residents and relatives said they never felt the need to complain but were aware that they could make a complaint. A box was also located by the complaints procedure displayed for comments and suggestions. However, the purpose of this box was not clear as it was not labelled and therefore did not readily invite suggestions or comments.

Residents had access to an independent advocacy service.

The complaints policy was reviewed and was found to be comprehensive. The complaints procedure contained timescales to investigate a complaint and an independent appeals process. However, a log of verbal day-to-day complaints was not maintained and therefore trends or areas of on-going dissatisfaction were not captured in a timely way. An audit on complaint management had not been completed to date.

2. Safeguarding and safety

Outcome 4

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:

Regulation 6: General Welfare and Protection

Standard 8: Protection

Standard 9: The Resident's Finances

Inspection findings

Inspectors found that measures in place to protect residents from being harmed or suffering abuse required improvement. The policy was in draft form. The person in charge had an accredited training qualification which provided him with the skills to

be involved in training staff on elder abuse recognition and prevention. The person in charge told inspectors that there was still a small number of staff who did not yet attend training in this area. The training records confirmed that four staff had not received this training. Staff spoken with were well informed and clearly articulated how they would respond to abuse and protect residents. They spoke about the different forms of abuse and all were clear on reporting procedures.

The contact details of the local designated elder abuse officer required updating on the policy viewed. There was a centre-specific elder abuse policy in place. This policy did not contain a procedure on how to manage an allegation of abuse against a senior member of the management team. An Garda Síochána vetting was not completed in all of sample files reviewed. In eight staff files reviewed, three did not have evidence of An Garda Síochána vetting.

Residents told inspectors and documented in pre inspection questionnaires that they felt safe in the centre and there were adequate measures in place to protect them from harm. Many residents attributed their safety to the front door being secured and having a call bell to summon assistance. There was also closed circuit television cameras fixed to view the activity at the doors of the centre.

There were two notifications referencing allegations of elder abuse received by the Authority from the centre. These allegations referenced physical and financial abuse. Details of the investigation carried out on one of the incidents in August 2010 were requested by the Authority on 08 August 2011. Details of management of the second incident (financial abuse) were reviewed by inspectors and were found to be adequate.

Inspectors reviewed the procedures for managing residents' finances. Twenty six residents money was maintained. Each resident's money was kept in an individual zipped folder in a safe. Each transaction was noted to be double signed and all residents concerned got a monthly statement of their account. The inspectors checked a sample of residents' monies in safe-keeping and the balance was accurately recorded in each case. Practices and procedures in this area were audited on a regular basis. The next audit was due on the 05 August 2011.

Outcome 5

The health and safety of residents, visitors and staff is promoted and protected.

References:

Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

Overall inspectors found that systems and practices in place promoted health and safety. There were systems in place for the management of a range of risk situations. There was a safety statement and a safety management structure in place to include a nominated health and safety staff coordinators. The details of the recently revised safety statement set out the responsibilities of the provider, person in charge and the safety coordinators. The health and safety policy included a recently revised environmental and clinical hazard risk analysis throughout the centre. Precautions to control or minimise risk were specified. The provider told inspectors that training was planned to ensure all staff were aware of their responsibilities in relation to risk assessment and hazard management.

While most risk assessments had been recently reviewed, all hazards throughout the centre were not documented. The main stairs from the ground floor to the first floor and two fire exits from the first floor to the ground floor via unprotected stairs had not been evaluated from the perspective of all residents' health and safety needs. There had been previous near misses documented and a resident was moved to accommodation on the ground floor following incidents where she was at risk of falling down the main stairs. Window opening restrictors were not engaged on two windows on the first floor and there were no risk assessments completed to ensure residents safety needs were met in these rooms.

The risk management policy required review to include procedures to guide staff in the event of violence, aggression, self harm and assault. There was evidence that all incidents were not recorded in the incident log. Inspectors noted two recent incidents in residents' documentation that resulted in an injury to them but were not recorded as incidents in the incident, accident and near miss log. Near misses were not recorded and therefore could not inform risk prevention or learning. For example, there were two variances per week identified by staff checking the medication dispenser packs from the pharmacist. Although the person in charge told inspectors that these variances were made known to the pharmacist, this action or the outcome was not documented in response to these findings. A procedure for formal review to ensure learning for all staff from serious or untoward incidents or adverse events was also not in place.

There was an emergency plan in place which also referenced a point of safety for residents should an evacuation of the centre be required. A gas safety inspection was carried out on the 07 July 2011.

The person in charge had a training qualification to provide training on moving and handling procedures. Inspectors viewed the training records which indicated that not all staff had up to date training in the safe moving and handling of residents. Inspectors observed staff assisting residents with manoeuvring and noted no incidents of unsafe practice was carried out.

A recent review of mandatory training completed had highlighted these staff members and training was being organised.

The inspectors was provided with written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for dependent people. Smoke detectors were located in all bedrooms and general purpose areas. Emergency lighting was provided throughout the building.

An inspector viewed contracts of the servicing of fire alarms, smoke and heat detectors. These were serviced by a professional four times a year. Fire extinguishers were serviced annually. Routine inspection of the automatic fire door closers and fire panel were undertaken to ensure they were operational. Fire fighting equipment was inspected frequently to ensure it was in place and intact. Plans to show the escape to the nearest fire exit were displayed on the back of most of the residents' doors. Notices of the procedures to follow in the event of finding a fire or on hearing the fire alarm was not displayed around the building.

There was a safe mechanism in place to evacuate immobile residents in the event of a fire. Fire evacuation sheets had been fitted under each resident's mattress which was recently audited to ensure all residents had one in place. The inspector viewed the staff training records and found that not all staff had participated in a fire drill or received training in fire safety procedures in the past twelve months to ensure all staff were familiar with the procedures to follow in the event of a fire in the centre. Some staff had attended a night-time fire drill on the 28 July 2011. A list of the numbers and types of fire fighting equipment was not maintained.

Outcome 6

Each resident is protected by the designated centres' policies and procedures for medication management.

References:

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

Inspection findings

There was a medication management policy in place recently reviewed and signed into practice on the 03 August 2011. However, the policy was not reflected in practice. For example, the policy stated that all staff involved in dispensing medications wore a red apron which was not done in practice. The policy also advised that a glass of water is given to each resident prior to taking medications, staff were not familiar with this practice and it was not observed as done by inspectors. Controlled drugs were secured in a locked cabinet. An inspector viewed the controlled drugs register. Controlled drugs were checked by two nurses from opposing shifts, at the change of each shift to ensure all drugs were accounted for. The policy advises that two registered nurses dispense schedule two medications (controlled by the Misuse of Drugs Act 1988). There is only one nurse on duty and a second nurse witnesses the night nurses signature in the morning. Inspectors noted that these controlled medications were being dispensed during the night. The procedure for the handling and disposal of unused and out of date medicines was in

draft format. There was no reference made to storage of medicines in the policy document.

The inspector observed the nurses on part of their medication rounds and found that medication administration times on the prescription did not match the pre formatted times on the administration record sheets.

There was no entry in most residents' medical files reviewed referencing review of medications by the GP. Some residents prescriptions were signed by the GPs in their surgery and residents. While residents had access to GP review at times of ill health, there was inconsistent evidence of medical review on an on-going regular basis. A specialist recommended discontinuation of a resident's medication on the 21 October 2010; this was not done or acknowledged in the resident's medical file. It was noted that the GP documented review of this resident on the 21 July 2011. However, inspectors noted that the medication referenced was still prescribed on the day of inspection. This was brought to the attention of the person in charge and provider at feedback of inspection findings to rectify.

Dates and GP signatures were missing from some other prescriptions in the files reviewed. Nurses in the centre were not involved in transcribing medications. Medication audits were in place and nurse competency assessments were in progress and completed with three nurses. While variant findings were noted they were not actioned.

Medication was crushed for a number of residents. The GP did not consistently sign this order. The unit for crushing medication was noted to be heavily contaminated with other medicines. There was evidence that medications were pre crushed and stored for administration at a later time which created a risk of medication error.

3. Health and social care needs

Outcome 7

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:

Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare

Inspection findings

The arrangements to meet residents' assessed needs were set out in individual care plans. Each resident had a care plan completed. A variety of assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional risk assessment, pressure related skin damage risk assessment and moving and handling assessments. Three residents had evidence of pressure related skin damage.

All residents' care plans were recently reviewed. This review was supported by an audit. The outcome of the audit was a large number of deficits that required additional internal training and training from an external source. Each staff nurse was given responsibility for updating care plans for a group of residents. Each resident had been allocated a nurse who took responsibility for the management of their care. The participation of residents or family members in care planning and review was clearly documented. There was links between residents' care plans and entries in the daily nursing notes therefore it was possible to gain accurate documentary feedback on residents' progress. Care plans were not updated three monthly and therefore did not reference all residents' changing needs. A daily flow sheet focussed on completion of tasks and although used to compliment recording of care delivery, it did not foster person centred care. However, it was complimented by the fact that all nurses entered a daily narrative note in line with the legislation.

The flow sheet involved carers in documentation of residents care and improved the information available for evaluation purposes.

There was an emphasis on social care, with prescribed interventions within care plans to promote residents' social care needs, based on residents assessed preferences, interests and capacities. A 'key to me' had been completed for up to 40 of the 50 residents which referenced personal and lifestyle choices. However this information had not been acted upon as it had not influenced the activities provided as some residents loved to knit. Residents were sitting out in the sun, some in assistive chairs listening to music; those at risk of sun burn wore hats. The activities coordinator and a colleague work Monday to Friday 09:30 hrs to 17:00 hrs.

Residents had access to a variety of scheduled activities. One-to-one hand massage was provided for residents by a reflexologist. Live music and a card games were part of activities provided to ensure meaningful engagement for residents. Inspectors observed staff taking the time to include those residents with cognitive impairment and to encourage them to take part in activities in a sensitive manner. Nursing staff, care staff, residents and relatives also confirmed that there were regular activities provided. There were two activity facilitators on duty each day however; they did not have training in facilitating recreational activities for this group of residents with mixed abilities. However, residents who remained in bed were not engaged in any meaningful activity other than watching television on the days of the inspection.

A number of residents had wounds three of which were related to pressure related skin damage. Inspectors noted that pressure relieving cushions and mattresses were provided for residents who were at risk of skin breakdown. However, pressure relieving procedures such as turning were not consistently implemented or recorded for all residents at risk of pressure related skin damage.

All aspects of wound care management were not in line with contemporary evidence-based practice. Although there was a wound care policy, it required development to reflect comprehensive contemporary evidence-based wound care procedures.

All residents with wounds had a wound chart in place. However, the documentation did not adequately inform the reader of the true condition of the wound. Inspectors noted that the narrative referenced deterioration in the wound but was not matched by a change in dressing procedure or frequency. The person in charge had taken some photographs of wounds at various stages of healing but they were not made available as a method of tracking wound progress. As not all wounds were photographed or the photographs made available for review, management of wounds was inconsistent. There was little evidence of referral to a wound specialist for many of the residents. One resident was referred to a wound specialist three weeks prior to inspection and had not been reviewed. There was no evidence that the person in charge had put systems in place to ensure that wound specialist referrals were timely. There was a wound care management policy in place reviewed on 08 March 2011.

Residents were able to retain the services of their own GP. An out-of-hour's service provided medical cover at weekends and bank holidays. A sample of medical records were reviewed which confirmed that the health and medication needs of residents were not been consistently reviewed and residents were at risk as a result. Although the provider had improved access to health care for many residents in the areas of physiotherapy and occupational therapy, all residents did not have adequate access to these services. The psychiatrist for later life and the community mental health nurse attended the centre as required. Medication was reviewed routinely by the psychiatrist to ensure optimum health. There was documentary evidence in the files reviewed that the psychiatrist wrote a letter to the person in charge referencing his findings and recommendations for the resident's GP. However, there was no evidence of follow-up by the GP on this occasion.

There was a policy on the use of restraint to inform practice in the centre dated 03 August 2011. Four residents documentation was reviewed because they were using restraints. The consent in the four files was signed by family members. There was no documentation relating to need for restraint or whether the restraint used was suitable for the residents needs without restricting the resident unnecessarily. While there was evidence that residents' personal care needs were maintained while in restraint, regular release schedules were not comprehensive. Care plans in relation to restraint were not fully reflective of best practice, for example, risk assessments did not provide a consensus judgement that the intervention was in the best interests of the resident, was the least restrictive solution and was being put in place as previous

less restrictive interventions had failed in all care plans reviewed. There was no evidence of other health professionals' involvement in the concluding decision to use bedrails or lap belts.

Outcome 8

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:

Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings

There was evidence of a person-centred approach to end of life care. There were arrangements where residents' families were facilitated to be with them. The person in charge said that families were provided with refreshments and meals and they could stay overnight if they so wished. Inspectors noted that there was a visitors' room with tea making facilities and a microwave. Residents and their relatives described the kindness of staff and how they made every effort to comfort and support residents who were not well. There were three residents in poor health on the day of inspection.

The policy on end of life care required review as it did not include clear procedures to guide staff actions and interventions. The policy did not reference residents' choice, as to the place of death including the option of returning home or the procedures to follow in the event of sudden death. Emergency cardiopulmonary resuscitation equipment was not readily accessible and was stored in a number of different places in the centre. The suction machine was not readily available as it was in use for another resident.

The inspector reviewed a sample of residents' care plans and noted that personal wishes in relation to end of life care were not documented in each case. While the centre does not have an oratory, the provider told inspectors that it was her intention to build one. There is a strong religious ethos in the centre, two resident priests celebrate Mass on a daily basis and one of the residents is the caretaker for the tabernacle. Non catholic residents have their religious needs met by attending ministers.

While residents receive palliative care in the centre, there were no residents availing of this service on the days of the inspection. However, inspectors were told that the local palliative care team attended the centre to review residents in receipt of palliative care and to provide support and advice when required. The local on-call GP service supports this service out of hours. The person in charge told inspectors that a new medication pump was recently introduced by the palliative care service. He had plans in place to ensure staff were provided with training so that they were familiar with its use if a resident required this type of treatment.

Outcome 9

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

References:

Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings

Inspectors sampled the lunchtime meal which was nutritious and of a good standard. Residents were offered a varied diet and mealtimes were unhurried social occasions. Many of the residents interacted with each other and with staff. Inspectors spoke to staff serving the meals in the dining room and kitchen staff and found they were knowledgeable about individual resident's specialised needs such as modified consistency or diabetic diets. A list was maintained in the kitchen advising of each resident's dietary requirements. A list of residents' likes and dislikes was also maintained and informed the menu provided. Residents who required assistance with nutritional intake were respectfully and sensitively helped. One resident's bread was only buttered for her when her permission was sought to do so.

An inspector observed the tea-time meal and noted that some residents did not like the dish on offer. They were immediately offered an alternative to meet their choice.

The chefs worked in the kitchen from 08:00 hrs to 18:00 hrs covering the seven days. Three catering staff worked 08:00 hrs to 20:00 hrs. Additional snacks and drinks were made available to meet residents' needs out of hours. The kitchen was visibly clean, well equipped and contained suitable facilities for the storage, preparation and cooking of food. It was well stocked with a plentiful supply of vegetables, fruit and meat. There was a good supply of juice including orange, prune and cranberry juice. There was a food safety system in place and staff in the kitchen were trained in food hygiene.

Fresh jugs of water were delivered to the residents' bedrooms by kitchen staff at night and again in the early morning observed by inspectors. Three residents had urinary catheters and were on fluid balance charts which inspectors noted to be fully completed. The care attendant totalled the fluid balance every 24 hours and communicated the result to the staff nurse. While additional jugs of juices and water were available in one of the communal areas, there was no water available in the other communal areas or along corridors. However, staff regularly offered drinks to residents. Residents told inspectors that they could have tea or coffee and snacks any time they asked for them.

There was a policy in place to guide and inform staff on the procedures to ensure residents' nutritional and hydration needs were met. Inspectors noted that not all residents assessed as 'at risk of weight loss' had their weights consistently monitored a nutritional risk assessment was completed and was reviewed on a monthly basis for some residents viewed by the inspector in the residents' care plans. Where the

assessment identified a risk, the resident was highlighted for a referral to a dietician. The provider has employed the services of a dietician. A record was kept of the date the referral was made to improve tracking and ensure residents were reviewed.

4. Respecting and involving residents

Outcome 10

Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:

Regulation 28: Contract for the Provision of Services

Standard 1: Information

Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

All residents had been provided with a contract of care. Five residents' contracts were reviewed. Inspectors found that not all contracts had details of the fees to be charged.

Outcome 11

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:

Regulation 10: Residents' Rights, Dignity and Consultation

Regulation 11: Communication

Regulation 12: Visits

Standard 2: Consultation and Participation

Standard 4: Privacy and Dignity

Standard 5: Civil, Political, Religious Rights

Standard 17: Autonomy and Independence

Standard 18: Routines and Expectations

Standard 20: Social Contacts

Inspection findings

Inspectors observed that residents' privacy and dignity needs were met by staff in a number of ways. For example:

- doors to bedrooms and shower rooms were kept shut while staff were assisting residents
- staff knocked before entering rooms on all occasions
- notices were placed on doors to indicate personal care was in progress

- staff were sensitive and gentle in their approach to residents. They discretely assisted them and spoke courteously to them. Inspectors observed staff managing an episode of behaviour that challenged. Their approach and techniques used dissipated the situation with the minimum of stress to the resident.

Residents were able to maintain social relationships. Inspectors observed that family contacts were welcomed at various times of the day. Residents and their relatives confirmed that flexible visiting was usual and residents were able and encouraged to go out with their families. One resident was returning to the centre after celebrating her birthday with her family as inspectors were leaving the centre. There was a comfortable visitors' room available as a private area for residents to spend time alone with their visitors that assured confidentiality. Tea making facilities and a microwave was available to facilitate residents and their families to have refreshments and snacks together.

A residents' forum was established which met on the 03 August 2011 attended by four residents. The previous meeting was held on the 15 September 2010 and was attended by nine residents. These two meetings were attended by the same residents. Residents at the meeting in September 2010 suggested a trip to knock which was done. Inspectors were told that residents go out on weekly trips on the centre's wheelchair accessible minibus to local sites. However, no trip took place on the week of the inspection. The person in charge and the provider told inspectors that they planned to have regular residents' meeting going forward which the advocate would attend and possibly facilitate in time. Inspectors read the minutes from the meetings and noted that one resident had made a complaint at the meeting which was appropriately addressed.

Newspaper clippings and photographs were displayed to assist residents to maintain links with the local community. There was also a photograph of the President on a visit to the centre. A room on the first floor was in the early stages of renovation for reminiscence purposes. An old range was in place and kitchen furniture was in place. The provider said she planned to develop this room further to a standard where residents could sit and remember their previous lives among familiar items.

Suggestions by residents had been implemented for example; chickens in the enclosed garden and large print books were made available. There were limitations for some residents on their participation in the organisation of the centre, given their high dependency levels and others with conditions causing cognitive impairment. To overcome this challenge, an advocate was available to assist residents' express their preferences.

There was evidence of open communication between the person in charge, staff and relatives, as inspectors observed relatives talking freely with the provider, person in charge and staff. Inspectors observed good interactions between staff and residents and it was clearly evident that this was usual practice and they knew each other well. Inspectors observed that residents had access to televisions, newspapers and a telephone by their bed. There were notices boards located around the building containing information on the staff on duty, the activities planned for the day, the

menu options, the season and the weather. Questionnaires completed by relatives confirmed they were satisfied with information provided by staff about their family members' healthcare and general wellbeing. Residents with conditions that impacted on their ability to effectively communicate did not have access to communication tools to assist them in this regard.

Residents' rooms were spacious and were very personalized in many cases. One resident had a library in his own furniture in his room. Other residents had presses and other pieces of furniture. Residents had pictures and mementos displayed in their rooms. One resident who was a religious sister was the care taker for the tabernacle used at Mass which she kept in her room. The provider told inspectors that this was a practice she encouraged and did not mind what pieces of furniture residents wished to have with them in the centre. Although there was no oratory, residents told inspectors they were able to practise their faith and worship according to their wishes.

Some residents got personal newspapers delivered to their bedroom on a daily basis. Newspapers were made available in the day room for other residents to read. The hairdresser attends the centre once every two weeks and there is a designated hairdresser room. One resident told inspectors that 'it's a great service' and she goes 'every time the hairdresser comes in'.

Outcome 12

Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:

Regulation 7: Residents' Personal Property and Possessions

Regulation 13: Clothing

Standard 4: Privacy and Dignity

Standard 17: Autonomy and Independence

Inspection findings

The laundry was clean and well organised. There were appropriate washing machines with cycles suitable to wash contaminated and non-contaminated linen. The laundry building was independent. There was an ironing service available that was used to ensure residents. Clothing was well managed. The laundry person was spoken with by inspectors and confirmed that she worked Monday to Friday from 08:00 hrs to 16:00 hrs each day. She explained the procedures she follows to ensure that clothing were laundered appropriately and returned to residents. All clothes were well looked after and the laundry person explained how she followed the manufacturers washing instructions on some clothes. Residents clothing was discreetly marked to indicate ownership. No concerns were raised regarding clothes going missing. There was a labelling machine which was used by laundry staff to label all clothes belonging to residents.

There was a policy on the management of residents' personal property and possessions which inspectors noted was consistent with practice. An up to date property list was not maintained for each resident. Some residents did not have a property list at all. Residents clothing was clean and in good condition. Some residents wore jewellery and were dressed according to their individual choice.

Residents had large wardrobes for their use and the wardrobes were kept tidy by the care assistants and the laundry person. A policy on managing residents clothing and possessions was in place.

5. Suitable staffing

Outcome 13

The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:

Regulation 15: Person in Charge

Standard 27: Operational Management

Inspection findings

The post of the person in charge was not a full time position as the person in charge was also person in charge of another centre. Improvements had taken place since the last inspection of the centre in 17 September 2010 the governance procedures required review to ensure good operational management, provision of clinical care and the general welfare and protection of residents. The person in charge explained the system in place to manage his time between the two centres. However, inspectors were concerned regarding this arrangement as not all staffing resources were in place as planned to enable the person in charge to fulfil his role in both centres. There were also a significant number of areas requiring improvement to ensure Newbrook Two is compliant with the legislation.

The person in charge was supported in his role by a staff nurse in Newbrook Two who deputised in his absence but who confirmed to inspectors that this was a temporary arrangement agreed by her. The provider and person in charge also confirmed this arrangement and explained how she was trying to recruit a Clinical Nurse Manager to support the person in charge.

The person in charge was documented on the rota for Newbrook Two as being in the centre on a full-time basis. This was not the case due to commitments to a second nursing home also on the same site, for which he was also in the role of person in charge. He carried a mobile phone at all times to ensure his accessibility.

The inspectors interviewed the person in charge and were satisfied that he had the relevant experience and clinical knowledge to provide leadership for the team in Newbrook Two. However, there was no evidence that he had a commitment to his own continued professional development. Throughout the two days of inspection he

demonstrated an adequate knowledge of the regulations and standards. The person in charge was a trainer with an accredited training qualification which included moving and handling and elder abuse recognition and prevention training.

All members of the team, spoken with were clear about their areas of responsibility and their reporting systems.

Outcome 14

There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:

Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

The inspectors reviewed the staff duty rota for a one month period which detailed all staff on duty over each 24-hour period.

The inspector noted that the planned staff rota matched the staffing levels on duty. The rota indicated that there were two staff nurses on duty during the day and one staff nurse on night duty. While the nurses on day duty had sufficient time to support and supervise staff, inspectors found that this was not possible on night duty. There was evidence to support the need for a review of staffing levels and skill mix from a review of the quarterly reports to the Authority. Inspectors reviewed the most recent quarterly report to the Authority which referenced accidents that occurred in May, June and July 2011. There were 13 incidents documented, none of which were witnessed by staff. Eight of the thirteen incidents occurred at times during the night. Four incidents occurred from 08:00 hrs to 08:30 hrs in the morning. Inspectors were also concerned that due to the dependency levels of residents the staffing skill mix on night duty may not be adequate to safely manage a change in a number of residents assessed needs.

Inspectors noted that there was a delay in responding to bells in the early morning and in the afternoon in particular on the days of the inspection. A call bell audit was carried out on the 23 July 2011. The outcome of this audit was that bells were ringing as it was mass time and residents were eager to be there. This audit has not been repeated at another time.

Most residents tended to rest in two communal rooms which facilitated staff supervision of vulnerable residents.

There were three residents in bed on the first day of inspection and one resident remained in bed on the second day of inspection. Staff were seen to check on the wellbeing of these residents regularly.

Copies of both the regulations and the Standards had been made available to staff, the provider spoke about putting an education programme in place to ensure all staff were well informed of the legislation and the standards required. A record of An Bord Altranais PINs (professional identification numbers) was reviewed by inspectors for all registered nurses including the person in charge and the provider and was up to date.

There was a detailed policy for the recruitment, selection and vetting of staff. It was not reflected in practice. This was evidenced from a review of staff files. A sample of eight staff files were examined to assess the documentation available, in respect of persons employed. One newly recruited staff nurse had only her employment history and PIN number on file. All other documentation was not available in respect of vetting, induction and certification of fitness to work. Inspectors found that two out of the eight files reviewed had all the documentation required by the legislation. However required documentation missing from the remaining six files included, Garda Síochána vetting, three references and certification of physical and mental fitness to work.

A range of modular training had recently commenced facilitated by an accredited trainer. The person in charge had also provided training in mandatory training and clinical education. Training included care of the elderly with dementia care needs and behaviours that challenge, restraint management, infection control, documentation and care planning and medication management. However, not all staff had received up to date mandatory training in fire safety, elder abuse recognition and prevention and the safe moving and handling of residents as discussed under outcome five. The person in charge and the provider told inspectors that a staff training programme of future planned training was under discussion and would be implemented to ensure all residents' needs were met by knowledgeable and skilled staff. Many staff did not have up to date training in cardio-pulmonary resuscitation techniques or end of life care.

6. Safe and suitable premises

Outcome 15

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:

- Regulation 19: Premises
- Standard 25: Physical Environment

Inspection findings

The centre was purpose-built to meet the needs of dependent older people. There was an enclosed garden along a protected canal. Bird feeders and a chicken coop with hens and a rooster were located in this garden. There was seating available for use by residents. Further external seating was provided to the front of the building close to the main entrance. Access to the entrance was ramped and fitted with handrails to assist residents to enter and egress with ease. Residents and their visitors were noted to be resting on the external seating provided as they chatted.

There was a range of spacious and suitable communal rooms provided. Residents tended to rest in two sitting rooms close to the enclosed garden. However, other rooms were available to rest in if they wished. One sitting room had no television installed so that it could be maintained as a quiet area. Another sitting room upstairs was been refurbished to reflect a more domestic, old style theme.

All residents' rooms had en suite shower, toilet and wash-hand basin facilities. The en suite facilities in bedrooms were provided with grab support rails in the shower and by the sink and toilet. There was an emergency call system insitu. There was a call bell system in place at each resident's bed within close access.

Bedrooms and communal areas were of a comfortable temperature facilitated by underfloor central heating. There were controls in place to ensure the temperature of the hot water at the point of contact did not pose a risk of scald to residents. Showers were fitted with thermostatic controls to ensure the temperature of the water is maintained at a level that does not cause risk of scald.

Appropriate cleaning chemicals were used including a room sanitizer which was in use on a vacant room. Cleaners had a designated room for their equipment with a sink. The sluice room was equipped with stainless steel sinks, a wash hand basin and storage areas for bedpans. A bed pan disinfection unit was provided. Bedrooms and bathrooms were maintained in a clean condition. While all rooms in the centre had a vinyl-type floor covering, carpets were on all the corridors and the lobby area. There was no schedule available for intermittent carpet deep cleaning other than Hoovering.

Inspectors found there was appropriate assistive equipment available such as specialised beds, hoists, pressure relieving mattresses, wheelchairs and walking frames. Service contracts were in place for servicing of beds, hoist, lift and air mattresses. However, two residents used electric wheelchairs and other used various assistive wheelchairs none of which had evidence of being serviced.

Inspectors reviewed maintenance records and found that the equipment was maintained and serviced regularly by a qualified contractor.

A maintenance person was employed on a full time basis to work between Newbrook One and Two Nursing Homes, both located on the same site and managed by the

same provider and person in charge. The maintenance person's role was to undertake repairs and ensure the building and services were well maintained. There was a maintenance log book available for staff to record details of any equipment, or item that required repair on a routine basis.

7. Records and documentation to kept at a designated centre

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings

** Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's guide

Substantial compliance Improvements required*
Each resident had a copy of the residents guide but the residents' guide in circulation in the centre did not reflect the updated Statement of Purpose and did not contain details of the residents' contract of care. There were no copies of the Inspection report of September 2010 readily available for residents to read if they so wished.

Records in relation to residents (Schedule 3)

Substantial compliance Improvements required*
Documentation was not consistently in place in all resident's medical records reviewed by inspectors to support regular review of residents' medication or condition.

General records (Schedule 4)

Substantial compliance

Improvements required*

A record was not maintained of all verbal complaints. A record was not maintained of all accidents that occurred to residents. Near misses were not recorded routinely.

Operating policies and procedures (Schedule 5)

Substantial compliance

Improvements required*

The policy for procedures to follow in the event of a resident's temporary absence and elder abuse recognition and prevention policy was in draft format.

Directory of residents

Substantial compliance

Improvements required*

Details of name and address of each resident's next of kin or the person to act on their behalf was not completed in all cases.

Staffing records

Substantial compliance

Improvements required*

Inspectors reviewed eight staff files and found that only two files contained all documentation required by the legislation

Medical records

Substantial compliance

Improvements required*

There was no documentary evidence to support that one resident was reviewed by the GP as requested by a specialist. Records of all medications prescribed were not adequate.

Insurance cover

Substantial compliance

Improvements required*

Insurance liability was not stipulated in the case of residents' personal property as stated in regulation 26 (2).

Outcome 17

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:

Regulation 36: Notification of Incidents

Standard 29: Management Systems

Standard 30: Quality Assurance and Continuous Improvement

Standard 32: Register and Residents' Records

Inspection findings

Practice in relation to notifications of incidents was not satisfactory. Inspectors reviewed a record of all incidents that had occurred in the centre since the previous inspection and cross referenced these with the notifications received from the centre. Inspectors found that a notification of serious injury where a resident sustained a fractured wrist on 06 April 2010 and already highlighted by the inspectorate in the centre's inspection report of 17 September 2010 was not reported. Quarterly notifications were not received by the Authority for the period ending 30 April 2011. Three residents had pressure related sores, two of which were healed, a third sore was viewed by an inspector and found to be a grade 2 – 3. None of these pressure related sores which were each grade 2 or above were notified to the Chief Inspector as required by the legislation.

The provider and person in charge confirmed that they were aware of their legal responsibility to notify the Chief Inspector as required and stipulated in the legislation.

Outcome 18

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

References:

Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre

Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre

Standard 27: Operational Management

Inspection findings

There were appropriate arrangements in place for the absence of the person in charge. A senior staff nurse deputised for the person in charge. The provider was aware of her responsibility to notify the Authority and documentation was completed in relation to the current person in charge who commenced in his role in the centre in September 2010.

Inspectors confirmed that there have been no absences of the person in charge for a period that required notification to the Chief Inspector

Closing the visit

At the close of the inspection visit a feedback meeting was held with the providers, the person in charge, the quality advisor and chief executive officer of the company 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:

Catherine Connolly-Gargan
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

04 August 2011

Action Plan

Provider's response to inspection report*

Centre:	Newbrook Two Nursing Home
Centre ID:	0680
Date of inspection:	04 and 05 August 2011
Date of response:	12 September 2011

Requirements

These requirements set out the actions that must be taken to meet 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*.

Outcome 2: Reviewing and improving the quality and safety of care

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

The quality of care and experience of the residents care was not monitored and developed on an ongoing basis.

Action required:

Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

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

Timescale:

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

<p>Provider's response:</p> <p>Regular audits will take place to ensure that all aspects of quality and safety of care and quality of life will be reviewed. Weekly feedback sessions will be held with staff.</p> <p>At least weekly meetings will be had between the person in charge and the CNM (New CNM commencing work 7 October 2011).</p> <p>At least monthly meetings will be had between person in charge and all staff</p> <p>At least monthly meetings will be had between person in charge, CNM and compliance coordinator and registered provider. Topics on agenda to include review audits that have been conducted action items closed.</p> <p>Registered provider and person in charge have daily contact. Meetings between person in charge and registered provider will take place at least weekly. There is no specific agenda and meetings with Sarah Ann are not minuted. Meetings address any issues arising. The CEO attends management meetings and actions arising from these meeting are noted. The PIC and CEO are in regular contact by telephone and e-mail ensuring that the PIC is supported in his role.</p> <p>Since the audit a meeting with the pharmacist was held to review the current medication administration system. An alternative system has been identified and a trial date currently being finalised. Training to take place on over a period of 2 weeks. Once trial period is complete an audit review of the system will take place and if new system is suitable it will be implemented on a full time basis as soon as possible. Any new medication system introduced will have staff training attached prior to commencement.</p> <p>Resident meetings will be held every second month.</p> <p>Resident Satisfaction Surveys to be completed on a quarterly basis</p>	<p>Commenced in September 2011 and ongoing in progress</p> <p>Commencing 7 October 2011</p> <p>Commenced 08 September 2011 and ongoing in progress</p> <p>Commenced 30 August 2011 first full meeting to include CNM scheduled for 02 November 2011 and ongoing in progress</p> <p>Commenced 08 August 2011 and ongoing in progress</p> <p>Completed by 30th of November</p> <p>Next residents meeting to be carried out by 20th Sept 2011</p> <p>Next resident Satisfaction survey to be completed and reviewed by 30 September 2011</p>
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Outcome 3: Complaints procedures

<p>2. The provider is failing to comply with a regulatory requirement in the following respect: Verbal complaints were not recorded in the centre.</p>	
<p>Action required: Record all complaints including verbal complaints, and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.</p>	
<p>Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Training on the complaints policy to be carried out with all staff to assist them with reporting and recording complaints in compliance with the policy. Only senior staff are involved in the investigation of complaints.</p> <p>An audit of the complaints will be carried out by the compliance coordinator every six months. These results will be communicated to the PIC and Senior Management by e-mail with a follow up discussion at management meetings if necessary.</p>	<p>Completed 9th November 2011</p> <p>First audit to be completed by 30th Sept 2011</p>

Outcome 4: Safeguarding and safety

<p>3. The provider and person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>All measures to protect residents being harmed or suffering abuse were not in place and appropriate action was not taken in response to allegations, disclosures or suspected abuse.</p> <p>One reported incident had not been investigated and managed appropriately.</p>	
<p>Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.</p>	
<p>Action required: Take appropriate action where a resident is harmed or suffers abuse.</p>	

Action required: Complete a review of the investigation carried out. Forward a copy of this review and a copy of the elder abuse policy referenced to the Inspectorate.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Training has taken place on recognition and responding to elder abuse for staff members on Saturday 10 September by person in charge. All staff attended the approved training.</p> <p>Staff with outstanding records have been notified by letter requesting essential documentation. Consequences of not conforming to our requests have been outlined in letters sent.</p> <p>New policy includes details on the management of suspected or actual cases of abuse and includes how to carry out preliminary screenings, investigation processes and reporting mechanisms, notification of next of kin and guidance as to what should be carried out in a case of confirmed abuse.</p> <p>Investigation review completed and forwarded with the 'Prevention, Detection and Response to Abuse' policy/</p>	<p>Completed 10 September 2011</p> <p>Complete by 30 September 2011</p> <p>Completed 14 August 2011</p> <p>Completed 29 August 2011</p>

Outcome 5: Health and safety and risk management

<p>4. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The health and safety of residents, visitors and staff was not promoted and protected in relation to risk management procedures in the centre.</p> <p>Risk assessments were not available for stairs and there were no opening restrictor on some of the windows to protect residents at risk of falling.</p> <p>All staff did not up to date training in moving and handling residents safely.</p>
<p>Action required:</p> <p>Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.</p>
<p>Action required:</p>

<p>Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.</p>	
<p>Action required: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.</p>	
<p>Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.</p>	
<p>Action required: Provide training for staff in the moving and handling of residents.</p>	
<p>Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Risk management policy has been enhanced and broken down into separate policies that include risk management strategy, hazard identification and risk assessment procedure, violence and aggression (including assault), self harm, accident/incident reporting, restraint management, challenging behaviour,</p> <p>New risk assessment forms (including restraint risk assessment, challenging behaviour (including self harm), violence and aggression (including assault) have been developed and put into practice.</p> <p>A comprehensive risk assessment on stairs will be completed taking into account resident profiles and environmental surroundings.</p> <p>Automatic release coded locks will be installed.</p> <p>All staff receive moving and handling training as mandatory bi-annually. Last training date 09 September 2011 for newly appointed staff.</p> <p>Window restrictors have been engaged in all rooms</p>	<p>Completed 14 October 2011</p> <p>Completed September 2011</p> <p>Completion date of 23 September 2011</p> <p>31 October 2011</p> <p>Remaining staff training completed by 31 October 2011 Completed 06 August 2011</p>

<p>Medication variances – staff have been instructed regarding the reporting of variances with medication management. A new form has been implemented to ensure that variances at all levels are recorded. Regular monthly auditing will ensure that these variances are being reported to the person in charge and the provider.</p>	<p>Complete</p>
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<p>5. The provider is failing to comply with a regulatory requirement in the following respect:</p>	
<p>The health and safety of residents, visitors and staff was not promoted and protected in relation to fire safety procedures in the centre.</p>	
<p>Action required: Provide suitable training for staff in fire prevention</p>	
<p>Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.</p>	
<p>Action required: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.</p>	
<p>Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety</p>	

<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>All staff who have not received training in the last 12 months will be trained in fire prevention. Fire prevention will be carried out on an annual basis.</p> <p>Fire drills will be conducted during day duty and night duty to ensure that all staff attends a minimum of two drills per year. Drills will take place monthly.</p> <p>New posters created detailing procedures to be followed in the event of a fire. These are now displayed in prominent places throughout the building.</p> <p>An inventory of fire fighting equipment was carried out and</p>	<p>Completed 31 October 2011</p> <p>Last drill for night and day duty 28 July 2011</p> <p>Completed September 2011</p> <p>Completed September</p>

finding are highlighted in the fire register.	2011
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Outcome 6: Medication management

<p>6. The provider is failing to comply with a regulatory requirement in the following respect: Each resident was not protected by the designated centre's policies and procedures for medication management in the centre in relation to documentation of medication prescribing and administration, crushing procedures, regular GP reviews and variances occurring with filling the residents' dispenser units from the pharmacy.</p>	
<p>Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures. These revisions must address documentation of medication prescribing and administration, crushing procedures, regular GP reviews and variances occurring with filling the residents' dispensing packs from the pharmacy.</p>	
<p>Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Following the inspection a meeting was held with the pharmacist to explore other medication dispensing/administration systems. A trial will commence on 19 September 2011 for three residents using the a closed pouch system. Once trial period (4 weeks) is completed a review of the new system will be carried out. If this system is satisfactory, it will be implemented by mid December for all residents.</p> <p>Nursing staff have received training in managing and reporting variances in medication. Variance forms have been introduced as part of the update in the medication management policy. These will be reviewed monthly by the person in charge.</p> <p>GP's are reminded in writing of their obligation to review their patients at least every three months which will include prescription of medication.</p> <p>A second pill crushing device has been purchased and is in use to facilitate non contamination when crushing medication where</p>	<p>Complete by 15 December 2011</p> <p>Completed September 2011</p> <p>Completed September 2011</p> <p>Completed September 2011</p>

<p>indicated. Crushing is timely. There is no pre-crushing or storage allowed as part of our procedure.</p> <p>Medication management policies have been updated to reflect best practice guidelines. Policy under review by nursing staff at present. Comments have been received from staff and are being reviewed. All nursing staff have received category 1 approved medication management training and further education will be given on changes to medication management policy as required.</p>	<p>Completed 04 December 2011</p>
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Outcome 7: Health and social care needs

<p>7. The provider and person in charge is failing to comply with a regulatory Requirement in the following respect: Each resident did not have opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.</p>	
<p>Action required: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities including residents who remained in bed.</p>	
<p>Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 17: Autonomy and Independence Standard 18: Routines and Expectations</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>All residents are invited to participate and are encouraged to participate in the daily activities programme.</p> <p>'Key to me' assessments are completed for all residents that chose to participate.</p> <p>Residents who remain in bed for the day are encouraged to take part in activities if possible. Assessed using Key to me. Otherwise activities are carried out at the bedside e.g. reading of newspapers to residents, passive active exercises are carried out and visits from the Irish Therapy Dog Service, weekly on a Monday.</p>	<p>Completed September 2011 Completed September 2011 Completed September 2011</p>

<p>8. The provider is failing to comply with a regulatory requirement in the following respect: There were no procedures in place advising staff of procedures to follow when residents are leaving the centre on a temporary basis.</p>	
<p>Action required:</p>	

Develop and implement a policy advising of procedures to follow when residents are leaving the centre on a temporary basis.	
Reference: Health Act, 2007 Regulation 29: Temporary Absence and Discharge of Residents Standard 10: Assessment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Admission, transfer and discharge policy has been amended to highlight procedures to follow when residents are leaving the centre on a temporary basis. Policy has been introduced to staff. Staff are signing off that they have read and understood policy. The person in charge is available to explain and answer queries that staff may have.	Completed 04 October 2011

9. The provider is failing to comply with a regulatory requirement in the following respect: Each resident's wellbeing and welfare was not maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care such as wound care and restraint management.	
Action required: Facilitate each resident's access to physiotherapy, chiropody, occupational therapy, or any other services as required by each resident such as wound care specialist involvement.	
Action required: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.	
Action required: Provide a high standard of evidence based nursing practice in relation to pressure area care management, wound care and restraint management.	
Reference: Health Act, 2007 Regulation 9: Health Care Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	

<p>Each resident has access to specialist providers (dietician, physio, tissue viability nurse, occupational therapist, speech and language therapist, chiropody etc) and is referred as and when required. Follow up treatment advised by these providers is carried out for each resident as prescribed.</p> <p>GP letters are now forwarded to the GP prior to three monthly review reminding them that they need to review their residents in the nursing home and update their prescriptions.</p> <p>For residents requiring specialist review their GP is made aware of the situation and asked to refer to the follow on specialist services. Liaison with specialist services e.g. community psychiatrist, consultant surgeons and physicians are carried out to ensure that there is a multidisciplinary approach to each residents care.</p>	<p>Completed September 2011</p>
<p>Medical treatment recommended by specialist providers is carried out upon agreement with the resident and where permitted family/relative/representative.</p> <p>For residents with more complicated needs case management meetings will be requested requiring multi-disciplinary team involved in the residents care</p>	<p>Completed Sept 2011</p>
<p>All residents' pressure areas and skin integrity are assessed on admission. Following initial assessment and treatment in place and changing conditions of the resident further assessments are carried out as required. Observed daily by carers/nurses. Routinely reassessed at least every three months. For higher risk residents the reassessment will occur more frequently as per individual care plan. Each person is assessed on an individual basis. Any resident identified as at risk will have a care plan put in place and be referred to the tissue viability nurse for assessment, guidance, and advice. Staff have been reminded of the importance of following all procedures relating to pressure area relief management including turning, standing etc and the correct documentation of practices carried out. See point 4. Training has been arranged. A system has been developed for collection weekly statistics on resident welfare which will include pressure ulcers.</p>	<p>Completed September 2011</p>
<p>Training has been arranged for care staff on pressure ulcer detection and classification.</p>	<p>Complete November 9 2011</p>
<p>Wound management update training currently being organised in conjunction with the tissue viability nurse for nursing staff</p>	<p>Complete November 15 2011</p>
<p>Residents' care plans based on risk assessment will reflect management of restraints individualised to residents who use them.</p>	<p>Complete 30</p>

Resident sign off for use of restraints will be sought. Where the Resident is unable to sign off the decision will become a clinical one (Nursing, GP and physio where necessary). Next of kin will be involved in this decision making process.	November 2011
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<p>10. The person in charge is failing to comply with a regulatory requirement in the following respect: Assessment and care plans for residents needs in relation to wound care and restraint management was not fully completed in relation to each resident.</p>	
<p>Action required: Ensure each resident's needs are assessed and comprehensively set out in an individual care plan in relation to wound care and restraint management.</p>	
<p>Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Wound management training for staff nurses is being organised in conjunction with the tissue viability nurse.</p> <p>Staff nurses have been re educated on the use of the camera</p> <p>The importance of updating care plans as residents needs / conditions change re emphasized with staff nurses</p> <p>Restraint management – Residents now sign off consent to use restraints after their own decision or as part of a risk assessment. Where residents do not have the capacity to consent, clinical decision to use consent will be carried out as part of the reviews by the GP's either on a regular basis or as requested. The least restrictive solution based on risk assessment will always be implemented where restraints are required.</p> <p>Wound management policy updated and will be implemented on the 14 October 2011. Policy will be introduced to staff. Staff will sign off that they have read and understood the policy. The person in charge will be available to explain and answer any queries that staff may have.</p>	<p>Complete 15 November 2011</p> <p>Completed September 2011</p> <p>Completed September 2011</p> <p>Completed September 2011</p> <p>Completed September 2011</p>

Restraint management updated and will be implemented on the 14 October 2011. Policy will be introduced to staff. Staff will sign off that they have read and understood the policy. The person in charge will be available to explain and answer any queries that staff may have.	Completed September 2011
Care plan audit schedule in place.	Completed September 2011

Outcome 8: End of life care

<p>11. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: All procedures were not in place so that each resident received care at the end of his/her life which met his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.</p>	
<p>Action required: Put in place written operational policies and protocols for end of life care.</p>	
<p>Action required: Identify and facilitate each resident's choice as to the place of death, including the option of a single room or returning home.</p>	
<p>Action required: In the event of the sudden death of a resident, manage and respond to the resident's death with dignity and propriety by having appropriate emergency equipment readily available if required.</p>	
<p>Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>End of life policy updated and includes an assessment form regarding palliative care wishes and end of life wishes. Staff training will be completed by the 30 November 2011. Staff have read/will read the policy. The person in charge is available to answer queries on the policy.</p> <p>An assessment of each residents needs with regard to end of life is currently being undertaken.</p> <p>Emergency equipment central location has been located.</p>	<p>Update completed 14 October 2011 and implemented by 30 November 2011</p> <p>Complete by 23 September 2011</p> <p>Completed August</p>

Processes under development for facilitating extra emergency equipment	2011 Complete 30 November 2011
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Outcome 9: Food and nutrition

<p>12. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: Water was not available throughout all the communal areas if required by residents. Monitoring of residents with nutritional deficits was not adequate in all respects.</p>	
<p>Action required: Provider each resident with access to a safe supply of fresh drinking water at all times at various points outside of the two rooms used by the majority of residents if it is safe to do so.</p>	
<p>Action required: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake including comprehensive weight monitoring.</p>	
<p>Reference: Health Act, 2007 Regulation 20: Food and nutrition Standard 19: Meals and Mealtimes</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Kitchen Staff have been informed that fresh drinking water must be provided for all communal areas and a designated place for storing same has been identified.</p> <p>All residents are weighed routinely every month or as necessary. Weight recorded in the care plan. New weight measured against previous weights and any significant change is reported to the Dietician for assessment. Frequency is increased according to the dietician's recommendations. Nutrition and hydration policy reviewed and updated. Staff have read/will read the policy. The PIC is available to answer queries from staff.</p>	<p>Completed August 2011</p> <p>Completed August 2011</p>

Outcome 10: Contract for the provision of services

<p>13. The provider is failing to comply with a regulatory requirement in the following respect: Each resident did not have an agreed written contract which included details of the services to be provided for that resident and the fees to be charged.</p>
<p>Action required:</p>

<p>Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.</p>	
<p>Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Contracts of Care have been updated highlighting fees to be charged.</p> <p>Contracts of Care have been signed off by the provider. We are waiting on some signed contracts to be returned by residents/next of kin.</p>	<p>Completed September 2011</p> <p>Completed September 2011</p>

Outcome 11: Residents' rights, dignity and consultation

<p>14. The person in charge is failing to comply with a regulatory requirement in the following respect: Residents were not afforded all opportunities to participate in the organisation of the centre.</p>	
<p>Action required: Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.</p>	
<p>Action required: Put in place practices that facilitate and encourage each resident to communicate.</p>	
<p>Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Regulation 11: Communication Standard 2: Consultation and Participation Standard 17: Autonomy and Independence</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>

<p>Provider's response:</p> <p>Resident meetings will be held every second month.</p> <p>Resident Satisfaction Surveys to be completed on a quarterly basis.</p>	<p>Next residents, meeting to be carried out by 20 September 2011</p> <p>Next resident satisfaction survey to be completed and reviewed by 30 Sept 2011</p>
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<p>15. The person in charge is failing to comply with a regulatory requirement in the following respect: Residents were not afforded all opportunities to assist them with communicating.</p>	
<p>Action required: Put in place practices including necessary equipment that facilitates and encourages each resident to communicate.</p>	
<p>Reference: Health Act, 2007 Regulation 11: Communication Standard 2: Consultation and Participation</p>	

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>All residents are given the opportunity to communicate in an appropriate manner. Through information gained from initial assessment, communication with family, consultation with external service providers, internal service providers and activities coordinators, nursing care plans referencing communication are developed in accordance with all of the above. For those residents with a cognitive impairment, "talking mat" books have been ordered and we are awaiting delivery. These will be distributed to those residents who have been identified with a need for such communication aids.</p> <p>Activities coordinators have been instructed in Sonas and sessions for groups of residents with dementia commenced in the week beginning 3 October 2011.</p>	<p>Completed September 2011</p> <p>Completed week beginning 3 October 2011</p>

Hearing aids will be reviewed three monthly as necessary.	Complete 30 November 2011
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Outcome 12: Residents' clothing and personal property and possessions

16. The provider/person in charge is failing to comply with a regulatory requirement in the following respect: Up to date property lists were not maintained of residents' clothing.	
Action required: Maintain an up to date record of each resident's personal property that is signed by the resident.	
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Residents' property lists updated. Going forward resident property lists will be reviewed and updated.	Completed September 2011

Outcome 13: Suitable person in charge

17. The provider is failing to comply with a regulatory requirement in the following respect: The centre was not managed by a full time person in charge.	
Action required: Ensure that the post of person in charge of the designated centre is full time and that the person in charge is a nurse with a minimum of three years experience in the area of geriatric nursing within the previous six years.	
Reference: Health Act, 2007 Regulation 15: Person in Charge Standard 27: Operational Management	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Person in charge currently meets the criteria required to hold the	Complete

<p>said post in the area of gerontology. I refer you to Regulation 15(4) which states that; "Nothing in these regulations shall prevent the person in charge filling that role for more than one designated centre within an agreed geographical area once the Chief Inspector is satisfied that they are engaged in the governance, operational management and administration of all of the designated centres on a regular and consistent basis."</p> <p>A new CNM post has been created and a person has been recruited to fill the post and will commence work in October 2011 This person meets all the criteria required to hold this post.</p>	<p>October 7 2011</p>
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Outcome 14: Suitable staffing

<p>18. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: There are not appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre.</p>	
<p>Action required: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.</p>	
<p>Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>New nurses have been hired and are currently undergoing an adaptation programme. Manual handling training and recognition and responding to elder abuse training have been completed for the new staff nurses. Once adaptation process is complete the new staff nurses will receive fire training and evacuation procedure training.</p> <p>Further training on challenging behaviour has been arranged for September 24 2011.</p> <p>Key Nurses have been assigned to residents. External service providers have been invited to meet with key personnel in order to design appropriate and up to date care plans for residents.</p>	<p>Completed October 31 2011</p> <p>Complete September 24 2011</p> <p>Completed August 2011 and in progress</p>

<p>19. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: Staff did not have up-to-date mandatory training and access to education and training to meet the needs of residents.</p>	
<p>Action required: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.</p>	
<p>Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.</p>	
<p>Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 25: Training and Supervision</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>New nurses have been hired and are currently undergoing an adaptation programme. Manual handling training and recognition and responding to elder abuse training have been completed for the new staff nurses. Once adaptation process is complete the new staff nurses will receive fire training and evacuation procedures. We will use a validated assessment tool to determine an appropriate skill mix.</p> <p>Manual handling training and recognition and responding to elder abuse training has been carried out 09 September 211 and 10 September 2011 respectively for staff who were not up to date.</p> <p>A training needs analysis will be conducted at least annually or as identified through risk assessments, resident care needs, external advisors, and staff appraisals. Staff appraisals, training matrix, audits, risk assessments and the changing needs of the residents will all be carried out and used to identify what training is required to ensure that care is provided in accordance with contemporary evidence based practice.</p> <p>In respect of one resident with an acquired brain injury following consultation with his case manager from Acquired Brain Injury Ireland, a core care team has been formed coordinated by his named nurse. They will receive specific training in caring for and meeting the needs of this resident in October or November which will be facilitated by ABI Ireland. Meeting with case manager ABI</p>	<p>Complete 31 October 2011</p> <p>Completed 09 September 2011 and 10 September 2011</p> <p>Ongoing and will be completed by 30 November 2011</p> <p>Core care team formed in September 2011. Training complete 22 November 2011</p>

Ireland booked 14:00 14 October 2011.	
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<p>20. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: All staff were not recruited, selected and vetted in accordance with best recruitment practice.</p>	
<p>Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.</p>	
<p>Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Essential records as outlined in Schedule two were requested from staff. Staff with outstanding records have been notified by letter requesting essential documentation. Consequences of not conforming to our requests have been outlined in letters sent.</p> <p>Going forward persons to be employed must submit documentation prior to commencing work.</p>	<p>Complete by 30 September 2011</p> <p>Completed 25 July 2011</p>

Outcome 15: Safe and suitable premises

<p>21. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: All wheelchairs and assistive chairs provided for use by residents was not maintained in good working order.</p> <p>There was not procedures in place to ensure all parts of the centre were kept clean such as carpets.</p>	
<p>Action required: Put procedures in place where all wheelchairs and assistive chairs provided for use by residents are serviced and maintained in good working order.</p>	
<p>Action required: Put procedures in place to ensure all carpets in the centre are kept clean.</p>	

Reference: Health Act, 2007 Regulation 19: Premises Standards 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Wheelchairs and assistive chairs are serviced on a regular basis and maintained as required. Going forward it will be ensured that all wheelchairs/assisted chairs are fitted with a label to identify servicing. A schedule for cleaning carpets has been commenced.	Completed August 2011 2 Schedules Completed September 2011. Cleaning will commence in October 2011.

Outcome 16: Records and documentation to be kept at a designated centre

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

The details in the residents' guide as listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were not maintained.

Action required:

Produce a residents' guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.

Action required:

Supply a copy of the updated residents' guide to the Chief Inspector.

Action required:

Supply a copy of the updated residents' guide to each resident.

Reference:

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

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

Timescale:

<p>Provider's response:</p> <p>Revised residents' guide forwarded to the Chief Inspector.</p> <p>Each resident was supplied with a copy of the up to date residents' guide.</p>	<p>Completed 13 September 2011</p> <p>Completed September 2011</p>
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23. The provider and person in charge is failing to comply with a regulatory requirement in the following respect:

The directory of residents did not contain all the residents' details required by the legislation.

Action required:

Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

Reference:

Health Act, 2007
 Regulation 23: Directory of Residents
 Standard 32: Register and Residents' Records

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

Timescale:

Provider's response:

All details have been updated in the directory of residents.

Completed August 2011

24. The provider and person in charge is failing to comply with a regulatory requirement in the following respect:

The centre did not have all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required:

Put in place all of the written and operational policies listed in Schedule 5.

Reference:

Health Act, 2007
 Regulation 27: Operating Policies and Procedures
 Standard 29: Management Systems

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

Timescale:

<p>Provider's response:</p> <p>All policies completed as requested. Staff will read the policies and sign to say that they have read them. Mandatory training will be provided. Other training will be provided if a training needs assessment shows it to be necessary. Audits, risk assessments, fire drills, missing person's drills and evacuation drills will be carried out periodically.</p>	<p>Completed 14 August 2011</p>
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<p>25. The provider and person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>The centre was not adequately insured against loss of residents' personal property as detailed in regulation 28 (2).</p>	
<p>Action required:</p> <p>Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).</p>	
<p>Reference:</p> <p>Health Act 2007 Regulation 26: Insurance cover Standard 29: Management Systems</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Insurance cover in place highlighting the maximum amount of €1000.</p>	<p>Complete</p>

Outcome 17: Notification of incidents

<p>26. The person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>A record of all incidents occurring in the designated centre was not maintained and, where required, notified to the Chief Inspector.</p>	
<p>Action required:</p> <p>Provide a written report to the Chief Inspector at the end of each quarter of the occurrence in the designated centre of any accident.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 36: Notification of incidents Standard 29: Management Systems</p>	

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response</p> <p>All reports will be provided to the Chief Inspector within the specified timeframe(s) and at the end of each quarter.</p>	<p>Completed August 2011 and ongoing</p>

Any comments the provider may wish to make:

Provider's response:

I would like to thank the Health Information and Quality Authority on the professional manner in which the inspection was conducted and I wish to thank the inspectors for their comments and recommendations which we will endeavour to implement in a timely fashion.

Provider's name: Sarah Ann McGivney

Date: 12 September 2011