

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Brindley Manor Private Nursing Home
Centre ID:	OSV-0000323
Centre address:	Letterkenny Road, Convoy, Donegal.
Telephone number:	074 914 7000
Email address:	brindleymanor@brindleyhealthcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	The Brindley Manor Federation of Nursing Homes Unlimited Company
Lead inspector:	Siobhan Kennedy
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	40
Number of vacancies on the date of inspection:	3

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
29 May 2018 12:00	29 May 2018 18:00
30 May 2018 08:00	30 May 2018 16:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Compliant
Outcome 02: Safeguarding and Safety	Substantially Compliant	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate	Compliant
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care.

The centre was not a special dementia care unit but 19 of the residents had some form of dementia.

The methodology included gathering the views of residents relatives and staff to assess how residents with dementia experienced life and care in the centre. A validated tool, the quality of interactions schedule (QUIS) was used to observe and analyse care practices and interactions between staff and residents. Documentation

such as care plans, medical records and staff files were reviewed.

In addition, a self-assessment form was completed by the provider in preparation for this inspection which identified performance against regulations and standards and highlighted ways to improve the service. The provider assessed the centre to be substantially compliant in respect of health and social care, safe guarding, staffing, complaints and safe and suitable premises with a moderate non-compliance regarding residents' rights.

Improvements identified by the provider included supporting residents with communication difficulties, re- designing the satisfaction survey, structuring care planning meetings, providing more meaningful activities for residents, the development of a coffee dock area in the visitors' room and staff training (positive approaches in dementia care, responsive behaviours, palliative care and the regulations and standards governing residential care). The majority of these initiatives had been addressed which led to improved outcomes for residents and increased compliance. Regarding the premises improvements included developing a dementia friendly garden and farm, improved signage and obtaining the views of residents to rename communal areas in the centre. With the exception of improved signage these matters had been addressed or were in progress.

Using the Health Information and Quality Authority's (HIQA) monitoring approach the inspector judged that the centre was in compliance with the standards in relation to dementia care with the exception of the premises. During the inspection of the 26 October 2016 in respect of safe and suitable premises a moderate non-compliance was found as the flooring in some areas showed signs of wear and tear and required replacement. At the time of this inspection this matter remained outstanding and the completion date set by the provider was 20 February 2017. However, the carpet has been ordered and due to be fitted week commencing 11 June 2018. There was a lack of colour contrast between the walls and doors in the corridors and good signage which included objects and multiple cues to support residents to find their way around.

Since the previous inspection persons participating in management had changed and the current persons were interviewed during this inspection. Those participating in this process were found to be satisfactory and knowledgeable of the regulations and standards.

Also since the last inspection unsolicited information was received by HIQA. This highlighted a number of issues which were reviewed and were not substantiated with the exception of the wedging open of fire doors to the main sitting room. The action plan of this report outlines requirements in respect of safe evacuation procedures.

The inspector found that the health and social care needs of residents were assessed and met and there was evidence to judge that end of life care was of a good standard. Residents were supported to live as independently as possible. Allied health professionals provided a service to meet resident's needs. Medication management was satisfactory and appropriate measures were in place to address the nutritional and hydration needs of residents.

There were policies and procedures in place around safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the action to take if they witness, suspect or were informed of any abuse taking place.

There were policies and practices in place around managing responsive and psychological behaviours and using methods of restraint.

In addition to the premises the only other area to be addressed in respect of compliance since the last inspection was updating the risk management policy/procedure. This had been satisfactorily actioned.

Other matters in relation to fire safety and infection control were noted and forms part of this report and action plan.

The Action Plan at the end of this report identifies areas where improvements are required to comply 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.

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: Health and Social Care Needs

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Primarily residents were admitted to the centre for long term care but some residents were being accommodated for periods of respite/convalescence care. There were 22 residents assessed as having maximum or high level care needs, 15 were assessed as having a medium dependency and 3 residents had low care needs. Nineteen residents had some form of dementia.

The wellbeing and welfare of residents with a diagnosis of dementia was maintained to a satisfactory standard through the provision of evidence based nursing and medical care. The Positive Approaches to Brain Changes GEMS model had been adopted. This emphasized the need to focus on remaining abilities rather than capacity losses. The model outlines abilities, characteristics and responsive behaviours of residents with dementia/cognitive impairments and provided staff with guidance on how to interact and provide support and care focusing on residents' preserved skills.

Some of the improvements to be achieved as a result of the provider's self-assessment in health and social care included a review of care plans to ensure that they are person centred and give sufficient direction to staff and to provide a more structured plan for family meetings. This was to be completed by 26 April 2018.

The inspector reviewed a sample of residents' nursing and medical records. These records confirmed that residents were assessed prior to admission to the centre. The pre admission assessment documentation was available in the residents' files. On admission to the centre each resident's needs were comprehensively assessed using a number of risk assessment tools, for example, risk associated with factors that included vulnerability to falls, dependency levels, nutritional care, risk of developing pressure area problems and moving and handling requirements. Each resident had a care plan completed that was maintained on a computer programme. This identified their needs and the care and support interventions that were implemented by staff to meet their assessed needs. Care plans for four residents with dementia and the management of nutrition and wound care were examined. These provided a good overview of residents' care and how care was delivered. There were good descriptions of the risks presented,

the control measures in place and the triggers for further intervention available in the relevant areas of the care records. There were two wound care problems in receipt of treatment. The care records described the extent of the wounds, the dressings used and the progress/change in condition from one dressing change to another. The information included how to prevent skin deterioration by ensuring a routine of position changes and referral to allied health professionals. Residents were offered a choice of general practitioners and an out of hours service was available.

Arrangements were in place to review and update care plans on a regular basis and there was evidence of involvement by the residents and or their next of kin. The person in charge informed the inspector that she had just completed a family meeting on the morning of the inspection.

Systems for monitoring the exchange and receipt of relevant information when residents were transferred to or returned from another healthcare setting were in place. Discharge letters for residents who spent time in acute hospital care and letters from consultants detailing findings following out-patient clinic appointments were available. A letter was completed by staff in the centre for residents requiring in-patient care in the acute hospital care setting.

The inspector found that there were policies and procedures in place to ensure residents received a good standard of end-of-life care which was person centred and respected their preferences. The inspector viewed some residents' care plans and these detailed the views and wishes of residents regarding their preferences for end-of-life care. At the time of the inspection no residents were receiving end of life care but the palliative care team had recently reviewed one resident. Staff told the inspector that the palliative care services offered a prompt and effective service. The staff team confirmed that relatives were welcome to stay with their relative and they encouraged them to do so and provided drinks and snacks during their stay.

Staff had participated in training in end of life care. Nurses were well informed about end of life care and offered appropriate pain relief options where needed. The resuscitation status and medical situation that prevailed were discussed with family members and their views were considered and reflected in care and medical records. Residents' cultural and religious needs were supported and arrangements were put in place to ensure that residents received the spiritual care they requested. There was a policy on consent with evidence that residents' wishes relating to treatment and care being discussed at family meetings was respected.

There were assessment and care procedures in place to ensure residents' nutritional needs were met and that they did not experience dietary or hydration deficits. Residents' weights were checked on a monthly basis or more frequently if necessary. Diet and fluid intake records were used as appropriate. Reference sheets were available to all staff including catering outlining residents' special diets including diabetic, modified and thickened consistency diets. The catering manager who is responsible for catering services across the six designated centres owned by the company had developed a manual for good nutrition management. This described the menus and the seasonal variations that were made, the dishes offered and the associated recipes with calorie and nutrition content and the preparation and presentation guidelines for specialist diets. There was evidence of the involvement of Allied health professional's such as speech and language therapists and dieticians. During the meal times staff were

observed to offer assistance in a respectful and dignified manner. Staff sat beside the resident they were giving assistance and were seen to patiently and gently encourage the resident throughout their meal. Independence was promoted and residents were encouraged to eat their meal at their own pace by themselves or with minimal assistance to improve and maintain their functional capacity. The quality of interactions was found to be person centred. Staff were familiar with residents' care needs and family background and efforts were continuously made to chat to residents about their family, previous interests or working life.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Nursing staff were observed administering medicines and the details of the medicines administered were recorded. Prescription records included all the appropriate information such as the resident's name and address, any allergies, and a photo of the resident. The General Practitioner's signature was present for all medicines prescribed and for discontinued medication. The maximum dose of PRN (as required) medication to be given in a 24 hour period was outlined. The inspector saw that a medication management audit had recently been completed. The pharmacist visits and provides support as necessary. Medications that required special control measures were safely managed and kept in a secure cabinet in keeping with professional guidelines. Nurses maintained a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at shift changeovers.

Judgment:
Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Measures to protect residents from being harmed or suffering abuse were in place. A policy on, and procedures for the prevention, detection and response to allegations of abuse was in place. Staff who communicated with the inspector confirmed that they had received training on safeguarding vulnerable adults and were familiar with the reporting structures.

There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. Staff confirmed that there were no barriers to raising issues of concern.

A notification in respect of an allegation of suspected or confirmed of abuse to a

resident was received by HIQA in March 2018. This was discussed with the previous person in charge at the time of the incident and was further reviewed on inspection. The matter did not occur in the residential centre and continues to be investigated by the community services. However, the residential service has provided support to the resident. Another notification received by HIQA in December 2017 was also reviewed. A full investigation had been carried out and safeguarding plans implemented.

There was a policy/procedure in place about behavioural and psychological signs and symptoms of dementia and restrictive practices. These were clear and gave good instructions to guide staff practice.

A review of training records indicated that staff were provided with up-to-date knowledge and skills, appropriate to their role to enable them to manage responsive behaviours. At the time of the inspection there were no residents displaying such behaviours. However, from past experience staff described potential triggers, the use of behaviour charts and interventions that could be adopted such as redirection, distraction, diversion and noise reduction. Staff nurses referred to infections or pain being a possible cause for changed behaviours.

The inspector saw that expert advice from the relevant professionals was sought where necessary before commencing any psychotropic medication. Staff focused on a proactive and positive approach to residents. Since completing the pre-inspection questionnaires staff had worked on improving their understanding of residents' communication needs and had developed a writing technique for communicating with one resident. Residents had a section in their care plan that covered communication needs and staff were familiar with this. There was a policy on the provision of information to residents. Some residents were seen to be wearing glasses and hearing aids to assist communication and the inspector saw that these were in place and functioning well for residents.

The centre had a policy on the use of restraint which was in line with "Towards a Restraint Free Environment" to ensure residents were protected from potential harm. The use of any measures that could be considered as restraints such as bed rails (10 in use) and lap belts (4 in use) was underpinned by an assessment and was reviewed on a regular basis. There was evidence that discussion had taken place with the resident, his/her representatives and in instances where these measures were requested the staff provided information on associated hazards and offered alternative options such as low to floor beds. Staff were clear these measures were a last resort and only considered when less restrictive interventions had not achieved the desired outcome to keep the resident safe.

There were systems in place to safeguard residents' money. The inspector communicated per telephone with the centre's financial service and it was confirmed that centre acts as an agent for four residents and this money is held in a residents' account separate to the centre's account. A policy/procedures, systems and practices were in place to manage small amounts of money on behalf of some residents. These were found to be satisfactory with regard to documenting transactions, for example, lodgments, withdrawals and balances. Signatures of two were available on the records.

Judgment:

Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that residents were positive about their experiences of living in the centre. They described being able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. Some residents had voted in the local referendum and had a discussion following the outcome of the vote. During the day residents were able to move around the centre freely.

They expressed satisfaction with the facilities, services and care provided. They conveyed that they would be able to talk to staff freely about their concerns.

There was evidence of good communication between residents and the staff team. The inspector observed that residents were well dressed and personal hygiene and grooming were attended to by care staff. Staff interacted with residents in a courteous manner and resident's privacy was respected as staff knocked on the residents' bedroom doors prior to entering.

There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends in the dining areas or communal rooms. Staff were observed to interact with residents in a warm and personal manner, using touch and eye contact appropriately and calm reassuring tones of voice to engage with those who became anxious restless or agitated. However the inspector noted that the telephone rang loudly throughout the centre which resulted in a noisy environment. See outcome 6 for action plan.

The inspector spent a period of time observing staff interactions with residents using QUIS to rate and record at five minute intervals the quality of these interactions. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place in the sitting/activity room in the afternoons. The inspector observed that the staff members knew the residents well and connected with each resident therefore scoring + 2. Reminiscence, sing song and imagination gym were therapies used to improve and maintain memory function during the observation period.

There was information available in "Key to Me" documents to inform staff about residents past life styles and the inspector found that these were used by staff to inform the activity schedule and the delivery of social care. Staff could describe the varied

personal routines of residents and conveyed that a person centred approach was adopted. Regular activities included arm chair exercises, puzzles, bingo, visits to the wellbeing suite, arts and crafts and film nights. There were a mix of group and individual sessions. The activity programme was reviewed regularly to ensure that the programme was relevant to residents' past lives and interests. The weekly programme included evenings and weekends. The inspector observed that some residents were spending time in their own rooms, and enjoyed reading and watching television, or taking a nap. Other residents were seen to be spending time in the communal areas of the centre. Newspapers and magazines were available and the inspector saw some staff reading to residents.

There was evidence that residents and relatives were involved and included in decisions about the organisation of the centre. There was a residents' forum which met regularly. An improvement from the completion of the provider's pre-inspection questionnaire resulted in improved noticeboards which provided a variety of information to residents and visitors. An external advocacy service was available to residents.

Judgment:

Compliant

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A policy/procedure was in place regarding the management of complaints and it met the requirements of the regulations. This procedure in leaflet format was on display. There was evidence from records and discussions with residents and relatives that complaints were managed in accordance with the policy. Issues recorded were found to be resolved locally or formally by the complaints officer as appropriate. A record of complaints was maintained. This outlined the investigation, action taken, whether the complaint was resolved or otherwise and whether the complainant was satisfied or not. Satisfaction surveys indicated that relatives found that management and staff were approachable if they had a complaint.

In January 2017 HIQA received unsolicited information. Primarily this was in relation to moving and handling techniques used by staff, residents being refused access to bedrooms, staff making residents go to bed early in the evening and using wedges to hold open fire doors.

An examination of the complaints record showed that the issue in relation to wedging open fire doors was highlighted to the management of the centre. A representative from

the company communicated with the complainant and explained that the fire safety officer had deemed the centre to be safe. The complainant was satisfied with the response.

The inspector reviewed the above matters and found that staff were well trained in moving and handling techniques and were able to use and operate equipment available such as sit to stand and full body hoists and handling belts. Moving and handling assessments had been complied for each resident and these were up to date and reflected resident's dependency and capacity to mobilise. The assessments indicated where hoist transfers were required and described the number of staff needed to undertake manoeuvres to ensure residents' safety. Equipment was noted to be in good condition and regularly serviced. The inspector saw residents freely moving around the centre and coming and going to their bedrooms throughout the day. Residents who communicated with the inspector confirmed that they could go to bed and get up at whatever time they wished. However, the inspector saw that at times throughout the inspection double doors to the main sitting room were wedged open. In the event of an emergency this may have a significantly impact on the safety of residents. See outcome 7 for action plan.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:

The numbers and skill mix of staff were sufficient to meet the needs of residents. There were two nurses on duty daily and this included the person in charge Monday to Friday. There were seven carers on duty up to 18:00 hours and this number included a senior healthcare assistant who allocated workloads and provided guidance to the care staff team. In the evening and early night from 18.00 to 22.00 hours an additional staff member was rostered to support the night duty complement of one nurse and two carers. Catering, household, administration, activity, maintenance and laundry staff complemented the team. The occupational therapist from the B-Fit team was available two days a week to support the care and nursing staff in the delivery of specific care programmes. The company are actively recruiting for a physiotherapist. Recruitment processes and a sample of documents in respect of persons working at the designated centre were reviewed and these were found to meet the requirements of Schedule 2 of the regulations. Volunteers were working in accordance with the regulation. There was a clear organisational structure and reporting relationships in place.

The company has a rolling training programme and the records showed that staff had participated in up to date mandatory training for example fire safety, moving and handling, responsive behaviours and safeguarding vulnerable persons. The staff also had access to a range of education appropriate to their roles and responsibilities, including dementia care, end of life care and restraint.

The inspector saw records of regular meetings at which operational and staffing issues were discussed. Copies of the regulations and standards were available and increasing staffs' knowledge was one of the improvements to be made following completion of the pre-inspection questionnaire.

Staff confirmed that they were supported by the provider and the person in charge to carry out their work. They were confident, well informed and knowledgeable of their roles, responsibilities and the standards regarding residents with dementia living in residential care. There was evidence of good teamwork and residents were complimentary of the care and support provided by the staff team.

Judgment:

Compliant

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

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

Findings:

The two matters arising from the previous inspection related to the risk management policy not having been reviewed and the replacement of stained/worn carpet in the corridor. The inspector found that the risk management policy had been reviewed and updated but carpeting had not been replaced but the inspector was informed that it had been ordered and would be fitted in the coming weeks.

The centre is a purpose built single storey residential care facility that can accommodate 43 residents. It is situated in a residential area. There was adequate private and communal accommodation. There are 33 single rooms and five twin rooms. All bedrooms have en-suite facilities of shower, wash hand basin and toilet with the exception of two single rooms. There are additional accessible shower/bathrooms and toilets located near communal rooms, a smoking room, kitchen, clinical room, storage areas, visitors' room and laundry area. There were locks on shower and toilets to ensure the privacy and dignity of residents was protected.

The centre is surrounded by large gardens and a "well-being" suite has been installed in

the grounds. This facility includes a massage chair and associated equipment for relaxation. It complements the "mens' shed" that is located in the grounds of the nearby sister centre. The well-being suite and outdoor garden and areas were well used during the inspection as the weather was sunny and bright. The grounds were laid out in lawns and were well maintained. Residents were accompanied when they used the garden as it is open to the driveway and car parking area which is a risk to residents who have sensory problems or who have dementia.

The inspector saw residents using communal facilities including the entrance hallway to congregate and meet visitors. Furnishings provided a homely atmosphere. Shared bedrooms provided screening to ensure privacy for personal care. Residents were supported to individualise their bedrooms with personal items. Grab rails were available to support residents to mobilise independently.

An on-going improvement and refurbishment plan was available for inspection. Areas identified for improvement since January 2018 up to the time of the inspection internally included re upholstery of some armchairs, the provision of new armchairs for the conservatory, decorating the walls, new curtains, development of a coffee dock in the visitors' room and the replacement of some fire extinguishers. Externally the resident walkway between the two centres was completed and shrubs were replanted.

From an examination of the premises the following matters were highlighted: –

- Skirting boards and doors required repair and painting.
- There was a lack of good signage which included objects and multiple cues and there was limited contrasting colours between the walls and the doors of the corridors to support residents to find their way around.
- There was no natural or sensory lighting in one of the corridors and the electric lights were switched off for a long period during the inspection so the area was dark for residents who were mobilising.
- There were no blinds/curtains on the conservatory.
- The dining room floor was chipped and worn and some dining room chairs required repair/replacement.
- A cement floor underneath carpet between rooms 32 and 35 was indented and carpet needed replacing.
- Some chairs in the sitting room were damaged and needed repair or replacement.
- All residents did not have a lockable storage space for the safekeeping of their personal valuables in their private space.
- The flooring in the ensuite of room 35 was split.
- Noise of stimuli was insufficiently controlled as the incoming telephone calls rang throughout the centre.
- Some grab rails were blocked by the hoists being stored on the corridor and linen trolleys left on the corridor as staff attended to residents.

The refurbishment programme provided identified some of the above issues and some matters were in progress.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The following issues in relation to evacuation procedures were identified: –

- At times throughout the inspection double doors to the main sitting room were wedged open. In the event of an emergency this may have a significantly impact on the safety of residents.
- The fire exit from the conservatory was blocked by furniture.
- The fire evacuation pathway from the main sitting room was blocked externally by the positioning of a wooden garden seat.
- Some of the fire plans were photocopies and were not very clear. Some did not identify the position “you are here”.
- There were two signs in the dining room indicating two exits from which you could evacuate, however, one was through the kitchen. The inspector was informed that simulated evacuations had not been carried out using this exit.

Infection prevention and control had not been fully addressed as towels, face cloths and a sling for the hoist were on open display in a communal bathroom/toilet.

Judgment:

Non Compliant - Moderate

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:

Siobhan Kennedy
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:	Brindley Manor Private Nursing Home
Centre ID:	OSV-0000323
Date of inspection:	29 and 30/05/2018
Date of response:	08/10/2018

Requirements

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

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

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

The following matters required to be addressed: –

- Carpets in the hallway were stained.
- Skirting boards and doors were chipped and required repair and painting.
- There was a lack of good signage which included objects and multiple cues and limited contrasting colours on the walls of the corridors and doors to support residents to find their way around.

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

- There was no natural or sensory lighting in one of the corridors and the electric lights were switched off for a long period during the inspection so the area was dark for residents who were mobilising.
- There were no blinds/curtains on the conservatory.
- The dining room floor was chipped and worn and some dining room chairs required repair/replacement.
- A cement floor underneath carpet between rooms 32 and 35 was indented and carpet needed replacing.
- Some chairs in the sitting room were damaged and needed repair or replacement.
- All residents did not have a lockable storage space for the safekeeping of their personal valuables in their private space.
- The flooring in the ensuite of room 35 was split.
- Noise of stimuli was insufficiently controlled as the incoming telephone calls rang throughout the centre.
- Some grab rails were blocked by the hoists being stored on the corridor and linen trolleys left on the corridor as staff attended to

1. Action Required:

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

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

S1 - The carpet in the hallway has been replaced.

M1 – The carpet in the hallway has been replaced.

A1 – Achieved

R1 – Realistic and advised to inspector on day of inspection.

T1 – Completed 21st June 2018

S2 – Painting of skirting boards and doors are part of ongoing maintenance.

M2 – Painting of skirting boards and doors where required was identified as a component in the refurbishment plan given to the inspector at the time of inspection. This will be audited by the Director of Nursing and the maintenance team.

A2 - Achievable

R2 – Realistic

T2 – 30th September 2018.

S3 – Signage, objects and wall colours will be reviewed by our GEM's Trainer and adjusted accordingly.

M3 – A review and consultation of Brindley Healthcare's GEM's Trainer onsite will identify the appropriate research based cues to be installed by the maintenance team.

A3 - Achievable

R3 – Realistic

T3 – 31st October 2018.

S4 – Replacement of a Velux roof lighting which became opaque due to intense sunlight

M4 – Replacement of the roof light by the maintenance team.

A4 – Achievable

R4 – Realistic.

T4 – 30th September 2018.

S5 – Curtain placement on new conservatory windows. As was explained at inspection, the curtains were on order and have since been erected.

M5 – Curtains were delivered and are in place.

A5 – Achieved.

R5 – Realistic.

T5- Completed 8th June 2018.

S6 – Review and refurbish dining room flooring and seating as required and identified on the refurbishment plan as shown to the inspectors during inspection.

M6 – Flooring and seating will be reviewed by the Director of Nursing and will be replaced as required by the maintenance team.

A6 – Achievable.

R6 – Realistic.

T6 – 30th October 2018

S7 – The area of floor has been smoothed and the carpet replaced by the maintenance team.

M7 – The floor has been smoothed and the carpet replaced by the maintenance team.

A7 – Achieved

R7 – Realistic.

T7 – 21st June 2018

S8 – As noted on the refurbishment plan given to inspectors during inspection, a review of and replacement where necessary of some seating in the sitting room will be completed.

M8 – Review by the Director of Nursing and replacement by the maintenance team of certain seating in the sitting room where necessary.

A8 – Achievable

R8 – Realistic

T8 – 30th September 2018

S9 – Review and installation of additional locks to personal storage areas where required.

M9 – Personal storage areas will be audited by the Director of Nursing and the maintenance team and locks will be installed where required.

A9 – Achievable.

R9 – Realistic.

T9 – 30th October 2018.

S10 – Flooring review of one ensuite and replacement where necessary.

M10 – Flooring of one ensuite will be reviewed by the Director of Nursing and the maintenance team and replaced where necessary.

A10 – Achievable

R10 – Realistic

T10 – 30th October 2018.

S11 – Reduction of telephone call stimuli throughout the centre.

M11 – It is important that calls from medical professionals and families can be heard by staff on duty, however in light of the inspector’s opinion, the telephone volume has been reduced from level 8 to level 4. This will be monitored by the Director of Nursing.

A11 – Achievable.

R11 – Realistic.

T11 – 30th August 2018

S12 – Linen trolleys and hoists are appropriately stored.

M12 – Following a review by the Director of Nursing, staff have been re-educated to store equipment appropriately after use and this will be monitored.

A12 – Achievable.

R12 – Realistic.

T12 – 30th August 2018.

Proposed Timescale: 31/10/2018

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

Infection prevention and control had not been fully addressed as towels, face cloths and a sling for the hoist were on open display in a communal bathroom/toilet.

2. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

S – Manual handling equipment including towelling is now stored appropriately.

M – Manual handling equipment including towelling is now stored appropriately. Staff have been re-educated regarding the appropriate storage of these items and the Director of Nursing will monitor same.

A – Achieved

R - Realistic

T – 31st July 2018

Proposed Timescale: 31/07/2018

Theme:

Safe care and support

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

The following issues in relation to evacuation procedures were identified: –

- At times throughout the inspection double doors to the main sitting room were wedged open. In the event of an emergency this may have a significantly impact on the safety of residents.
- The fire exit from the conservatory was blocked by furniture.
- The fire evacuation pathway from the main sitting room was blocked externally by the positioning of a wooden garden seat.
- Some of the fire plans were photocopies and were not very clear. Some did not identify the position "you are here".
- There were two signs in the dining room indicating two exits from which you could evacuate, however, one was through the kitchen. Simulated evacuations had not been carried out using this exit.

3. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

S1- Installation of a sound activated closer to the double doors to the sitting room which will release upon fire alarm activation.

M1 – Installation of the specialist door closer by the maintenance team.

A1 – Achieved

R1 - Realistic

T1 – 30th June 2018

S2 – The armchair which was placed by a visitor obscuring a fire exit was removed. Signage has been erected reminding visitors of the importance of same.

M2 – The armchair was appropriately placed and the sign erected.

A2 – Achieved.

R2 - Realistic

T2 – 31st July 2018.

S3 – The wooden garden seat which had been moved towards a fire exit by a family member was removed upon identification on the second day of inspection.

M3 – Ongoing monitoring of unobstructed fire exits has been reiterated to staff by the Director of Nursing.

A3 - Achievable

R3 - Realistic

T3 – Complete 30th May 2018.

S4 – Further updating of some fire plans with clearer identification of an individuals location.

M4 – A review of all fire plan signs and appropriate updating will be completed with the Director of Nursing and the maintenance team.

A4 - Achievable
R4 – Realistic
T4 – 30th October 2018.

S5 - Fire evacuation procedures from the dining room will be reiterated to all staff and updated at all fire trainings onsite. Appropriate simulated evacuations will continue to take place.

M5 – The Director of Nursing and the Fire Warden Trainer will speak with all staff in relation to dining room evacuation as all staff trained onsite are fire wardens.

A5 - Achievable
R5 - Realistic
T5 – 31st August 2018

Proposed Timescale: 30/10/2018