

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Newpark Care Centre
<b>Centre ID:</b>	OSV-0000150
<b>Centre address:</b>	Newpark, The Ward, Co. Dublin.
<b>Telephone number:</b>	01 864 3465
<b>Email address:</b>	info@newparkcc.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Newpark Care Centre Limited
<b>Provider Nominee:</b>	Matthew McCormack
<b>Lead inspector:</b>	Ann Wallace
<b>Support inspector(s):</b>	Siobhan Kennedy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	71
<b>Number of vacancies on the date of inspection:</b>	1

## **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 monitor compliance with National Standards. This monitoring inspection was announced and took place over 1 day(s).

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

From: 09 November 2017 09:00 To: 09 November 2017 18:30

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	Compliant
Outcome 02: Governance and Management	Substantially Compliant
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	Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	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 purpose of the inspection was to monitor 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. There were 70 residents accommodated at the centre on the day of the inspection, one vacancy and one resident in hospital.

As part of the inspection the inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. The inspectors also reviewed a number of questionnaires returned to HIQA by residents and relatives prior to the inspection.

The centre had completed the actions relating to staffing , health and social care and medications since the last inspection. Overall inspectors found a good level of

compliance across all outcomes inspected. However improvements were required in the centres recruitment and selection processes as Garda vetting was not in place for one member of staff working in the centre. The provider addressed the issue immediately and the member of staff left the premises at the time of the inspection and did not return to work until the required vetting had been obtained.

There was a clearly defined management structure in place and governance arrangements had improved in line with the action plan following the previous inspection. The provider nominee and the person in charge (PIC) demonstrated knowledge and an awareness of their responsibilities in relation to the legislation and cooperated fully with the inspection process.

Care was found to be person centred and staff knew the residents well. Throughout the day inspectors observed that staff demonstrated genuine respect and empathy in their interactions with the residents that they cared for.

The centre is a purpose built single storey building which provides accommodation for 72 residents. The premises is set in a pleasant countryside area close to major road links. Public transport links are available but these are limited. The centre has a large staff and visitor car park to the front. The premises are fully wheelchair accessible and there are disabled parking spaces available.

There are 69 single en-suite rooms and one multi-occupancy room with three beds. Accommodation is laid out over three distinct units, Aisling, Papillon and Mayfield. Mayfield and Papillon provide accommodation for longer term residents and Aisling is a short term and respite unit. Papillon has been designed to provide dementia specific care. Each unit has its own enclosed garden space with seating and pleasant landscaping.

The centre provided an activities programme for residents from Monday to Sunday. Two dedicated activities coordinators planned and supervised the daily programme.

The in-house physiotherapist provided a range of physical exercise programmes to meet individual resident's needs. The inspectors noted that this was a particular strength of the centre.

Visitors were made welcome and the inspectors observed a number of visitors in the centre throughout the day of the inspection.

Comments from residents and relatives who had returned the questionnaires prior to the inspection reported high levels of satisfaction with the care and services provided at the centre.

**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:**

There is a written Statement of Purpose that accurately describes the service that is provided in the centre.

The Statement of Purpose included a statement of the aims, objectives and the ethos of the designated centre and a statement of the facilities and services that were available for residents. The document included all of the information required in Schedule 1 of the Health Act 2007 (Care and Welfare of residents in Designated centres for Older People) Regulations 2013.

The Statement of Purpose was reviewed regularly and was last reviewed in October 2017.

**Judgment:**

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):**

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

**Findings:**

There were effective management systems and sufficient resources in place to ensure that residents received safe and appropriate care and services. The actions from the previous inspection in relation to the annual review of the service had been addressed by the provider.

The inspectors found that there was a clear management structure in the designated centre and that staff were clear about the structure. The centre is operated by Newpark Care Centre Limited. The senior management team included the person nominated on behalf of the provider (the provider), the person in charge (PIC) and two further directors of the company. The provider works full time at the centre and was on site throughout the day of the inspection. The provider had line management responsibility for housekeeping, catering and maintenance staff in the centre.

The person in charge is a qualified nurse and works full time at the centre. She has been in post as the PIC in the centre since 2005. She holds a management qualification and is a Best Practice Facilitator in Dementia Care with the University of Stirling. The PIC had line management responsibility for physiotherapy, nursing and care staff, and activities staff.

The PIC is supported in her role by two clinical nurse managers (CNM) who are responsible for the support and supervision of nursing and care staff and the clinical audit programme. The CNMs provide senior nurse cover over seven days and deputise for the PIC in her absence. The CNM role is a new role in the centre and the two senior nurses work part time as nurse in charge of their unit and part time dedicated hours in the CNM role. At the time of the inspection the PIC and CNMs were developing the CNM roster to ensure that the dedicated CNM time was protected in the future.

Inspectors found that the provider regularly reviewed the allocation of resources to ensure that they were in line with the statement of purpose. Additional nursing staff had been recruited since the last inspection and the CNM role had been developed to provide support and supervision and clinical oversight on the units. Records showed that staffing levels were reviewed regularly. For example in response to the findings of falls audits in 2017 the centre had developed a Falls Prevention Strategy. Part of the strategy had been to introduce new shift patterns to ensure adequate staffing levels were available to supervise residents in the communal areas and when they were mobilizing in the centre. This had helped to reduce the number of falls that had occurred in the centre in 2017.

The provider and PIC were seen to work well together to provide leadership and management support and supervision to the various departments in the centre. They met regularly and each had a clear system of delegation and communication with the departments that they managed. For example the PIC held weekly multi-disciplinary meetings with nursing and care staff and the in-house physiotherapist. These meetings discussed resident issues and incidents and accidents such as falls and medication errors. Action plans were agreed following the meetings and the plans were reviewed at subsequent meetings. The provider met with catering, maintenance and housekeeping

teams.

The provider and PIC held monthly risk management meetings with staff representatives from each department. At these meetings staff from the various departments presented a monthly report of how complaints, risks and incidents had been managed and reviewed the progress of the action plans that had been put into place.

Inspectors reviewed the systems that were in place to monitor care and services provided in the centre. The provider carried out regular audits of practices against the centre's policies and procedures and each policy was audited over a two year period. Action plans indicated where policies needed to be updated to reflect new practice guidance or legislation and where practices in the centre needed to be improved to bring them into line with the policies and procedures.

In addition the PIC and CNMs audit calendar included three monthly audits of care plans, incidents, restraints, medication errors, pressure sores, end of life and nutrition and hydration. Documentation in relation to these audits needed to be improved to ensure that clear action plans were recorded in order to support the implementation and review of improvements identified.

In line with the regulations the provider had completed an annual review of the safety and quality of care and services provided to residents. Following the actions required from the previous inspection the provider had included a resident satisfaction survey and comments and feedback from residents meetings and the complaints process as part of the annual review for 2016. The 2016 review had identified areas for improvement in the activity programme, opportunities for residents to take exercise and resident's opportunities for engagement in the local community. Records showed that these areas had been addressed by the provider and that the planned improvements were being incorporated into the current activities and social programmes. For example local volunteers had been recruited to come in to the centre to meet and chat with residents.

**Judgment:**

Substantially Compliant

***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):**

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

**Findings:**

The records required in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were well maintained and easily retrievable. However Garda vetting was not available for one member of staff as required in Schedule 2.

The designated centre had all of the written operational policies in place as required by Schedule 5 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Policies and procedures were reviewed and updated.

Inspectors found that the actions from the previous inspection in relation to the information about residents on admission, the prescribing of crushed medications and the documentation of fire drills in the centre had been satisfactorily completed.

However inspectors found that one member of staff who was newly appointed at the centre did not have Garda vetting in place. This was addressed by the provider and the member of staff left the premises immediately and did not return to work until their Garda vetting had been received by the provider. As a result all the documents required by Schedule 2 of the regulations in relation to all staff members were not available at the time of the inspection.

**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 suffering abuse are in place and appropriate actions are taken in response to allegations or disclosures of suspected abuse. There was clear evidence that the centre was working towards a restraint free environment.

The designated centre had policies and procedures in place for the prevention, detection and response to abuse. Staff were trained on the policy and were clear about their

responsibilities to safeguard residents and protect them from abuse. Staff who spoke with the inspectors knew what constitutes abuse and what to do in the event of an allegation or disclosure of abuse. Staff knew who to report the concerns to.

Residents who spoke with the inspectors told them that they felt safe in the centre and that staff were kind and respectful towards them. Residents said that if they had any concerns they could approach a member of staff.

Inspectors reviewed a sample of staff files and found that one member of staff who was newly appointed at the centre did not have Garda vetting in place. This was addressed by the provider at the time of the inspection and the member of staff left the premises immediately and did not return to work until their Garda vetting had been received by the provider. This is discussed further under Outcome 5. The provider informed the inspectors that all other staff and volunteers working in the centre at the time of the inspection had Garda vetting in place.

The centre had clear policies and procedures in place to safeguard residents' monies in the centre. Monies were stored securely and two members of staff signed for all transactions.

There was a policy in place for managing residents with responsive behaviours (how a person with cognitive impairment might respond to their environment or other stimuli). A number of staff had completed training in dementia care and managing responsive behaviours. The person in charge held a specialist qualification in dementia care and took the lead in developing care and services in this area in the centre.

Residents who were identified as having responsive behaviours had a care plan in place which recorded the potential triggers for the behaviours and the interventions that were required to support and reassure the resident. Staff were observed to use gentle encouragement and support in their interactions with residents who became anxious or displayed responsive behaviours. Staff knew individual residents and how to support them at these times. Care plans also identified potential underlying problems that could trigger responsive behaviours such as urinary tract infections and constipation.

Inspectors found that the centre was working towards a restraint-free environment and that processes and practices in relation to restraint were in line with best practice guidance. The number of restraints had been reduced over the previous twelve months and there were three bedrails in use at the time of the inspection. Resident's care records showed that alternatives such as low-low beds and crash mats were trialled before bedrails were installed. Residents, their families and their General Practitioner (GP) were involved in the decision to use bedrails. The centre maintained a restraint register but not all restraints had been included in the register. This was addressed at the time of the inspection.

**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):**

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

**Findings:**

Inspectors found that the health and safety of residents, visitors and staff was promoted and protected in the designated centre. The actions from the previous inspection had been addressed.

There were comprehensive policies and procedures in place to promote and protect residents, visitors and staff. Policies and procedures were reviewed regularly. There was an up-to-date health and safety statement. The risk management policy included the issues set out in Regulation 26 and the arrangements that were in place for recording, identifying, investigating and learning from incidents and adverse events that involved residents.

There was an emergency plan in place in the event of a serious event which caused disruption to the care and services provided for residents in the centre or damage to the property.

The centre held monthly risk management meetings with staff from the various departments to discuss ongoing and new risks that had been identified. Minutes and action plans were recorded and implemented. Staff who spoke with the inspectors were aware of any risks relating to the residents that they were caring for. The person in charge prepared a detailed quarterly review of all incidents.

The centre had a clear falls prevention policy in place which included the multi disciplinary assessment and review of residents who were identified as being at risk of falls and a monthly falls audit. The centre had a full time physiotherapist who worked with nursing and care staff to implement the centre falls management plan. Inspectors observed that residents were seen regularly by the physiotherapist and that individual residents had an up to date mobility care plan in place. Residents were encouraged to mobilise either independently or with the support and supervision of staff. Staff were knowledgeable about individual resident's mobility needs. Inspectors noted that this was a particular strength of the centre.

A small number of residents continued to smoke in the designated smoking area. Residents who smoked had a risk assessment in place. Risk assessments documented the measures that needed to be in place to maintain the resident's safety and include the level of staff supervision and where the resident's cigarettes and lighter were to be kept. Inspectors found that staff were aware of the measures that were in place for each resident but found that one resident had a lighter in his possession. This was addressed by the person in charge at the time of the inspection and the resident

returned the lighter to staff for safe keeping.

The centre had clear fire safety policies and procedures in place. The centre had reviewed the fire drill procedure and was using a card system which ensured that each staff member attending the emergency was clear about the actions they were to take. All staff had been trained in the procedure and documents showed that fire drills were carried out regularly and clearly documented.

Staff who spoke with the inspectors were clear about the procedure in the event of a fire emergency.

The records of fire drills were reviewed and inspectors noted that times, date, staff involved and the adequacy of the response was documented. This was an action from the previous inspection.

The fire evacuation procedure was displayed at several points throughout the centre. Service records showed that equipment such as emergency lighting, the fire alarm and fire fighting equipment had been serviced regularly by a reputable company. Weekly checks were carried out on the fire panel and emergency doors. Fire exits were kept clear.

The centre had a comprehensive range of infection control policies and procedures which had been reviewed and reflected best practice guidance. Staff received infection control training as part of their mandatory induction training. Regular training updates were provided for all staff. Staff told the inspectors that they had good access to PPE. Inspectors observed that staff demonstrated good infection control procedures in their day to day work.

**Judgment:**

Compliant

***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):**

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

**Findings:**

There were appropriate management systems in place to ensure safe medication practices. The inspectors found that the improvements required in relation to the prescribing of nutritional supplements following the previous inspection had been satisfactorily implemented.

There was a comprehensive medication policy in place which gave clear guidance to nursing staff on the procedures to follow for ordering, monitoring, documenting,

administering and the disposing of un-used and out-of-date medications. The policy included the procedure to follow in the event of medication errors. Monthly medication administration audits were completed and a comprehensive pharmacy audit of all areas relating to medications was completed every three months.

A sample of medication records was reviewed. The inspectors found that the records included the name of the drug and the time of the administration and that the nurse signed the medication record after each administration. The drugs were administered within the prescribed timeframes. If a resident refused medication this was recorded correctly. Drugs being crushed were signed by the general practitioner (GP) as suitable for crushing and liquid alternatives had been sourced where possible. Nutritional supplements were prescribed by the resident's GP in line with recommendations from the resident's dietician. Residents' medication was reviewed regularly by their GP.

Staff administering medication were seen to follow appropriate medication management practices in line with relevant professional best practice guidance.

Medications were stored securely. Controlled drugs were stored in a locked cupboard within a locked cupboard in the clinical room. Nurses kept a register of controlled drugs. They were checked by two nurses at the change of each shift. The inspectors checked a selection of controlled drug medication balances and found them to be correct. Medications that needed to be stored in the fridge were stored as directed. Opened medication was labelled with date of opening. The inspectors found that the temperature of the drugs fridge had been recorded daily in line with best practice guidance and the centre's own medication policy.

There was an effective system in place to manage the return of out-of-date and un-used medications with records providing a clear audit trail.

**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):**

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

**Findings:**

Each resident had a comprehensive assessment of their needs and a written care plan that described how their needs were to be met. Care plans were devised with input from residents and or their families. The inspectors found that the actions required following the last inspection had been satisfactorily implemented. These were in relation to care plan documentation and the management of residents' nutritional needs.

There were comprehensive policies and procedures in place that set out the processes that should be used to assess each individual resident prior to admission and on admission to the centre and the care planning process that was in use in the centre. The care planning policy described the processes in place to ensure that resident's needs were reviewed four monthly or more often if there was a change in their health or wellbeing and that their care plan was updated accordingly.

A selection of residents' records was reviewed. The inspectors found that each resident had a pre-admission assessment completed prior to coming into the centre. Following admission, nursing staff worked with the resident and or their family to complete a comprehensive assessment of the resident's needs including actual and potential risks such as weight loss, falls or responsive behaviours. Where health or social care needs were identified, a care plan was drawn up and agreed with the resident and or their family. Care plans were person centred and provided clear information about individual residents current needs and preferences for care and routines. This was an improvement from the previous inspection.

Clinical risk assessments were completed for skin integrity, falls, nutrition, continence, moving and handling needs and responsive behaviours. Risk management plans were seen to promote residents' independence and self-care abilities where possible.

The inspector found that residents had good access to GP services and a range of allied health care professionals including dietician, speech and language therapy, chiropody, dentist and optician and specialist teams such as the palliative care team, community mental health services and psychiatry of later life. Referrals were made appropriately, and where allied professionals had made recommendations for care these were found to have been implemented. For example; modified diets as recommended by the dietitian or speech and language therapist and exercise and mobility improvement plans as designed by the physiotherapist.

Residents and their families reported high levels of satisfaction with the care and support provided in the centre and said that they were kept informed about any changes in their care or services.

Where residents were temporarily absent from the centre, records showed that relevant information was sent with them. Also, when residents returned from another care setting to the centre there was a clear summary of the resident's needs and plan of care.

**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 at times and in quantities adequate to meet their needs.

The inspectors found that there were systems in place for ensuring that individual resident's food and nutritional needs were assessed and that appropriate care plans were put into place. Residents were weighed monthly and any weight loss or gain was responded to appropriately.

Where nutritional risks were identified referrals had been made to dietetic and/or speech and language services. The inspectors found clear evidence that when recommendations were made by dietetic and speech and language therapists these were implemented promptly and the relevant care and catering staff were made aware of the changes.

Residents were seen to receive modified diets in line with their current care plans. Where indicated residents fluid and dietary intake was recorded by care staff and these records were checked by the nurse in charge at the end of each shift.

The centre had a new chef in post. The chef was aware of individual resident's needs and preferences for meals and nutrition. All meals and snacks were prepared on site. The kitchen was clean and tidy. Food was seen to be appropriately stored and safely prepared, cooked and served.

Inspectors observed that residents had a choice at each meal time. Menus were provided in written and pictorial form. Residents could take their meals in the dining room on each unit or in their rooms. Some residents preferred to take their meals in the lounge areas. The tables in the dining rooms were set with individual place settings and condiments. Meals were nicely presented including the textured diets. Staff were observed to offer discreet support and encouragement to those residents who needed help at meal times. These needs were documented in individual resident's care plans.

Residents were asked at each meal time which option they preferred. Staff spoken with informed the inspectors that snacks and drinks were available at all times in the kitchen. Residents and relatives were able to request drinks at any time and staff were observed to respond to these requests promptly.

Resident meetings showed that meal times were discussed regularly and any

suggestions were communicated to the catering team. Menus had been reviewed as a result of feedback from residents. Residents spoken with during the inspection told the inspectors that they enjoyed their meals at the centre. This was supported in the feedback from resident/relative questionnaires that were returned to the inspectors as part of the inspection process.

**Judgment:**

Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***

***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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspectors found that residents were consulted in how the centre was run and that there was a person centred approach to the residents that respected their privacy and dignity.

Inspectors observed that staff were courteous and respectful in their interactions with residents and their families. Staff were observed to knock before entering a resident's room or a bathroom and to wait for a response before entering. Staff used privacy notices on bedroom doors to alert others when the resident was in their room receiving personal care.

Throughout the inspection residents were seen to be making choices about their day to day life at the centre. For example when to get up, what to eat and drink at meal times, where to spend time in the centre and what activities to take part in during the day. There were televisions, radios and newspapers available for residents to access.

Where residents had communications needs these were identified in their assessment and care plans and staff were familiar with the most effective way to engage with individual residents. The inspector observed that staff demonstrated empathy and patience in their dealings with residents who had cognitive and communication needs.

Residents were offered a range of recreational activities to meet their needs and preferences. The centre had a planned activities programme which was organised by a dedicated activities team. The programme included 1:1 and group activities. Residents

were seen mobilizing around the unit on their way to the various activities on offer including arts and crafts and an exercise to music session in the main lounge.

The centre had a calendar of planned days out and there was an upcoming trip to a seaside hotel booked for ten residents. Events such as a Jersey Day had been organized by staff and residents and their families had participated to raise funds for charity. Photographs showed that residents enjoyed a number of outside events in the warmer weather and these were organized in the garden areas.

A number of staff had completed training in activities for residents with cognitive impairment. Staff were observed to be skilled in motivating and supporting residents with cognitive impairments to participate in activities and to engage socially. However inspectors observed that one resident did spend long periods of time in the communal area with no meaningful activity. This was discussed with staff and the PIC who acknowledged that the resident had not engaged with activities but this had been their choice.

There were regular residents meetings and records showed that topics such as meal choices and activities in the centre were regularly discussed. The centre produced a quarterly newsletter with input from staff and residents. Residents and families told the inspectors that they looked forward to getting the newsletter when it came out each quarter.

Residents and families who spoke with the inspectors said that they saw the provider and the person in charge regularly and that they were approachable. Relatives reported that if they had any concerns that these were addressed promptly and that they were kept informed about any changes to the residents health or wellbeing.

The centre had carried out an annual survey of residents and their families. In line with the action plan from the previous inspection the survey was used to inform the centre's annual review for 2016.

The records of the resident's meetings held since the last inspection were made available to the inspectors. The records showed that resident feedback was listened to and was used to improve services in 2016/17. For example menus were reviewed to take account of resident's feedback and when residents had requested specific outings these were arranged.

Residents were supported to engage in religious activities of their choice. Mass and communion were available in the centre. Staff were aware of individual residents religious preferences and needs and were respectful of same.

There was access to advocacy in the centre and details were provided in the resident's guide and on notices throughout the centre.

Residents were supported to vote in elections if they wished to do so.

**Judgment:**  
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):**

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

**Findings:**

The inspectors reviewed the staffing levels, actual and planned staff rosters, staff training records and spoke with staff, residents and visitors. The inspectors found that the actions from the previous inspection in relation to staffing levels had been addressed. There were sufficient staff with the required skills to deliver safe and effective care to meet the assessed needs of the residents who lived at the centre.

Since the last inspection the centre had completed a successful recruitment drive for nursing staff. The appointment of two clinical nurse managers from existing nursing staff had created one further nursing vacancy which had also been filled.

There were three nurses on duty 8am to 8pm including the clinical nurse managers. There were two nurses on duty on 8pm to 8am. Health care assistant vacancies were currently being covered by existing staff in the centre. As a result the staff on duty reflected the planned roster on the day of the inspection.

Those staff who spoke with the inspectors reported that there were adequate numbers of nurses and health care assistants available in the centre.

The planned rosters took into account the layout of the centre and the levels of care and supervision required. Staffing levels were reviewed regularly in response to changing resident dependencies and care requirements. In line with their Falls Management Strategy the centre had developed new shift patterns to ensure adequate staffing levels were available to supervise residents in the communal areas and when they were mobilizing in the centre.

The inspector found that the centre had sufficient housekeeping, laundry, catering and administration staff to ensure that the service was run effectively for the benefit of the residents who lived there. Ancillary staff reported to the provider. There was a clear roster in place for staff in all departments. The roster reflected the staff that were working in the centre on the days of the inspection.

Staff were seen to be respectful and cooperative in their dealings with each other and

with the residents and their visitors. Residents and their families expressed high levels of satisfaction in their relationships with the staff team at the centre often commenting on their kindness and courtesy.

The centre had effective selection and recruitment processes in place. All staff had a probationary period during which attitude, attendance and competencies were reviewed with the individual. Staff records showed that performance issues were addressed by the management team. As a result staff were clear about their roles and responsibilities and were observed to take responsibility for their work.

Training records showed that staff had been provided with a rigorous induction training which included mandatory sessions in the centre's policies and procedures, key health and safety issues such as infection control, fire safety and moving and handling and relevant legislation such as the prevention of abuse and restraint. The centre had an annual training programme which included mandatory training in moving and handling, prevention of abuse and fire safety as well as other relevant training including managing responsive behaviours, dementia awareness, nutrition and hydration and end of life care.

Records showed that nursing staff were registered with the Irish Nursing and Midwifery board.

**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:***

Ann Wallace  
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>	Newpark Care Centre
<b>Centre ID:</b>	OSV-0000150
<b>Date of inspection:</b>	09/11/2017
<b>Date of response:</b>	08/12/2017

### 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 02: Governance and Management

#### Theme:

Governance, Leadership and Management

#### The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Documentation in relation to some audits needed to be improved to ensure that clear action plans were recorded in order to support the implementation and review of improvements identified.

#### 1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The structure of the identified documentation has been reviewed and amended to clearly separate outcomes and action plans within the audit document.

**Proposed Timescale:** 08/12/2017

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

**Theme:**

Governance, Leadership and Management

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

Inspectors found that one member of staff who was newly appointed at the centre did not have Garda vetting in place.

**2. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

As outlined in the report this matter was dealt with immediately and the member of staff left the premises and did not return to work until the Garda Vetting had been obtained. The process to obtain his Garda Vetting had already started prior to the inspection and his completed Garda vetting was sent to the HIQA on the 15th Nov This was within 3 working days of the inspection

**Proposed Timescale:** 08/12/2017