

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	New Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000073
<b>Centre address:</b>	Stocking Lane, Rathfarnham, Dublin 16.
<b>Telephone number:</b>	01 495 0021
<b>Email address:</b>	info@bloomfield.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Bloomfield Care Centre Limited
<b>Lead inspector:</b>	Helen Lindsey
<b>Support inspector(s):</b>	Sheila McKeivitt
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	28
<b>Number of vacancies on the date of inspection:</b>	8

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

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.

Regulation has two aspects:

- **Registration:** 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.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 15 January 2018 09:30 To: 15 January 2018 17:30

The table below sets out the outcomes that were inspected against on this inspection.

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 15: Food and Nutrition	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This was an announced inspection by the Health Information and Quality Authority [HIQA]. The inspection was carried as part of the process of gathering information to inform the renewal of the certificate of registration.

Inspectors reviewed 11 outcomes and found that 4 were fully compliant, 3 substantially compliant and four were moderate non compliant. Therefore improvement is required to ensure the regulations from the Health Act 2007 [Care and Welfare for Residents in Designated Centres for Older People] Regulations 2013 [as amended] are being met.

During the inspection inspectors met with residents, family and staff members. They also observed practices and reviewed documentation such as policies and procedures, care plans, medical records and records from allied health professionals. Nine questionnaires were returned with generally positive feedback about the service offered and the staff team. There was a general theme in relation to choice of food, and opportunities for activities out of the centre being areas where residents would

like improvements.

Residents were seen to receive care and support from a staff team who knew them well, and assessments were in place to identify their needs, with reviews taking place regularly if needs changed. Medication management was also well managed with clear processes in place for the receipt, storage and administration of medications. Staff were available to support the residents when required, for example during mealtimes, and a review of the rosters showed staffing levels were maintained at an agreed level to ensure residents need were being met.

There was good safeguarding and safety practice in the centre. Staff had been trained in relation to the safeguarding policies and procedures and know what to do if reports were made to them. There were processes in place to support residents with responsive behaviours and where restrictive practice was in use.

Areas identified as requiring improvement during the inspection related to oversight of the service being provided. They relate to governance and management arrangements, recording a rationale for some restrictive practice, care planning, layout of communal areas, and the times meals were served. This is discussed further in the report and in the action plan at the end.

Of the three actions made at the previous inspection, one had been addressed fully. Two actions remained outstanding relating to outcome 8 and outcome 11.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Statement of Purpose***

*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.*

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The Statement of Purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. However it was noted that it did not include all of the information set out in the registration certificate (conditions of registration) and the arrangements, if any, for emergency admissions.

**Judgment:**

Substantially Compliant

***Outcome 02: Governance and Management***

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.*

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There was a clearly defined management structure and management systems were in place. However some management systems were not being implemented in a way that ensured the delivery of safe, quality care services.

There was a clearly defined management structure setting out who was in charge of the centre, and the lines of accountability right up to the Board level. There was a newly appointed person in charge at the centre, but inspectors were unable to meet them during the inspection as they were on leave. The CNM2 was clear of the procedures in the centre, and was working with the staff team to ensure residents' needs were being met. Staff spoken with were clear of the management arrangements in place in the centre and who to report to in different situations.

The arrangements to oversee the running of the centre included a range of meetings with key personnel, a range of reports about performance in areas such as clinical indicators, and less formal arrangements including regular contact between the staff and senior management team. There was also lead staff in relation to health and safety, human resources and finance who had responsibilities for practice and reporting in the centre.

A range of management meetings used for governance and oversight were seen to take place regularly, and covered topics such as audits, clinical governance, and health and safety. The remit of the meetings was for the running of the designated centre along with the other services provided on the campus. The provider representative and CNM2 confirmed they met along with the person in charge every two weeks and discussed issues specific to the designated centre, but did not minute the topics discussed or the agreed actions.

Inspectors reviewed a range of audits in relation to medication errors, accidents and incidents, and complaints. While each of the reviews collated the number of events and compared them month by month there was no evaluation of the cause and no action plan of how to address any shortfalls noted. Staff were able to verbally describe actions they were taking but did not have written information that confirmed the approach, for example in relation to missed signature medication errors, and a recent audit completed in the centre during January 2018 found 50-60% compliance level in relation to care planning documentation. The provider did report that options to achieve improvements for care planning were being explored but this was not documented as part of the audit format. This links to the action made under risk assessment processes in the centre under outcome 8.

The provider was aware of issues identified by inspectors during this inspection (poor quality care planning, high use of agency staff, fire safety practice in relation to bedroom doors). They informed inspectors they received information through management meetings in the centre and were able to verbally describe how they were to be addressed. However the inspectors did not see documented evidence of how these issues had been identified, how agreement had been reached about what steps to take, monitoring of agreed actions and assurance that improvements were being made. This gap in risk management is discussed further under outcome 8 and the action is made under outcome 5.

The application for renewal had been requested, and submitted, but at the time of writing this report had not been accepted as complete. This is required 6 months in advance of expiry date. The registration expires on 12 June 2018.

**Judgment:**

Non Compliant - Moderate

*Outcome 05: Documentation to be kept at a designated centre  
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.*

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

As described in outcome 2, 7 and 8 examples were seen where the risk management policy was not being implemented in practice.

**Judgment:**

Non Compliant - Moderate

**Outcome 07: Safeguarding and Safety**

*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. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There were measures in place to protect residents from being harmed or abused.

There was a policy in place which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The staff had received training on identifying and responding to elder abuse and were able to describe to inspectors the signs of abuse and types of described in the policy. They were also clear what action to take if they witnessed or had abuse reported to them.

There was a policy provided to staff which gave clear guidance on 'managing behavioural and psychological symptoms of dementia' and provided useful information on signs of residents requiring support and the different approaches available. At the time of the inspection no residents were identified as having responsive behaviour, but staff were clear of the steps to put in place in relation to assessing needs and ensuring effective care plans were in place.

Progress was being made in working towards a restraint free environment and the use of restrictive practice was lower than at previous inspections. However a review of the risk assessment and review documentation found that the rationale for use of restraints and a record of the alternatives trialled, in the case of bed rails, were not consistently being completed. The action for this is made under outcome 8. A multidisciplinary team was in place to consider any applications for restrictions and records showed they met regularly to review the use of any restrictions in place.

The centre did not hold cash for any of the residents, and where possible added any costs, such as hairdressing or newspapers to the monthly invoice. At the last inspection it was identified that appropriate arrangements were in place where the provider was pension agent for residents and no changes had been made.

**Judgment:**

Compliant

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

**Findings:**

The health and safety of residents, visitors and staff was promoted in the centre. However the risk management procedure was not being fully implemented, this included an ongoing risk in relation to fire doors identified at the last inspection.

There was a health and safety statement for the centre which covered the health and safety of residents, staff and visitors. There was also a set of policies that covered health and safety issues. For example infection control, where practice in the centre was seen to follow the procedure and a range of personal protective equipment was available and hand washing facilities.

There was an emergency plan in place that described the arrangements in place for the centre in a range of different emergency situations. It gave clear instructions and a clear procedure for identifying the lead person in a range of scenarios.

There was a risk management policy in place. It covered hazard identification and assessment of risk and how risks were to be managed in the centre, including using a risk register.

The risk register was not up to date as risks identified during this inspection were not recorded. Inspectors reviewed documentation and had conversations with the provider representative and the CNM and identified that the risks were known, but had not been identified and managed through the risk management process as set out in the guidance. It was stated by the provider representative and CNM2 that the issues identified were discussed at a two weekly meeting of senior staff in the centre but not recorded, and so inspectors could see no evidence of any improvements that may have been achieved. Examples of risks not recorded and managed through the risk management process were bedroom fire doors, use of agency staff, and the care planning documentation. The action for this is made under outcome 5.

Inspectors reviewed policies on responding to accidents and emergencies, the incident reports, and the audit of all incidents in 2017. The provider described initiatives to reduce incidents such as falls, including setting up a working group to review current practice and how it could be improved. The number of falls was seen to have reduced.

On the day of the inspection the premises were seen to be clear of hazards, corridors were clear, and the centre was well maintained. There were records to indicate that staff had attended training in moving and handling. A range of hoists and slings were available in the centre to meet individual's needs. Inspectors observed that there was fire equipment provided throughout the building, and there were clearly marked escape routes that were free from obstructions. The procedure for evacuation was displayed on the wall in different parts of the centre. Records showed that fire extinguishers and emergency lighting had been serviced annually. The fire alarms were serviced quarterly.

Two fire drills had been carried out in 2017. They involved a scenario linked to an activation point. Records showed the staff involved and any lessons learned from the drill. There was also a weekly drill on a Friday where the self releasing doors were checked, and staff were reminded of the centres procedures. Staff spoken with were very clear of what to do in the event of a fire which was evidence of the training being effective. Inspectors read the training records which confirmed that all staff had attended training within the last year on fire safety.

At the last inspection it was identified that the bedroom doors had been designed with a door and a narrow panel that could be opened if a bed or a wide wheelchair needed to pass through. During this inspection it was noted this practice had not changed in relation to leaving the panel open as a number were seen open. This meant that in the case of a fire there would be no smoke or fire protection from the door as designed. There was no record of the procedure to manage this risk or whether the risk had reduced since it was drawn to the provider's attention on the last inspection.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

*Each resident is protected by the designated centre's policies and procedures for medication management.*

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Residents were protected by the designated centres procedures for medication management.

There was a medication management policy in place which provided guidance to staff to manage aspects of medication including prescribing, storing and administration. Staff spoken with were clear of the policies in the centre and their responsibilities when administering medication. Practice was observed and seen to be in line with An Bord Altranais agus Cnáimhseachais guidelines.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet. Where medications were to be given to residents crushed this was stated and signed by the general practitioner (GP).

The system for management of controlled drugs was reviewed and found to be in line with national standards. Nurses kept a register of controlled drugs and the balance was checked by two nurses at the change of each shift. The inspector checked a selection of the medication balances and found them to be correct.

All medicines were being stored safely and securely in a allocated room which was secured.

There was a clear process in place for the receipt of medication in to the centre, and the return of any unused medication to the pharmacy. Staff spoken with were clear about the process and showed how it was put in to practice.

There was a regular review of residents medication including the use of psychotropic medication. The process ensured allied professionals were reviewing prescriptions and ensuring they remained appropriate to meet residents healthcare needed

There was a system in place for the monitoring and review of medication practice in the centre. Recent audits were reviewed, and this is discussed further under outcome 8.

**Judgment:**

Compliant

*Outcome 11: Health and Social Care Needs*

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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.*

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Resident's health and social care needs were identified at the point of admission and processes were in place to ensure care plans were developed and then regularly reviewed. There was also good access to a range of healthcare professionals. However improvement was needed to ensure clear and consistent guidance was provided in the residents' records and care plans to ensure staff knew how to meet resident's needs. This action remains outstanding from the previous two inspections.

There were processes in place for preadmission assessments prior to residents being offered a place at the centre. The CNM2 and the provider representative were both clear of the process, and also clear of what needs could and could not be met. There was a process in place to complete an assessment on admission, and to set up care plans in relation to residents identified needs. There was also a clear process in place to review resident's needs. Reviews were carried out by the multidisciplinary team and were carried out every three months. Residents and their families were invited to attend. The reviews considered if the care and support offered to the resident remained appropriate and whether any additional supports were required.

While there were care plans in place they did not provide sufficient detail to guide staff practice, and the evaluation and progress notes did not correspond with them. For example a communication assessment had been updated but the care plan was not updated to reflect the changes. This meant there was a risk that residents would not receive the care and support required to meet their current needs. Care plans reviewed by inspectors continued to lack detail about individual choice and preferences and used generic statements when describing care.

The system for auditing care plan documentation required improvement and is addressed under outcome 2.

Residents and relatives who spoke with inspectors, and those who completed the HIQA questionnaires were positive about the care and support provided in the centre, and about the quality of the staff team. During the inspection staff were seen to be attending to residents needs including responding quickly to alarm calls. At the meal times staff were seen to know residents dietary requirements and the appropriate way to support individual residents. Effective communication approaches were also seen to

be used by the staff, for example when talking with residents with hearing impairment. All residents were well presented and many were up and ready for the day when the inspection commenced, with those who chose to stay in bed having their choice respected.

There was access to a range of healthcare professionals to meet the resident's needs. For example occupational health, psychiatry and a pharmacist. Selections of assessments by healthcare professionals were seen to be in place, and referrals for the assessments were seen to be in line with the organisations policies. For example when nutritional needs required review a dietician attended to complete an assessment.

A range of clinical nursing tools were used to support nurses in monitoring resident needs. For example risk of falls, or developing pressure areas. Also assessments to ensure appropriate manual handling practices were being used for the resident. However as stated above, examples were seen where the results of the assessments were not then used to review the care plan. For example a change in skin integrity was not described in a care plan which could result in appropriate care and treatment being missed.

Nursing staff were seen to complete a detailed hand over where verbal information was shared and the examples reviewed did reflect the resident's current needs.

**Judgment:**

Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***

***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. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The centre was well maintained internally and externally. It was kept clean and was suitably decorated. However the layout of some rooms required review to ensure it met the needs of the residents.

The designated centre is part of a campus providing a range of different services. Access is through a communal reception area that was staffed 24hrs a day with a receptionist during working hours, and security staff at other times. There was access to joint facilities such as a large canteen for residents, staff and visitors.

The centre is made up of 32 single en-suite bedrooms and two double bedrooms, which were also en suite. There was screening available in the double rooms for privacy of the residents. All rooms had a wash hand basin, storage for clothing and belongings, and each bed had a call bell system within reach, and in working order. Residents rooms were seen to be personal in nature, with their own belongings and photographs to make a homely environment, as they preferred. Those spoken with described them as comfortable and with sufficient furniture to meet their needs.

The design of the centre was seen to promote residents dignity and independence of movement in the service, with handrails along the corridors. Bathrooms and toilets also had grab rails and shower seats for those who needed them.

It was noted that one area in the centre was used by the residents throughout the day. It was a large room next to the nurses' station. It was furnished with dining tables and dining chairs. There was a small selection of other seating available in this room, but overall the layout was of a dining room. It was noted through the day that residents were not generally moving from this room, and a number were seen to be sitting at the tables for long periods. While there was adequate space in the centre overall and a separate lounge area with a range of seating options was available, it was not being used. Relatives and residents commented on this to inspectors, and also provided feedback in the questionnaires submitted to HIQA that they felt this arrangement should be reviewed to improve comfort for residents.

There were a range of outdoor spaces with extensive views over Dublin and residents and relatives commented that they really enjoyed these when the weather was good. Residents were also able to garden if they wanted to. The gardens were well maintained, and easy to access from the main rooms, and some of the bedrooms.

There was a good standard of cleanliness and hygiene was maintained in the centre. Cleaning staff were seen to be respectful about entering resident's bedrooms. On the day of the inspection the centre was found to be of a comfortable temperature, with adequate lighting and ventilation.

There was also a range of equipment available to meet residents needs, for example a selection of hoists.

**Judgment:**

Substantially Compliant

***Outcome 13: Complaints procedures***

***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.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

A review of complaints showed that where they had been made, they were dealt with in a timely manner. Each record included the outcome and whether the complainant was satisfied.

**Judgment:**

Compliant

***Outcome 15: Food and Nutrition***

*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.*

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Residents were provided with food and drink in quantities adequate for their needs, however a review was required of the timings of meals and also the choice and options available for residents who required a modified diet.

There were policies in place that directed the practice of staff in the centre to ensure procedures were in place to support good nutrition and hydration in the centre.

The menu was seen to operate on a four week cycle, and had been reviewed by the dietician to give input on the nutritional value. Meals served were seen to be hot and well presented. The menu showed that choices were available, however it was noted that for residents taking a modified diet (liquidised) a similar meal of meat and potato was served at lunch and tea time. Some residents who fed back on the HIQA questionnaire said the choices were limited.

Drinks were served throughout the day, and residents had access to water at all times.

Inspectors noted that the lunch time meal was served at 12.45. For those residents receiving a modified meal they were supported to eat their next meal from 16.15. A supper was then available for those who chose to take it at 19.30. Breakfast was reported to be served around 9am. This pattern meant that two hot meals were served to some residents with only a 3 and a half hours gap and there was a thirteen and a half hour gap between supper and breakfast. While no residents reported being hungry or not having access to food and drinks when they wanted them, this should be reviewed to ensure all residents' nutritional needs were being met including those who were not able to make their choices known through verbal communication.

While the dining room was generally well presented it was noted that condiments such as salt and pepper were not available on tables, and sauces were in packets that residents were noted to have difficulty opening. Also drinks were available in jugs at the side of the room, so residents would have to ask staff for them. To promote independence a review should be carried out of these practices.

During a mealtime inspectors observed positive interactions between staff and residents, with support being provided by the staff team where required. Residents were chatting and engaging with peers and staff during the meal, and so it was observed to be a pleasant social experience.

While residents made some suggestions for improvements as set out above, others said they enjoyed the food very much. It was also noted that no complaints had been made through the formal procedure or during the recent residents meetings.

**Judgment:**

Substantially Compliant

***Outcome 18: Suitable Staffing***

*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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.*

**Theme:**

Workforce

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There were appropriate staff numbers with the relevant skills and training to meet the needs of the residents.

At the time of the inspection the staffing levels were seen to take in to account the layout of the centre and the needs of the residents. Residents were being supported by appropriate numbers of staff, and those residents spoken with confirmed that staff responded to requests for support quickly. It was fed back to the provider that a small number of respondents to the HIQA questionnaire felt staff numbers at night limited options in relation to when to retire, they agreed to look in to this.

The CNM2 was supernumerary and dealt with the running of the centre, supported by the person in charge. As at the last inspection there was a person nominated in charge of each shift, and they were broken down in to three teams. Nursing staff were on duty at all times, supported by healthcare assistants and household staff. Feedback from

residents was very positive about the staff team, describing them as very caring.

There was ongoing recruitment of staff to cover a number of vacant healthcare assistant posts. To cover all shifts agency staff were being used most days. Where possible the same agency staff attended the centre to provide more consistency for residents. There was an agreement in place with the agency to ensure all staff had appropriate checks in place, such as Garda vetting.

There were effective recruitment procedures in place in the centre. Staff files of the four most recent recruits were reviewed and they all contained the requirements as per Schedule 2 of the regulations (References, qualifications and a full employment history). All nurses employed in the centre were registered with the Nursing and Midwifery Board of Ireland. The provider confirmed all staff had Garda vetting in place.

All volunteers working in the centre had appropriate checks, including Garda vetting prior to commencing their role in the centre. They also had a description of their role, and were supervised at all time in the centre.

Records showed that staff had completed fire safety training and protection of residents from elder abuse. A tool was in place to identify when staff were due to update their training, and also included other courses offered by the provider. Examples of other training staff had completed included supporting people with responsive behaviour, nutrition and dysphasia falls prevention, palliative care needs.

The human resources staff were also working with the provider to complete a training needs analysis to guide them in what other courses would support the staff team to have the relevant skills to meet the identified needs of residents.

**Judgment:**

Compliant

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

Helen Lindsey  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



#### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	New Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000073
<b>Date of inspection:</b>	15/01/2018
<b>Date of response:</b>	14/02/2018

#### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

#### Outcome 01: Statement of Purpose

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

The statement of purpose did not include:

- arrangements for emergency admissions (if any)
- all the information set out in the certificate of registration, specifically the conditions of registration.

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

**1. Action Required:**

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The Statement of Purpose has been revised to include a statement that we are unable to facilitate emergency admissions and the standard conditions attached to registration.

**Proposed Timescale:** 14/02/2018

**Outcome 02: Governance and Management****Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

The application to renew registration had not been submitted with all prescribed documentation.

**2. Action Required:**

Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

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

The original application for the renewal of registration was submitted on 12 December 2017 with identified documentation to follow. This documentation was submitted on 31 January 2018.

**Proposed Timescale:** 14/02/2018

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Management systems were not being implemented to ensure the service was safe and effectively monitored.

**3. Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

A more detailed set of minutes are now being produced from fortnightly management meetings to identify in written format the plan and outcome of actions and improvements.

**Proposed Timescale:** 14/02/2018

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

The risk management policy was not fully being implemented in practice.

**4. Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

A more detailed set of minutes are now being produced from fortnightly management meetings to identify in written format the plan and outcome of actions and improvements.

**Proposed Timescale:** 14/02/2018

**Outcome 08: Health and Safety and Risk Management**

**Theme:**

Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Adequate arrangements for containment were not in place due to the practice of a panel on bedroom doors being left open with no associated plan in place to manage in the event of a fire.

**5. Action Required:**

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

The preference identified by four residents to have their bedroom door partly opened at night-time is respected and the practice in the event of a fire to close the door to ensure containment has been put in writing in the fire procedures. A further revision of the plan now includes the installation of automatic door release units on the identified

four bedroom doors.

**Proposed Timescale:** 14/02/2018

### **Outcome 11: Health and Social Care Needs**

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Examples of care plans were seen that did not provide clear direction on how residents needs were to be met, and were not person centred.

**6. Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

A review of the content of care plans is underway to ensure that they provide clear and consistent guidance for teams.

**Proposed Timescale:** 30/04/2018

### **Outcome 12: Safe and Suitable Premises**

**Theme:**

Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

The dining room and lounge should be reviewed to ensure they layout is suitable for the needs of the residents.

**7. Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

A review is underway to determine improves that are required to the dining and lounge areas for residents.

**Proposed Timescale:** 30/03/2018

## Outcome 15: Food and Nutrition

**Theme:**

Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Choice of meals for residents required review, including for residents requiring a modified diet.

**8. Action Required:**

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

A review is underway of the choice of meals for residents requiring a modified diet will be completed by 23 March 2018.

**Proposed Timescale:** 23/03/2018

**Theme:**

Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Meal times required review to ensure residents nutritional needs were being met.

**9. Action Required:**

Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

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

Currently residents currently have breakfast, lunch, tea and supper. A review is underway of the nutritional requirements of residents and will be completed by 23 March 2018.

**Proposed Timescale:** 23/03/2018