

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	New Lodge Nursing Home
Centre ID:	OSV-0000073
Centre address:	Stocking Lane, Rathfarnham, Dublin 16.
Telephone number:	01 495 0021
Email address:	info@bloomfield.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Bloomfield Care Centre Limited
Provider Nominee:	Damien O'Dowd
Lead inspector:	Helen Lindsey
Support inspector(s):	Shane Walsh
Type of inspection	Unannounced
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. 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:
05 July 2017 19:30	05 July 2017 20:30
06 July 2017 09:00	06 July 2017 17:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This monitoring inspection was unannounced and took place over two days. On the first day two inspectors arrived in the evening to review practice in the centre, and then one inspector completed the inspection the following day.

On the day of the inspection there was a good level of compliance with regulations inspected from the Health Act 2007 (Care and welfare for Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Significant improvements had been made from the last inspection, but two actions remained outstanding.

As part of this inspection, the inspector met with residents, relatives and staff members. They observed practices and reviewed documentation such as care plans, audits, management meeting minutes and policies and procedures. They also met the person in charge and assistant person in charge who were able to provide clear information to the inspector when requested.

During the inspection staffing levels were seen to meet the needs of residents. It was reported that staffing levels had been lower for a period of time, but following feedback from staff and families staffing levels and supervision had increased. There was ongoing recruitment to ensure all vacancies were covered to ensure the use of agency staff continued to reduce. All staff had received relevant staff training including fire safety and protection of vulnerable adults. Residents who spoke with inspectors confirmed they felt safe in the centre.

There was evidence residents had good access to healthcare to meet their identified needs, and that the staff team was responsive to their changing needs. Assessments of care needs were carried out prior to admission, and care was seen to be provided as described in care plans for residents specific needs.

There was a clear management framework in place that worked to ensure the quality of the service provided was maintained. The centre was sufficiently resourced to meet the needs of the residents. A new person in charge and assistant had been appointed and were putting a plan in place to address improvements required in the centre.

Three areas for improvement were identified in relation to complaints, care planning records and safe fire practice in relation to bedroom doors. This is discussed further in the body of the report and the action required is included in the action plan at the end

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 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

There was a clearly defined management structure that identified the lines of accountability.

The person in charge was new to the service having joined the team about two months before the inspection. They were supported in their role by an assistant person in charge.

There were both formal and informal systems in place in the centre to ensure that the service provided was safe, and met the needs of the residents. Improvements had been made since the previous inspection to ensure there was clear oversight of the designated centre, rather than a focus on the whole service on the campus

There were monthly management meetings, and minutes seen by inspectors showed that they covered topics such as complaints, recruitment, risk management, staff development and care planning. This meeting was specific to the designated centre. There continued to be meetings covering all the services provided on the campus related to quality assurance. The risk register had been reviewed and updated prior to the inspection, and was monitored during the management meetings. Evidence was seen that actions had been taken to make improvements, for example improved governance and management arrangements and fire safety arrangements since the previous inspection. The provider had also met with relatives of people in the centre and made improvements to address their concerns, as described in outcome 18.

There were also other meetings that focused on different areas of practice for example a clinical risk subcommittee who reviewed issues such as medication errors, incidents, falls, and safeguarding. It was noted that areas identified as requiring improvement are in line with the findings of the inspection, for example training being needed for writing

care plans.

There were identified leads in the service for areas such as finance, recruitment and facilities. They all sat on the management meeting, and were responsible for any changes that needed to be implemented.

The senior team in the centre carried out audits and collated data on clinical issues such as the number of falls, number of residents with pressure sores, and residents using psychotropic medication. The audits and data were then reviewed to see if action was required to improve nursing practice in the centre. The new person in charge was in the process of formulating an action plan to address any areas identified.

Inspectors reviewed a number of audits that had been undertaken of areas such as patient clothing, a general health audit and care of the dying. The audits supported the management team to ensure the service was being run in line with the operational policies and identify areas for improvement.

There was a resident's forum in the centre and meetings took place every few months. They discussed a range of topics and were guided by the residents. In the last meetings residents gave feedback on catering, the redevelopment of the quiet room, outings and activities and staffing issues. The provider and person in charge were reviewing the format of the meeting and seeking to involve more relatives to advocate on behalf of residents who were less able to express their views.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge had been in place for approximately two months at the time of the inspection. They had the relevant skills and qualifications to undertake the role and were seen to be identifying areas for improvement and putting plans in place to ensure improvement occurred.

There was a deputy to the person in charge who covered in their absence.

Judgment:

Compliant

***Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

Theme:

Safe care and support

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

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

Findings:

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

There was a policy in place which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The staff had received training on identifying and responding to elder abuse, and those spoken with during the inspection were clear of what action to take if they witnessed or had abuse reported to them. Residents spoken with during the inspection said they felt safe in the centre, with staff around at all times to call on if needed.

Some residents with responsive behaviour were being supported in the centre. Staff had received training in supporting residents with dementia and were also guided by a policy developed by the provider. The policy provided clear guidance on 'managing behavioural and psychological symptoms of dementia' and provided useful information on signs or residents requiring support and the different approaches available, for example person centred strategies. There were care plans in place for residents, but they did not follow the format set out in the guidance. The action for this is included under outcome 11.

Progress was being made in working towards a restraint free environment and the use of restrictive practice was lower than at previous inspections. A review of resident's records showed that a multidisciplinary team was in place to consider any applications for restrictions such as bed rails or bracelet monitoring device for residents at risk of leaving the premises without appropriate supervision. They considered what alternatives had been trialled and the residents view in the decision making process. Risk assessments had been completed, and records showed regular checks were carried out when they were being used. A number of residents were using low beds, sensor alarms and soft mats to reduce the use of bed rails in the centre.

The provider was appointed pension agent for some residents who were unable to manage their affairs. The arrangements were seen to be in line with the guidance from Department of Social protection in that the money went in to a patient account. The account showed clearly who the funds in the account belonged to and an invoice could

be made available on request. They did not hold any cash for residents. Where residents were making use of services in the centre, such as hairdressing, the centre paid and then invoiced the resident for the amount due.

Judgment:

Compliant

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

Theme:

Safe care and support

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

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

Findings:

The health and safety of residents, visitors and staff was promoted in the centre. However, the practice of leaving a section of the bedroom doors open required review.

Significant improvement had been made in relation to fire practice in the centre in the centre since the last inspection and all actions had been met.

Since the last inspection the fire detection system had been replaced in the whole building that had resulted in a renumbering of all the rooms in the designated centre for clarity. Maps were available in the centre clearly stating the exit routes to follow. There was also a new phone system, with all members of staff carrying a handset that would alert them if there was a fire and the exact location of the fire using the room or area number for ease of location. The phone system was also used for medical emergencies and more general contact between staff members.

The policy and associated procedures had been updated with the new practice. Staff spoken with were very clear of the system for alerting them of a fire and the approach to take. The policy set out a horizontal evacuation plan, and this was described clearly by the staff. A review of training records showed all staff had completed fire training or were attending refresher training within two weeks of the inspection.

Fire drills were taking place in the centre to help evaluate the centres evacuation procedures. The record showed the method used, the staff involved, the effectiveness of the drill and any lessons learned. There was also a weekly test in the centre which included all the doors and alarms functioned correctly.

There was a record of the level of assistance each resident would require if an evacuation was required.

One area in relation to fire safety required review. The bedroom doors were designed

with a main door and a narrow panel that could be opened if a bed or wide wheelchair needed to pass through. During both days of the inspection it was noted that practice was to have the main door closed and to leave the narrow panel open while the main part of the door was shut. In the event of a fire the narrow panel would not automatically close and so the door would not provide protection from fire or smoke. The policy did say staff had to close doors, and they confirmed they knew to do this. However, this practice could pose a risk to residents and needs to be appropriately assessed.

The fire alarm was serviced on a quarterly basis and fire equipment was serviced annually, for example the emergency lighting. Certificates were available and recorded the findings and any actions taken to rectify any faults or issues identified.

In relation to other areas of practice there was a Health and Safety statement and emergency plan for procedures to follow in the event of a fire, gas leak, flood or power failure.

The centre maintained a policy on risk management and this included all the risk areas identified in the regulations. There was a centre-specific risk register that identified the hazards associated with the centre and included risks such as trips and slips, and missing persons. All risks had the hazard identified, a risk rating applied, any actions taken to reduce the risk and the person responsible for carrying out the actions.

Incidents and accidents were recorded and then reviewed during management meetings to identify if there were any trends or actions required to reduce known risks in the centre.

There was a detailed policy on infection control, and staff were seen to be putting the procedures in to practice. There was an adequate amount of sanitising hand gel dispensers in the corridors and lobby. The household staff had received training in infection control and were observed changing personal protective equipment such as gloves when moving between rooms.

Judgment:

Substantially Compliant

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

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

Findings:

The residents were protected by staff practice that followed policies and procedures for medicine management.

The inspector reviewed a sample of completed prescription and administration records with the nursing staff which were found to be complete. They included a picture of the resident, the medications prescribed, and signatures of the nurse who administered the medication. The 'PRN' or 'as required' medicines prescribed had the maximum dose in a 24 hours period clearly stated, and where a medication was to be crushed, this was also clearly recorded.

Nursing staff were observed administering medication and seen to be following national guidelines. They were able to describe the arrangements for accepting and checking deliveries of medication. They also described the process for returning out of date and spoilt medication, including controlled medications. They were also knowledgeable of the policy and professional guidelines in relation to this area of practice. Care plan should provide clear information about how residents' needs are to be met, and with regular use of agency staff it is important they can get clear direction on how to support each resident.

Controlled medications were appropriately managed and were kept in a secure double locked cabinet in keeping with professional guidelines. Nurses kept a register of controlled medication. The stock balance was checked and signed by two nurses at the change of each shift. The inspector checked the balance of a sample of medicine and found it to be correct.

Temperature controlled medicines were stored in a refrigerator in a locked store room. The temperature was monitored and checked daily by the nursing staff, and a record of the check was maintained.

Records showed that three-monthly reviews of residents' medicines were carried out. The general practitioner (GP) and pharmacist in the centre completed a review for each resident. Evidence was seen that medications were reduced or stopped where they were no longer required and the interactions of medications were also considered with alternatives prescribed if there were any indications to do so.

There was also an audit of medication management in the centre. The recent report found high levels of compliance with national standards.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

Resident's health and social care needs were identified at the point of admission and processes were in place to ensure they were met. However improvement was needed to ensure clear and consistent guidance was provided in resident's records and care plans to ensure good outcomes for residents.

Inspectors reviewed a sample of residents' care plans and medical files. There was a pre-admission assessment completed prior to offering a resident a place in the centre. A range of assessments were completed on admission and the assessment tools used reflected evidence based practice.

Care plans were developed for all identified care needs. Some examples were seen where they were individual to the resident and provided clear instruction to staff on how to support them. However other examples were seen where the guidance was made up of general statements and were not linked to the resident's preferences and routines. For example 'give reassurance and re-direction' without an explanation of what that would be for that individual resident.

There was evidence that residents and families were involved in the review of residents needs, and were able to speak to the multidisciplinary team who carried out a review every four months. Inspectors saw that care plans were reviewed on an ongoing basis at least every four months and more often if there was a change in a resident's condition

Some care plans reflected the advice of allied professionals, however examples were seen where advice or recommendations had not been followed up, for example a dietician had recommended supplements be considered for a resident, but on the next visit noted this had not been progressed with the GP and so made the recommendation again.

Records were maintained of referrals to other specialists support services which included speech and language therapy, chiropody, dietetics and an optician. There was a physiotherapist available in the centre, and they lead work on reviewing falls and approaches to reduce their frequency and seriousness. There was also access to psychology and psychiatry support on the campus as required for residents.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available. This included where residents were attending appointment at local clinics or with consultants.

An observation of the nurse hand over provided evidence that each resident was being monitored for changes in their presentation and action was taken swiftly where changes were identified. For example requests for the general practitioner to visit, and out of hours doctor if the residents need required it.

The inspector followed up arrangements in place for catheter care and management of PEG feeding tubes as they were highlighted as requiring improvement at the last inspection. There was improvement and examples were seen where care plans were very clear about equipment, management, cleaning and replacements. However one example was seen where guidance varied between documents and the recording of the delivery of the intervention.

Judgment:

Substantially Compliant

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

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

Findings:

The previous inspection noted that the complaint log did not consistently detail if the complainant had been informed of the outcome of the complaint.

This was reviewed during this inspection and the same gap was identified. It was noted that the template used did not have a designated space, but the person representing the provider confirmed that they would be checking that this information is included prior to signing them off in future.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing

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

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

Theme:

Workforce

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

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

Findings:

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

At the time of the inspection the staffing levels were seen to take in to account the layout of the centre and the needs of the residents. It was reported to inspectors that there had been some changes to the standard roster as a shift in the evening had been removed and then reinstated after feedback was received it was having a negative impact on the care being delivered to the residents. Staff, residents and relatives were satisfied with the levels as they were at the time of the inspection and felt that residents needs were being met.

The person in charge and the assistant person in charge were supernumerary to the staffing roster. There was a person nominated in charge of each shift, and they were broken down in to three teams. Nursing staff were on duty at all times, supported by healthcare assistants and household staff.

A recruitment drive had lead to a number of staff taking up post in the few weeks prior to the inspection, and more were due to commence in the following weeks. The staff spoken with said the induction had been of a good standard and they felt supported in their role in the centre.

The recruitment of staff had lead to a reduction in the use of agency staff, with the aim to reduce it further in the coming weeks. Where agency staff were used the management team said they tried to get staff who were familiar with the centre to ensure continuity for the residents. The provider had confirmation from the agencies used that staff had undergone thorough recruitment checks including getting a garda vetting disclosure.

There were effective recruitment procedures in place in the centre. Staff files of the four most recent recruits were reviewed. All of these staff files contained the requirements as per Schedule 2 of the regulations. All nurses employed in the centre were registered with the Nursing and Midwifery Board of Ireland. The provider confirmed all staff had garda vetting in place.

All volunteers working in the centre had appropriate checks, including garda vetting prior to commencing their role in the centre.

Records showed that all staff had completed 'fire safety training' and 'protecting residents from elder abuse'. Some staff were booked on refresher training to be completed in the coming weeks. New staff confirmed they were completing and induction covering the needs of residents and the policies and procedures to be followed in the centre. Other training offered included basic life support, children first and safeguarding vulnerable adults, dementia care, falls prevention, infection prevention and control, manual handling, managing violence and aggression, and nutrition. Staff who spoke with the inspector confirmed they had completed all the training required by the provider and through discussion with the inspectors showed they could put their learning in to practice.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	New Lodge Nursing Home
Centre ID:	OSV-0000073
Date of inspection:	05 & 06/07/2017
Date of response:	31/07/2017

Requirements

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

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

Outcome 08: 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:

The practice of part of bedroom doors being left open required review to ensure their ability to contain fire was not compromised.

1. Action Required:

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

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

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

A review will be conducted to ascertain the Fire Safety of the practice whereby part of bedroom doors are left open.

Proposed Timescale: 30/11/2017

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:

Care plans were not consistently developed to provide information to guide practice.

2. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

A programme of education and review will be undertaken to assist in the development of consistency in careplans.

Proposed Timescale: 30/11/2017

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 complaint log did not consistently detail if the complainant had been informed of the outcome of the complaint.

3. Action Required:

Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

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

The complaint log book has been reviewed and a new layout to include the complainant being informed of the outcome of the complaint will now be included.

Proposed Timescale: 30/08/2017

