

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Newbrook Lodge Nursing Home
Centre ID:	ORG-0000680
Centre address:	Ballymahon Road, Mullingar, Westmeath.
Telephone number:	044 939 7520
Email address:	phil@newbrooknursing.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Newbrook Nursing Home
Provider Nominee:	Philip Darcy
Person in charge:	Breda Casey
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	52
Number of vacancies on the date of inspection:	0

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 judgements 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.

Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
19 March 2014 10:30	19 March 2014 18:30

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

Outcome 01: Statement of Purpose
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 09: Notification of Incidents
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 13: Complaints procedures
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This monitoring inspection was unannounced and took place over one day. This was the sixth inspection by the Authority. The inspector reviewed progress with completion of the action plan from the last inspection of the centre on 15 May 2013 in addition to review of information received by the Authority in respect to the governance arrangements in the centre. The details of the information received were discussed with the provider and the person in charge on the day of inspection who confirmed that the governance procedures were as stated in the centre's Statement of Purpose. The inspector found no evidence to support the content of the information received on this inspection. Areas reviewed included delivery of care, medication management and administration, provision of activities, risk management and fire safety in addition to documentation in support of same. During the inspection the inspector met with residents and staff members.

The inspectors found that residents had access to general practitioner (GP) services and a range of allied health professionals to support their health and wellbeing. While residents healthcare needs were found to be generally met, care planning required improvement to ensure residents' needs were clearly documented and that progress documentation accurately reflected outcomes of care interventions for residents. Residents' recreational needs were found not to be adequately met in some cases. While positive initiatives were taking place to involve carers in

facilitating recreational activities for residents, supervision in this area required improvement to ensure that this aspect of care was of a sufficient standard that satisfied all residents including those with dementia care needs and those residents who choose not to participate.

Medication management procedures were the subject of an action plan from the last inspection in May 2013 and were found to continue to require improvement to meet the professional standards and legislative requirements.

There were systems in place to manage risk and risk identified had controls in place to mitigate potential for occurrence. While fire safety procedures were adequate, fire preventative precautions required review to ensure residents' exit in an emergency was not hindered.

Serious incidents to residents were not notified appropriately to the Authority in some cases. There was a significant number of falls occurring during the night in the absence of a review of night-time staffing levels.

The inspectors found that eight actions were complete and seven were partially completed from the inspection in May 2013. Actions partially completed have been restated in the action plan at the end of this report in addition to new areas requiring improvement identified on this inspection. Actions partially completed included aspects of medication management, access of residents who did not wish to participate in activities provided. Completion of assessment of capacity and capability of residents, with conditions that caused cognitive impairment to avail of suitable meaningful recreational activities required improvement. Staffing levels and skill mix on night duty required review and also complaint management.

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

Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:

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

Findings:

This action was completed. The Statement of Purpose for Newbrook Lodge Nursing Home had been reviewed 24 February 2014 and was forwarded to the Chief Inspector as required. The document was the subject of an action plan from the previous inspection of 15 May 2013 requiring review to reflect staff changes including changes to the whole time equivalents staff employed. The revised Statement of Purpose accurately described the services and facilities provided to meet the diverse needs of residents accommodated in the centre.

Judgement:

Compliant

Outcome 04: Records and documentation to be kept at a designated centre

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

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:

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

Findings:

An action plan developed from findings related to incomplete records of hours employed

in some staff files, on the inspection of 15 May 2013 was found to be complete on this inspection. The inspector reviewed three staff files and found that all information including the hours that staff were employed to work each week as required in schedule 4 records was present. A member of administrative took responsibility for ensuring all required staff employment documentation was in place.

Judgement:

Compliant

Outcome 06: 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.

Theme:

Safe Care and Support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector found that measures were in place to protect residents from being harmed or suffering abuse. Staff were familiar with the adult protection measures in place to ensure the safety of residents. Staff described potential types of abuse and were aware of their duty to report any suspected or alleged instances of abuse. They identified the persons to whom they would report a suspicion or allegation of abuse appropriately. Residents told the inspector that they felt safe in the centre and that staff responded to meeting their needs for assistance promptly and were patient and gentle with them.

The inspector reviewed a sample of residents' money kept in safekeeping on their behalf in the centre. A record was maintained of all transactions which were double signed. Each resident's money and transaction record book were kept in individual files. The inspector checked balances of money which were found to be correct in each case. Residents or their families were provided with a receipt to evidence transactions and a statement of account was provided at regular intervals. The inspector confirmed that residents had access to their money whenever they required it. Residents also had access to a lockable facility in their bedroom for safekeeping of personal belongings if they wished and to promote their autonomy and independence.

The centre has an electronic controlled access procedure on all doors to protect residents and staff. There was a visitors' book at the entrance to the centre to record all persons entering and exiting the centre. While completion of this book was monitored during office hours by the centre's receptionist from Monday to Friday, its completion was not monitored at other times. The person in charge's office and the reception area are located inside the entrance to the centre. Additional external lighting was installed to improve security to the back of the centre.

Judgement:

Non Compliant - Minor

Outcome 07: 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:

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

Findings:

There was a risk management system in place that described a range of risk factors and identified the actions to be taken to mitigate risks identified. A risk register was in place, updated in December 2013 where risks were identified with controls established to mitigate their occurrence. Unidentified risks with associated controls were the subject of an action plan developed from findings during the last inspection in May 2013. This action was found to be satisfactorily completed on this inspection. The person in charge told the inspector she was currently reviewing the risk register for 2014. The document was centre specific and controls implemented to mitigate risks identified evidenced learning from incidents that had occurred in the centre, for example, the potential for injury to residents from use of wheelchairs.

The inspector reviewed the fire safety arrangements and documentation in the centre. There was appropriate signage displayed throughout the building to guide staff, residents and visitors to the nearest exits and to inform them of the action to take should a fire situation be detected or the fire alarm activated. Fire risk assessments had been completed for each resident taking individual resident life habits into account, for example smoking, lighting candles. Smoking was not permitted in any area outside the designated smoking room. The individual evacuation needs of residents had been assessed and were kept in their accommodation. An up to date summary of these risk assessment records were kept with the documentation referencing fire safety management for ease of reference in the event of an emergency and to assist the emergency services if necessary.

Procedures for fire detection and prevention were in place. Specific fire protection and prevention duties were assigned to individual staff members. Smoke detectors were located in bedrooms and communal areas. Records were available which showed that daily inspections of fire exits were carried out to ensure they were clear of obstruction. However, the inspector saw that a stairwell which was part of the emergency exit route on the ground floor had a chair and boxes in it which could hinder evacuation in the event of a fire. The inspector reviewed the record of fire evacuation drills. There was a record of fire drills on the 04 and 18 February 2014. The commentary record of the drill on the 04 February 2014 did not include adequate information regarding staff response or length of time taken to complete the simulated evacuation procedure. This information was required to ensure that staff followed procedures correctly and that evacuation was expedited within recommended timelines.

There was a process in place to record incident and accidents to residents and others. There was a monthly record of all resident falls and a post fall assessment was completed after each resident fall to identify the circumstances that may have contributed to falls to identify prevention strategies such as use of hip protectors and

alarms were put in place to prevent further falls and injuries. There were ten resident falls logged from 01 January 2014 up to the day of this inspection. Each resident who fell was referred to the centre's physiotherapist for more specialist assessment and exercise programmes where required.

Information was available to guide staff on the management and prevention of infection including influenza, norovirus, Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C-Diff). Cleaning staff could describe the procedures they followed when cleaning and dealing with infectious material. The person in charge confirmed that there were no residents with active infections in the centre. Staff used personal protective equipment (PPE) and carried out hand hygiene appropriately.

The inspector was told that some residents in the centre had skin tears. Moving and handling procedures with residents on the day of inspection were observed by the inspector to be done in line with evidence based practice. All staff had attended mandatory training in moving and handling and use of assistive equipment. The type of equipment to be used for individual residents was outlined in their moving and handling risk assessments.

There was a missing person policy in place which included procedures to guide staff should a resident be reported missing. The person in charge informed the inspector that there was one resident who was at risk of leaving the centre unaccompanied. This resident wore a wandering alert bracelet to ensure this did not happen. A missing person profile was completed with a copy of a recent photograph to assist the emergency services in locating this resident quickly should the procedures in place fail to prevent the resident leaving the centre unaccompanied.

Judgement:

Non Compliant - Moderate

Outcome 08: Medication Management

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

Theme:

Safe Care and Support

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector carried out a review of medication prescription and administration records belonging to residents in the centre. Discontinued medications were signed and dated by the residents' GP. One resident with a swallowing deficit was receiving medications in crushed format. However, prescription of individual medications to be administered in crushed format was not made. There was no reference guide available to advise staff of medications where crushing was contraindicated or medications that could not be administered together. Medication management competency assessment was underway and was completed for one staff nurse at the time of this inspection. A medication

prescription sheet and administration record review was completed on the 18 December 2013. A number of non-compliances with recommended practice as outlined in the centre's medication management policy were identified. However there was no action plan developed detailing how improvements would be achieved or the timescales within which the non-compliances identified would be actioned.

Each resident's medication was stored in their room in a secure cabinet. The inspector was told that this arrangement contributed positively to safer medication administration procedures in the centre.

Judgement:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Care and Support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector reviewed the quarterly notifications for the periods June to September and September to December 2013, forwarded to the Authority as required. An incident that occurred on the 08 September 2013 where a resident sustained a laceration over their temporal bone which required hospital treatment was not correctly notified as a serious injury to the Authority within the required timeframe. Another incident that occurred on the 27 October 2013 where a resident sustained an injury to her head requiring transfer to hospital was also not notified as a serious injury to the Authority within the required timeframe. Although not notified to the Authority, appropriate care and treatment was provided in each case.

Judgement:

Non Compliant - Moderate

Outcome 10: Reviewing and improving the quality and safety of care

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

Theme:

Effective Care and Support

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector found that there were systems in place to review several aspects of the quality and safety of care and quality of life of residents. The centre's practice development co-ordinator chairs a Quality committee that meets every month. Quality and safety of care and resident's quality of life in the centre is a fixed agenda item for discussion at the centres management meetings. A variety of clinical, environmental and resident satisfactions audits and reviews had been completed, including infection control, resident files, staff files, resident falls, fluid balance chart completion, oral hygiene care, resident weights and resident satisfaction.

A report had been compiled on aspects of the audits and improvements completed to date and were available for review by the Authority as required.

The inspector found that audits and reviews were effective in that they identified areas where practice required improvement. There was also evidence of improvements made in response to audits completed. Although there was evidence of improvements made as a result of findings from audits, there was inconsistent action plan development and where developed, there was inadequate monitoring of action completion dates. For example, actions to address areas of infection control and prevention and resident files requiring improvement had missing completion dates or timescales for completion recorded as 'ongoing' with little evidence of closeout. Audits of falls did not highlight incidence of falls at night-time.

Judgement:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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:

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

Findings:

The healthcare needs of residents were met by the centre. Sixteen (32%) of residents had maximum dependency needs, twelve (24%) had high dependency needs and twenty two had medium and low dependency needs. The centre also accommodates

residents with dementia care needs, convalescence needs or with palliative care needs. There was evidence that residents had good access to allied health professionals and specialist services. Two residents were in receipt of palliative care services for the purposes of chronic pain management. A pain assessment and monitoring tool was in place and was noted to be up to date for each resident, completed each time a resident's pain level was assessed or relief medication administered. The person in charge told the inspector that while none of the residents had recent acute weight loss, some residents were been closely monitored to ensure they maintained their current weight levels. The provider contracts the services of a dietician to assess residents who were at risk of weight loss and to advise on treatment plans including strategies to encourage intake. For example, some residents had sauces added to their food to enhance the sensory aspect of the food. There were guidance notes on the foods to be given to ensure optimal nutritional intake and this was supported by an assessment from a speech and language therapist where required to determine the appropriate food texture and consistency. A physiotherapist is employed by the group to assess and support residents with mobility needs and who are at risk of falling or post a fall incident. The centre has a physiotherapy room to facilitate residents to avail of specific treatment programmes in a purpose-built area. There was also evidence that residents had access to occupational therapy specialist services. Many residents had assistive chairs and supports which they were individually assessed for. For example, a resident assessed on the 10 January 2013 as requiring a tilt chair with head and neck support was in the process of trialling a number of assistive chairs to ensure the chair procured would meet the residents support and comfort needs. The person in charge confirmed that none of the residents had pressure related skin conditions. Each resident was risk assessed to determine vulnerability to developing pressure related skin breakdown. Residents who were assessed as being at risk had appropriate pressure modifying aides including mattresses and chair cushions.

All residents had a documented care plan completed to inform their care needs. Each resident's ability to carry out daily activities was assessed on admission to the centre using recognised assessment tools and these assessments informed staff of residents care needs. The evidence-based assessment tools included assessments of cognitive impairment, nutrition, potential for pressure area problems, dependency scales and falls risks. Where risks were identified, care plans were in place to inform the care to be provided and were completed by the person in charge or nurses.

The inspector reviewed a sample of care plans and found that in general they contained person-centred information about residents. However, improvement was required to ensure pertinent information on care needs was easily accessible. The inspector found that due to the presence of a large amount of narrative documentation, care actions to meet resident needs were not clear or easily accessible. Some care plans were in place in the absence of an assessed care need and as such contributed to unnecessary documentation which was found to negatively impact on accessibility of pertinent information referencing care needs. The inspector reviewed daily progress notes and found that they were not reflective of residents care plans in most cases. For example, 'usual day' in a resident's progress notes did not inform on outcomes for the resident/whether assessed needs were met including immobility, 'fear of putting feet to the floor', poor swallowing reflex and poor appetite.

There was evidence that assessments, care plans and medical conditions were reviewed on a three monthly basis and more frequently where necessary. Residents spoken with were aware of their care plans however, it was unclear from care plans reviewed what

actions in care plans were removed or revised in consultation reviews with residents or their representatives.

There was an activity programme in place for residents. The person in charge confirmed that the centre was developing life story records and activity care plans for each resident. However this part of resident care requires urgent attention to ensure residents have their needs met in this area. In keeping with the findings at the last inspection in June 2013, the inspector observed that not all residents in the room participated in the activity taking place and residents with dementia care needs did not have assessments completed to ensure access to suitable and meaningful activities. While this may be their choice, they did not currently have a choice to move to another quieter area, although available. The person in charge told the inspector that she was reviewing the environment to provide a quieter area where residents who wished to, could relax or participate in an alternative activity. This action was found to be partially completed. The activity coordinator had completed training in providing a suitable activity programme for residents with dementia and cognitive impairment needs. While the activity co-ordinator was trained in facilitating a focussed sensory programme for residents with dementia care needs, she was on leave on the week prior to and the week of the inspection of the centre, there was inadequate evidence to support conclusion that this group of residents' recreational needs were sufficiently met. In addition the activity programme provided was not adequately supervised on weekdays while the activity coordinator was on leave. While most residents spoken to were satisfied with the level of recreational activity they participated in, two residents spoken with indicated to the inspector that their day felt 'long'. There were eight (16%) of residents with dementia and/or cognitive care needs living in the centre in addition to others with disabilities that hindered and/or impaired their ability to participate in communal activities.

Judgement:

Non Compliant - Moderate

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:

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

Findings:

The centre has a complaints policy and procedure in place which was prominently displayed in communal areas of the centre. The person in charge is the nominated person to deal with all complaints. The person in charge confirmed that there were no active complaints currently under investigation. The inspector reviewed a complaint made in January 2014 regarding missing clothing belonging to a resident. While some of

the clothing was found, the provider compensated the resident for the loss of the remaining items which were not located. As a result of this complaint, laundry management in the centre was reviewed and changes were made to ensure residents clothing was returned intact. The satisfaction of the complainant with the outcome had not been ascertained; however a reminder note was posted to complete this procedure. Closure of this complaint required address as findings from the inspection in May 2013 raised the issue of an unnecessary delay in completing the complaint process.

Judgement:

Non Compliant - Minor

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.

Theme:

Workforce

Outstanding requirement(s) from previous inspection:

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

Findings:

The person in charge described how she had reviewed the staffing levels since she commenced in her role in the centre and as a result increased the staffing levels in the morning when the needs of residents were higher.

The inspector saw that there was a comprehensive staff training and development programme. Staff had completed mandatory training and refresher training was in progress for 2014. Staff were well supported and supervised in their daily work caring for residents in the centre. The group had employed a practice support co-ordinator who provided consistent and strong clinical developmental support to the person in charge and other staff members. The inspector found that the centre had a committed and well informed staff team. The staff team were found to be committed to meeting the needs of residents and ensuring they had a good quality of life. Staff were knowledgeable regarding residents' needs and preferences which they were observed to make every effort to fulfil.

The deployment of staff allowed for three nurses excluding the person in charge to be on duty during the day. They are supported by nine/ten carers during the morning reducing to six/seven in the afternoon. The person in charge and clinical nurse manager both work the same days and finish at 17:00 hrs each day. The inspector was of the view that the governance of the centre could be strengthened by review of this arrangement to provide some support and supervision by the clinical nurse manager in the evenings and over the weekends. After 22:00 hrs, there are two nurses and two carers on duty for the duration of the night.

The need for ongoing staff deployment review has been a theme in inspections by the Authority to date, to ensure adequate staffing and skill mix on both floors to meet the complex needs of residents. The inspector carried out a review of the times of resident falls from September to December 2013 documented on the quarterly notification template forwarded to the Authority as required. Findings referenced that eight (53%) of the falls occurred between 21:50hrs and 06:30hrs. This finding necessitates review of night-time staffing levels to ensure there are adequate staff numbers and skill mix to meet residents' needs to reduce the incidence of resident falls when staffing levels are significantly reduced for night-time rosters. The inspector was also not satisfied that some residents' recreational needs were adequately met when the activity co-ordinator was not in the centre. Acknowledgement is made that the person in charge is in the process of involving and developing care staff to facilitate recreational activities with the activity coordinator as a lead. Care staff facilitated activities on the day of inspection as the activity co-ordinator was on leave. The inspector observed that care staff were not adequately supervised in the absence of the activity coordinator. Missing required documentation from staff files was the subject of an action plan from the last inspection in the centre on 14 June 2013. The inspector reviewed a sample of staff files and found that all documentation required by the Legislation was present in each case.

Judgement:

Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
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 report¹

Centre name:	Newbrook Lodge Nursing Home
Centre ID:	ORG-0000680
Date of inspection:	19/03/2014
Date of response:	05/06/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 06: Safeguarding and Safety

Theme:

Safe Care and Support

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

While completion of the visitor's book was monitored during office hours by the centre's receptionist from Monday to Friday, its completion was not monitored at other times.

Action Required:

Under Regulation 6 (1) (a) you are required to: Put in place all reasonable measures to protect each resident from all forms of abuse.

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

The front door is locked from 17:00 onwards and staff who open the door to let in visitors after this time will remind visitors of the requirement to sign in.

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

Proposed Timescale: 05/06/2014

Outcome 07: Health and Safety and Risk Management

Theme:

Safe Care and Support

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

A stairwell which was part of the emergency exit route on the ground floor had a chair and boxes in it which could hinder evacuation in the event of a fire. The inspector reviewed the record of fire evacuation drills.

Action Required:

Under Regulation 32 (1) (b) you are required to: Provide adequate means of escape in the event of fire.

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

The Maintenance Man was moving the boxes and chair to his van on the day of the inspection, through the fire escape. This was a momentary occurrence and the Maintenance Man has been told not to repeat the practice.

Proposed Timescale: 05/06/2014

Theme:

Safe Care and Support

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

The commentary record of the drill on the 04 February 2014 did not include adequate information regarding staff response or length of time taken to complete the simulated evacuation procedure.

Action Required:

Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

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

Training was provided to all of the Directors of Nursing within the Newbrook Group in January 2014 on running fire drills. We have reviewed the fire training records and on drills before and after the 4th February 2014 and found that staff responses and times were recorded. We will keep this under review to ensure that this once off occurrence does not happen again.

Proposed Timescale: 05/06/2014

Outcome 08: Medication Management

Theme:

Safe Care and Support

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

One resident with a swallowing deficit was receiving medications in crushed format. However, prescription of individual medications to be administered in crushed format was not made. There was no reference guide available to advise staff of medications where crushing was contraindicated or medications that could not be administered together.

Action Required:

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

The prescription sheets had a note to say that medication to be administered in crushed format and this was signed by the GP. We have reviewed our prescription sheets so that each individual line is marked "Y" to crush.

In relation to contraindications to crushing medications, no medicines prescribed by a doctor can be given without first being dispensed by our pharmacist. At the dispensing stage he checks the prescription and if there are any contraindications he contacts the Centre and the GP until this has been rectified. Any advice or special conditions on the administration of medications are highlighted on the prescription sheet. There is an up to date BNF in the Centre for the use of the GPs and the Nurses.

Proposed Timescale: 05/06/2014

Outcome 09: Notification of Incidents

Theme:

Safe Care and Support

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

An incident that occurred on the 08 September 2013 where a resident sustained a laceration over their temporal bone which required hospital treatment was not correctly notified as a serious injury to the Authority within the required timeframe. Another incident that occurred on the 27 October 2013 where a resident sustained an injury to her head requiring transfer to hospital was also not notified as a serious injury to the Authority within the required timeframe.

Action Required:

Under Regulation 36 (2) (c) you are required to: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

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

All accidents and incidents have been reviewed and notified to the Authority if required.

Proposed Timescale: 02/07/2014

Outcome 10: Reviewing and improving the quality and safety of care

Theme:

Effective Care and Support

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

Although there was evidence of improvements made as a result of findings from audits, there was inconsistent action plan development and where developed, there was inadequate monitoring of action completion dates. For example, actions to address areas of infection control and prevention and resident files requiring improvement had missing completion dates or timescales for completion recorded as 'ongoing' with little evidence of closeout. Audits of falls did not highlight incidence of falls at night-time.

Action Required:

Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

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

We now have realistic completion dates inserted on action plans.

Our audit of falls did highlight to us incidents of falls at night time as requiring further control measures. Through discussion with the multidisciplinary team an additional HCA was rostered for night duty for almost two weeks from the 13th October 2013 to the 23rd October 2013. After this period it was reviewed and also the circumstances of each fall was examined. The outcome of this review was that we felt that a further staff allocation at night would not reduce the number of falls.

For example three residents who were capable of ringing the call bell and who would do so normally did not do so on this occasion. Another fall was as a result of a resident disconnecting a posy alarm. This resident now has a wireless posy alarm.

Falls management within the Centre is a priority. Consequently we have a physiotherapist who attends weekly and any resident who sustains a fall is reassessed by him and if further control measures are required, then these are put in place immediately. We endeavour to maintain independence in the resident for as long as possible and also to give them a good quality of life for as long as it is safe to do so.

As part of our quality improvement process our Practice Development Officer has requested that if there are four falls within a given month a root cause analysis will be carried out and an action plan developed.

Proposed Timescale: 05/06/2014

Outcome 11: Health and Social Care Needs

Theme:

Effective Care and Support

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

While the activity co-ordinator was trained in facilitating a focused sensory programme for residents with dementia care needs, she was on leave on the week prior to and the week of the inspection of the centre, there was inadequate evidence to support conclusion that this group of residents' recreational needs were sufficiently met. In addition the activity programme provided was not adequately supervised on weekdays while the activity coordinator was on leave. While most residents spoken to were satisfied with the level of recreational activity they participated in, two residents spoken with indicated to the inspector that their day felt 'long'. There were eight (16%) of residents with dementia and/or cognitive care needs living in the centre in addition to others with disabilities that hindered and/or impaired their ability to participate in communal activities.

Action Required:

Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

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

We have recruited a new activities coordinator who is developing our activities programme. The newly appointed activity co-ordinator has the required skills and sensory training techniques to facilitate a programme to meet the needs of residents with dementia care needs. In addition two healthcare assistants have completed the Sonas programme which they will deliver twice weekly.

The activities coordinator will meet with all residents or their representatives on an individual basis to identify what their interests and capabilities are. The activities programme will then be developed based upon the residents' abilities and interest.

We have also made many environmental changes and created different sitting rooms to cater for residents with varying cognitive abilities.

A review of staff levels on the 6th May 2014 saw additional HCA hours on the roster from 08:00 to 21:00. This will further facilitate the delivery of our activities programme.

Proposed Timescale: 31/07/2014

Theme:

Effective Care and Support

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

Improvement in residents' care plan documentation was required to ensure pertinent information on care needs was easily accessible. The inspector found that due to the presence of a large amount of narrative documentation, care actions to meet resident needs were not clear or easily accessible. Some care plans were in place in the absence of an assessed care need and as such contributed to unnecessary documentation which was found to negatively impact on accessibility of pertinent information referencing care needs. The inspector reviewed daily progress notes and found that they were not reflective of residents care plans in most cases. For example, 'usual day' in a resident's progress notes did not inform on outcomes for the resident/whether assessed needs were met including immobility, 'fear of putting feet to the floor', poor swallowing reflex and poor appetite.

Action Required:

Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

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

We are implementing a computerised care plan system, Epicare. The implementation process will require a complete review of all care plans. These issues will be addressed during the review. Training will be provided for staff by Epicare, the Director of Nursing and the Practice Development Officer in completing the daily progress notes and the holistic care plans in addition to actually using the Epicare system.

Proposed Timescale: 31/07/2014

Theme:

Effective Care and Support

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

Residents spoken with were aware of their care plans however, it was unclear from care plans reviewed what actions in care plans were removed or revised in consultation reviews with residents or their representatives.

Action Required:

Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

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

We are implementing a computerised care plan system, Epicare. The implementation process will require a complete review of all care plans. These issues will be addressed during the review. Training will be provided for staff by Epicare, the Director of Nursing

and the Practice Development Officer.

All care plans are reviewed at three monthly intervals and more frequently if the residents' condition changes. These care plans will be developed in consultation with the residents and/or their representatives.

Epicare has an area where these consultations can be recorded.

Proposed Timescale: 31/07/2014

Theme:

Effective Care and Support

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

The person in charge confirmed that the centre was developing life story records and activity care plans for each resident. However this part of resident care requires urgent attention to ensure residents have their recreational needs assessed and met in this area.

Action Required:

Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

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

We have recruited a new activities coordinator who is developing our activities programme. The newly appointed activity co-ordinator has the required skills and sensory training techniques to facilitate a programme to meet the needs of residents with dementia care needs. In addition two healthcare assistants have completed the Sonas programme which they will deliver twice weekly.

The activities coordinator will meet with all residents or their representatives on an individual basis to identify what their interests and capabilities are. The activities programme will then be developed based upon the residents' abilities and interest.

Proposed Timescale: 31/07/2014

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The satisfaction of the complainant with the outcome had not been ascertained; however a reminder note was posted to complete this procedure. Closure of this complaint required address as findings from the inspection in May 2013 raised the issue

of an unnecessary delay in completing the complaint process.

Action Required:

Under Regulation 39 (6) you are required to: Investigate all complaints promptly.

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

The relevant complaint has now been closed and the satisfaction of the complainant documented.

We will ensure that in future our complaints procedure follows our complaints policy.

Proposed Timescale: 05/06/2014

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Review of staffing numbers and skill mix was required. The inspector carried out a review of the times of resident falls from September to December 2013 documented on the quarterly notification template forwarded to the Authority as required. Findings referenced that eight (53%) of the falls occurred between 21:50hrs and 06:30hrs. This finding necessitates review of night-time staffing levels to ensure there are adequate staff numbers and skill mix to meet residents' needs to reduce the incidence of resident falls when staffing levels are significantly reduced for night-time rosters. Some residents' recreational needs were adequately met when the activity co-ordinator was not in the centre.

Action Required:

Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

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

Our audit of falls did highlight to us incidents of falls at night time as requiring further control measures. Through discussion with the multidisciplinary team an additional HCA was rostered for night duty for almost two weeks from the 13th October 2013 to the 23rd October 2013. After this period it was reviewed and also the circumstances of each fall was examined. The outcome of this review was that we felt that a further staff allocation at night would not reduce the number of falls.

A review of staff levels in May 2014 saw an additional HCA rostered from 08:00 to 21:00.

For example three residents who were capable of ringing the call bell and who would do so normally did not do so on this occasion. Another fall was as a result of a resident

disconnecting a posy alarm. The Resident now has a wireless posy alarm.

Falls management within the Centre is a priority. Consequently we have a physiotherapist who attends weekly and any resident who sustains a fall is reassessed by him and if further control measures are required, then these are put in place immediately. We endeavour to maintain independence in the resident for as long as possible and also to give them a good quality of life for as long as it is safe to do so.

As part of our quality improvement process our Practice Development Officer has requested that if there are four falls within a given month a root cause analysis will be carried out and an action plan developed.

Proposed Timescale: 05/06/2014

Theme:

Workforce

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

The inspector observed that care staff facilitating activities on the day of inspection were not adequately supervised in the absence of the activity coordinator.

Action Required:

Under Regulation 17 (2) you are required to: Supervise all staff members on an appropriate basis pertinent to their role.

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

We have recruited a new activities coordinator who is developing our activities programme.

We have also made many environmental changes and created different sitting rooms to cater for residents with varying cognitive abilities.

A review of staff levels saw additional HCA hours on the roster from 08:00 to 21:00. This will further facilitate the delivery of our activities programme.

At present the following levels of supervision are available for HCAs:

- 1) Director of Nursing
- 2) CNM who plays an active role in the supervision of staff. She is on the floor observing work practices including manual handling; and
- 3) Staff nurses

Proposed Timescale: 05/06/2014